State of Wisconsin

SENATE CHAIR
Alberta Darling

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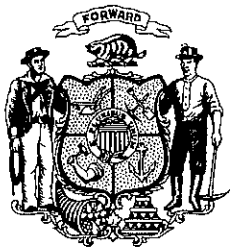

ASSEMBLY CHAIR
John Nygren

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Joint Committee on Finance

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative John Nygren

Date: April 20, 2020

Re: 14-Day Passive Review Approval – DHS

Pursuant to s. 20.940(4), Stats., attached is a 14-day passive review request from the Department of Health Services, received on April 20, 2020.

Please review the material and notify **Senator Darling** or **Representative Nygren** no later than **Thursday, May 7, 2020,** if you have any concerns about the request or if you would like the Committee to meet formally to consider it.

Also, please contact us if you need further information.

Attachments

AD:JN:jm

State of Wisconsin
Department of Health Services
Tony Evers, Governor
Andrea Palm, Secretary

April 18, 2020

APR 2 0 2020
Jt. Finance

The Honorable Alberta Darling, Senate Co-Chair
Joint Committee on Finance
Room 317 East
State Capitol
P.O. Box 7882
Madison, WI 53707

The Honorable John Nygren, Assembly Co-Chair
Joint Committee on Finance
Room 309 East
State Capitol
P.O. Box 8953
Madison, WI 53708

Dear Senator Darling and Representative Nygren:

Per s. 20.940(4), created by 2017 Act 370, I am submitting the proposed federal waiver renewal requests for the Include, Respect, I Self-Direct (IRIS) 1915(c) community-based services waiver.

The expiration date of the current waiver is December 31, 2020. Prior to submission of the renewal requests to the Centers for Medicare and Medicaid Services (CMS), DHS must also provide public notice, offer a period for public comment on the proposed renewal, and engage in tribal consultation. It will take up to three months to receive and evaluate these comments.

DHS must submit the renewal request to CMS no later than 90 days prior to expiration, or October 2, 2020. However, CMS recommends submission of the renewal request 120 days prior to expiration to allow sufficient time for CMS to complete its review. It is our goal to follow this recommendation and submit the waiver to CMS on September 2, 2020.

The IRIS program provides self-directed long-term care services and supports to over 20,700 of Wisconsin's most vulnerable adults with physical and developmental disabilities and our frail elders. The daily supports the program provides are critical to allowing enrollees to continue living independently in their homes and communities. Given the crucial role of this program, it is very important to receive federal approval prior to the current waiver expiration date.
The 1915(c) waiver renewal includes the following changes to the current waiver:

- Revises and clarifies the Quality Improvement Strategy (QIS) to reflect the IRIS waiver quality strategy, policies, and processes currently in place.
- Restructures the IRIS Consultant Agency (ICA) and Fiscal Employer Agent (FEA) Monthly Rate of Service (MROS) methodology to more accurately reflect program operational costs, including both fixed and variable costs.
- Changes the process for distribution of the participant's monthly budget. Under the revised waiver, the monthly budget allocation will be provided by the ICA, rather than by the Aging and Disability Resource Center (ADRC) during options counseling, to ensure consistent options counseling across all adult long term care programs.
- Expands the role of the ICA to include the responsibility of assisting participants in maintaining eligibility for Medicaid and long-term care services.
- Improves standardization of IRIS service rates by establishing ranges for per unit or per participant monthly waiver service rates based on actual historical costs, adjusted for considerations such as geographic variation and cost trends.
- Changes the FEA selection process; under the revised waiver, participants will select both an ICA and FEA during options counseling at the ADRC. The current practice is to select an ICA during options counseling and an FEA following enrollment. This change streamlines the participant enrollment experience.
- Divides the Assistive Technology/Communication Aids/Interpreter Services service into several discrete services. This change assists participants in identifying the appropriate service to meet their needs and provides uniformity in service claims.
- Combines service categories for the '3-4 Bed Adult Family Home' and 'Residential Care Apartment Complex' services to clarify and focus on service provision, rather than service providers.
- Improves standardization of the participant room and board financial obligation determination process by requiring use of a consistent methodology. The updated process aligns with other adult long term care programs.
- Clarifies the roles and responsibilities of the ICAs.
- Clarifies entities responsible for reporting and identifies the agencies responsible for investigating critical incidents of abuse, neglect, and exploitation.

In addition, the 1915(c) renewal application includes updates to clarify language and realign the waiver with current practice. Please contact me if you have any questions about this submission.

Sincerely,

Andrea Palm
Secretary-designee

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 waivers 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:

Appendix C1/C3 - Assistive Technology/Communication Aids/Interpreter Services service disaggregated into several other discrete services (Assistive Technology and Interpreter Services). Adaptive Aids service coverage is now provided under the Assistive Technology service.

Appendix C1/C3 - ICAs will now provide participants with their IRIS Individual Budget Allocation (IBA) and also maintain participant long-term care and Medicaid eligibility.

Appendix C1/C3 - 1-2 Bed Adult Family Home service renamed to Residential Services (1-2 Bed AFH).

Appendix C1/C3 - 3-4 Bed Adult Family Home and Residential Care Apartment Complex services were combined and renamed to Residential Services (Other).

Appendix C1/C3 - Community Involvement Support consists of a combination of services that were previously covered under Supportive Home Care and Counseling and Therapeutic Services.

Appendix C1/C3 - Customized Goods and Services renamed to Individual Directed Goods and Services.

Appendix I.2.a - Updated ICA and FEA Monthly Rate of Service (MROS) methodology.

Appendix I.2.a - Established per unit or per participant per month rate ranges for waiver services based on actual historical costs, adjusted as necessary for considerations such as geographic variation and cost trends.

Appendix I.5 - Defines one consistent methodology to determine participant room and board financial obligation to be used by all relevant providers.

Appendix G.1 - For reportable critical incidents, clarifies entities responsible for reporting and identifies the agencies responsible for investigating critical incidents of abuse, neglect, and exploitation.

Appendix H - Revised and clarified Quality Improvement Strategy (QIS) to reflect the current updated waiver quality strategy, policies, and processes.

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*):

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

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **WI.004.03.00**

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

Regular Waiver

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

01/01/21

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 (Include, Respect, I Self-Direct) waiver is intended to provide persons with an ICF-IID level of care or nursing home level of care with a 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 participants the choice of a fully self-directed Medicaid home and community-based services (HCBS) waiver.

The IRIS program is operational statewide. The following process exemplifies the roles of the entities that support participants as well as the opportunities the participant has to self-direct during his or her time in the program:

All prospective IRIS program participants receive unbiased enrollment options counseling from the Aging and Disability Resource Centers (ADRC) at which the participant receives information in order that the participant may make an informed choice of long-term care program.

After selecting the IRIS program, the participant receives information about available IRIS Consultant Agencies (ICA) and Fiscal Employer Agents (FEA) from which they can choose. The ICA and FEA provides the participant with information and assistance with self-direction and financial management services, respectively.

Participants then meet with their chosen ICA to receive program orientation information, assistance with creating the participant's Individual Support and Service Plan (ISSP), and provided with their IRIS Individual Budget Allocation (IBA) amount.

The IRIS participant and/or legal representative receives information and individualized assistance from the chosen ICA. The amount of ongoing support from the ICA varies based upon the participant's needs, but at a minimum, the ICA effectively assures the participant's health and safety and that the participant's needs are assessed, outcomes developed, and services and supports coordinated to address assessed needs and associated outcomes.

FEAs support the participant by completing payroll functions, maintaining provider agreements for participant-hired workers, and ensuring tax and 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 SMA's encounter data system.

Once the ISSP has been developed, the IRIS Consultant reviews the ISSP to ensure that it is consistent with the waiver-allowable services and supports and addresses assessed long-term care needs and outcomes, including health and safety of the participant. All IRIS participants, with support from the IRIS Consultant, make arrangements to purchase needed services and supports, consistent with the ISSP, from service providers. When participants exercise employer authority, they recruit, hire, train, monitor, and discipline (when necessary) their own workers. Participants also 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). This includes ensuring protections of minimum wage and overtime regulations for direct care workers. The information in the approved ISSP is conveyed by the IRIS Consultant to the FEA by way of the SMA's case management system (WISITS).

The State Medicaid Agency facilitates an IRIS Advisory Committee that advises on policy-related issues as it pertains to the administration of the IRIS program. Committee members are individuals who have relevant knowledge, experience, expertise, and community relationships that allow them to present ideas, opinions, or facts for the betterment of the IRIS program.

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:

☐ **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:

In April 2019, the SMA extended an invitation to all of its stakeholders (contracted ICAs, FEAs, tribes, members of the long-term care community, advocates, providers, etc.) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received numerous submissions and conducted extensive review of the submissions.

Major Wisconsin newspapers contained public notices on 5/29/2020 that the draft IRIS (Include, Respect, I Self-Direct) 1915(c) waiver renewal applications was available on the SMA's website for a 30-day public input period, at https://www.dhs.wisconsin.gov/iris/whatsnew.htm. The draft IRIS (Include, Respect, I Self-Direct) 1915(c) waiver renewal applications was posted for a 30-day public input period. The public input period ended July 1, 2020. As described in the newspaper publications, members of the public could request paper copies of the waiver renewal applications by sending an email request to DHSLTCComments@dhs.wisconsin.gov or mailing a request to Attn: IRIS (Include, Respect, I Self-Direct) 1915(c) Waiver Renewal, PO Box 309, Madison, WI 53701-0309.

Wisconsin tribes received written notice that the draft IRIS (Include, Respect, I Self-Direct) waiver renewal application was available on the SMA's website for a 30-day tribal input period on 5/29/20. The SMA also provided in person tribal consultation on (TBD) at the Mid-Year Tribal Consultation Meeting and on (5/13/2020) at the Tribal Health Directors Meeting. The written notice, agendas, and meeting notes are included with this waiver renewal submission.

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

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

7. Contact Person(s)

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

Last Name: Chartier

First Name: Amy

Title: Section Chief, IRIS Management Section

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

Address: One West Wilson Street, Room 518

Address 2: P.O. Box 309

City: Madison

State: **Wisconsin**

Zip:

53707-7851

Phone:

(608) 267-7205 **Ext:** ☐ **TTY**

Fax:

(608) 266-5629

E-mail:

Amy.Chartier@dhs.wisconsin.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This application 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.

All portions of the Wisconsin Statewide Transition Plan apply to the IRIS waiver #0484.

The State assures that this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

ANALYSIS OF IRIS WAIVER RENEWAL PUBLIC COMMENT

PUBLIC COMMENT PERIOD: TBD – TBD, 2020

STATISTICS:

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 Medicaid Services

(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:

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

Appendix A: Waiver Administration and Operation

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

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

Aging and Disability Resource Centers (ADRCs) (independent public entities):
1) Provide information and assistance;
2) Provide preadmission pre-enrollment options counseling;
3) Conduct level of care evaluation activities using the SMA's automated long term care functional screen;
4) Coordinate other program eligibility activities on behalf of the SMA; and
5) Carry out prevention and community outreach activities.

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

MetaStar (complaints, grievance, and program oversight):
1) Document, track, and resolve all participant complaints;
2) Staff, train, and provide a direct hotline for participant complaints;
3) Provide data and reports to SMA;
4) Additional Oversight functions (elaborate before final draft)

WPS Call Center (customer service information and participant assistance):
1) Facilitate participant inquiries, including providing referrals to the appropriate contractors (i.e. ICAs, FEAs, ADRCs, Ombudsman, etc.);
2) Maintain comprehensive contact management tracking system used to manage calls and other inquiries;
3) When necessary, communicate with ICAs and FEAs to address participant concerns; and
4) Document the contact with the participant in the SMA case management system.

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

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

○ **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:

   DHS Division of Medicaid Services (DMS)

Appendix A: Waiver Administration and Operation

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

The State Medicaid Agency (SMA) assures contracted entities adhere to policies and procedures through multiple oversight methods. Accordingly, methods used to assess performance vary by agency type:
1) Complaint and grievance hotline – The SMA contracts with MetaStar to provide program oversight. Additionally, MetaStar facilitates a complaint and grievance hotline through which participants can report concerns and if necessary, request SMA review.

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

3) Aging and Disability Resource Centers (ADRCs) - ADRCs disseminate information regarding the waiver to potential participants; review options counseling materials annually; assist individuals in waiver enrollment; monitor enrollment processes on an ongoing basis; review grievances and appeals quarterly; and conduct level of care evaluation activities.
a) The SMA provides ADRCs with unbiased, person-centered enrollment counseling materials that meet CMS requirements for readability, availability in prevalent languages, and annual updates. The enrollment process is monitored regularly via an enrollment plan and documentation that outlines the roles, responsibilities, and processes for eligibility and enrollment. The SMA provides ADRC oversight and directs quality improvement activities. The SMA also provides technical assistance and oversight for adherence to documented procedures. Quality of ADRC services for determination of functional eligibility, facilitation of the financial eligibility process, and enrollment is ensured by ongoing ADRC training both in-person and online.
b) ADRC governing boards review grievances and appeals. A statewide grievance and appeal policy is followed to resolve complaints and to inform individuals of their appeal rights. Additionally, the SMA can access ADRC client tracking databases for quality assurance reviews and independent investigations of complaints and grievances.
c) The SMA conducts quality reviews of level of care evaluations using the automated Long Term Care Functional Screen on an ongoing basis and provides feedback and remediation, if necessary. Certified screener continuing knowledge and skills are tested at a minimum of every two years. The SMA offers functional screen administration trainings to ADRCs multiple times per year, conducts quarterly screen liaison calls, and provides screen reviews upon request.
d) ADRCs operate under a contract with the SMA. They submit periodic reports to the SMA regarding information and assistance functions and monthly expenditures. ADRCs also submit annual narrative reports. On-site reviews are conducted annually by the SMA. ADRC customers are surveyed via a neutral third party evaluator to evaluate their options and enrollment counseling experience.

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

Additionally, the SMA-Ombudsman contract requires a quarterly report to the SMA on the performance expectations and requires the Ombudsman to perform the following quality assurance activities:
a) Distribute an annual recipient survey to individuals it has assisted to measure consumer satisfaction with the Ombudsman's service and report results to the SMA. If the results are unsatisfactory, the SMA can require a corrective action plan;
b) Participate in and present data at meetings upon SMA request; and
c) Conduct ongoing internal quality assurance activities, including:
i. Regular supervisory case progress reviews;
ii. Monthly team case rounds;
iii. Annual supervisory file reviews;
iv. Annual performance reviews of all staff.

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

5) Other performance issues may be reported by agencies that provide advocacy services.

6) SMA oversight of TADRS includes: SMA Regional quality specialists are centrally located to tribes; SMA screen liaison for TADRS that provide the long-term care functional screen; SMA performs desk reviews to ensure consistency & accuracy; SMA ongoing technical assistance regarding matters associated with the TADRS scope of work, including functional screen; & regional, on demand, & in-person trainings for TADRS.

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 States quality improvement strategy, provide information in the following fields to detail the States 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:
ICAs must complete all Record Review remediation timely. Numerator/Denominator: Number of participant records that were remediated timely over Number of participant records reviewed.

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

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

	Specify:	

Data Aggregation and Analysis:

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

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

To ensure waiver and program compliance by contracted ICAs and FEAs, the SMA developed performance indicators that aligns with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures. Contractor oversight operations also provide valuable discovery information.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

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

Annually, the SMA conducts the "Contractor Recertification Site Visit" with each contractor. Following the site visit, the SMA provides the contractor with the outcome of the Annual Recertification Visit.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The site visits also seeks to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA's Program Oversight Tracking document.

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

ii. Remediation Data Aggregation

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

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

Participants in the physical disabilities target subgroup who reach the age of 65 while participating in this waiver are considered to be part of the Aged target group. No other change occurs for the participant.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	27175
Year 2	29376
Year 3	31555
Year 4	33734
Year 5	35912

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:

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

◉ **§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**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **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:

- Parents and other caretaker relatives specified in 42 CFR § 435.110
- Pregnant women specified in 42 CFR § 435.116
- Children Under Age 19 specified in 42 CFR § 435.118
- Former Foster Care Youth (up to age 26) specified in 42 CFR § 435.150
- Transitional Medical Assistance specified in § 1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA
- Extended Medicaid Due to Spousal Support Collections specified in 42 CFR § 435.115
- Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increase since April, 1977 specified in 42 CFR § 435.135
- Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI specified in 42 CFR § 435.137
- Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security specified in 42 CFR § 435.138
- Disabled Adult Children specified in 1634(c) of SSA
- Targeted Low-Income Children specified in 42 CFR § 435.229
- Independent Foster Care Adolescents Under Age 21 specified in § 435.222
- Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash specified in 42 CFR § 435.210 and § 435.230
- Individuals eligible for Cash except for Institutionalized Status specified in 42 CFR § 435.211
- Institutionalized Individuals Eligible under a Special Income Level specified in 42 CFR § 435.236
- Individuals Receiving Hospice Care specified in 1902(a)(10(A)(ii)(VII) and 1905(o) of SSA
- Medically Needy Pregnant Women specified in 42 CFR § 435.301(b)(1)(i) and (iv)
- Medically Needy Children Age 18 through 20 specified in 42 CFR § 435.308
- Individuals Needing Treatment for Breast or Cervical Cancer (under age 65) specified in 42 CFR § 435.213
- Protected Medically Needy Individuals Who Were Eligible in 1973 specified in 42 CFR specified in 42 CFR § 435.133
- Institutionalized Individuals Continuously Eligible Since 1973 specified in 42 CFR § 435.132
- Individuals Who Lost Eligibility for SSI/SSP Due to an increase in OASDI Benefits in 1972 specified in 42 CFR § 435.134
- Individuals Who are Essential Spouses specified in 42 CFR § 435.131

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage: ☐

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

Specify dollar amount: ☐

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI**

program (42 CFR §435.121)

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §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 September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 is the state's SSI-E payment; plus an allowance for employed members equal to the first $65 of earned income and one-half of remaining earned income; plus special exempt income, including court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit. The basic needs allowance is published in the Wisconsin Medicaid Eligibility Handbook.

○ **Other**

Specify:

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

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**

Specify:

Level of care determinations for new applicants are made by the SMA screening tool, determined through information input and assessment performed by Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. Reevaluations of level of care for participants are performed by ICAs.

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:

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

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

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

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

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

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

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

The long-term care functional screen (LTCFS) is an automated tool developed by the SMA to determine the appropriate nursing home level of care for waiver applicants. The functional screen was developed with SMA registered nurses who evaluated Physician Plans of Care to determine Medicaid eligibility for nursing home residents. It has been evaluated by the SMA and determined to be valid, reliable, and to result in comparable level of care.

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

Information used in level of care assessments for new applicants is gathered by certified screeners at Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. The screener gathers information during a face-to-face meeting with the applicant using the SMA's automated LTCFS, which returns a level of care for the prospective participant. Information for annual re-evaluations of level of care is gathered by the ICA through the same process.

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:

Every 365 days

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

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

○ **The qualifications are different.**

Specify the qualifications:

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

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

The long-term care functional screen's result is sent from the functional screen electronic system to the Medicaid Management Information System (MMIS) and the Medicaid eligibility system. MMIS also verifies both Medicaid and functional eligibility for all participants on a monthly basis and disenrolls participants who do not meet eligibility requirements. The Income Maintenance (IM) agency verifies that participants have a completed annual functional screen during annual Medicaid eligibility re-certification. If a functional screen has not been completed within the last 365 days, the IM agency closes the financial eligibility for long-term care.

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 (FSIA).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
All applicants must have an eligible level of care prior to enrollment.
Numerator/Denominator: Number of applicants enrolled in the IRIS program who do not have an eligible level of care over Total number of applicants enrolled during the calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Functional Screen Information Access System (FSIA)

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.

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Case Management System (WISITS) and Long-Term Care Functional Screen data (FSIA)

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.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual problems with level of care determinations are typically discovered by the SMA in one of three ways: (1) the screener contacts the SMA about unexpected results of the functional screen; (2) the SMA discovers errors when reviewing screens with results that are under appeal; or (3) the SMA quality reviewers discover errors during regular sampling of past screens. In all cases, the SMA contacts the Aging and Disability Resource Center, Tribal Aging and Disability Resource Specialist, or ICA to ascertain the correct facts and to direct correction of the screen, if possible. Correction is verified via observation of the corrected screen in the functional screen information access system. The SMA maintains a record of individual level of care remediation.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The ADRC or TADRS is required by contract to inform the potential enrollee and/or their legal representative about the available services and enrollment options, specific to institutional service options and home and community-based services offered through the waiver. A potential participant documents their choice by signing an enrollment form, which is maintained by the ADRC or TADRS.

Once a participant enrolls, they are again informed about: 1) the choice between institutional care and home and community based services, 2) the choice of waiver services, and 3) the choice of qualified providers during the initial plan development process, by the ICA.

These discussions are documented on the Individual Support and Service Plan (ISSP) and verified by the participant or legal decision-makers signature. The participant verifies 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.

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.

Copies of SMA enrollment forms are maintained by the Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist. Copies of ISSPs are maintained by the SMA.

Appendix B: Participant Access and Eligibility

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

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

Aging and Disability Resource Centers (ADRCs) and Tribal Aging and Disability Resource Specialists (TADRS) are required to have enrollment forms and other materials related to self-directed long-term care, including an SMA-developed brochure, available in the prevalent non-English languages spoken in Wisconsin.. ADRCs are also required to obtain interpreters or telephonic interpretation services when needed by an applicant or member.

The SMA requires ICAs and FEAs to provide written materials for potential participants regarding, the availability of accessible materials in prevalent non-English languages, as well as large print (no smaller than 18-point font), explaining the availability of written translation or oral translation to understand the information, the toll free number of the ADRC providing choice counseling, and the toll free and TTY/TDY telephone number of the ICA's customer service unit. ICAs must also make available all written materials that are critical to obtaining services, including handbooks, appeal and grievance notices, and notices of action, available in all prevalent, non-English languages in the ICA's service area. Participants may also request auxiliary aids and services or for materials produced and/or used by the ICA to be made available in alternative formats, at no cost. Finally, ICAs and FEAs must provide qualified interpreter services when needed by participants to ensure effective communication regarding treatment, medical history, and health education, and other information, as pertinent to their long term care needs.

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	**Day Services**		
Statutory Service	**Live-in Caregiver**		
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**		
Supports for Participant Direction	**IRIS Consultant Services**		
Other Service	**Assistive Technology**		
Other Service	**Community Involvement Support**		
Other Service	**Community Transportation 2**		
Other Service	**Community Transportation**		
Other Service	**Consultative Clinical and Therapeutic Services for Caregivers**		
Other Service	**Consumer Education and Training**		
Other Service	**Counseling and Therapeutic Services**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Modification**		
Other Service	**Housing Counseling**		
Other Service	**Individual Directed Goods and Services**		
Other Service	**Interpreter Services**		
Other Service	**Personal Emergency Response System (PERS)**		
Other Service	**Relocation - Community Transition Service**		
Other Service	**Residential Services (1-2 Bed AFH)**		
Other Service	**Residential Services (Other)**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Support Broker Services**		
Other Service	**Supported Employment - Group**		

Service Type	Service		
Other Service	Supportive Home Care		
Other Service	Training Services for Unpaid Caregivers		
Other Service	Vehicle Modifications		
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: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Adult day care services are the provision of services for part of a day in a non-residential group setting to participants who need an enriched social or health-supportive experience or need assistance with activities of daily living, supervision and/or protection.

Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the participant's place of residence and the adult day care center may be provided as a component part of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day).

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

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**
- [ ] **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):*

Wis. Stat. § 49.45

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Education

Alternate Service Title (if any):

Daily Living Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Daily Living Skills Training services is the provision of education and skill development to the participant to teach or improve the skills involved to independently performing routine daily activities, including skills to increase the participant's independence and participation in community life. This service may include teaching money management, home care maintenance, parenting skills, driving evaluation and lessons, information technology training, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources.

Daily Living Skills Training services may involve training the participant or the natural support person to assist the participant.

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

Accordingly, the participant’s progress towards obtaining the daily living skill and outcome identified on the participant's ISSP may be monitored by both the SMA and the participant's ICA. Monitoring ensures the efficacy of the training.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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)*:

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Daily Living Skills Trainer
Agency	Daily Living Skills Training Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Daily Living Skills Trainer

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Two years of experience working with the target population in providing this service or similar services. Provider also receives comprehensive participant-specific training to enable the provider to competently work with the participant to meet the participant's objectives outlined in the ISSP. If personal care or housekeeping services are provided along with skills training, the scope of the required provider standards for this service is described in SMA IRIS program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Daily Living Skills Training Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing Daily Living Skills Training, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

If personal care or housekeeping services are provided along with skills training, the scope of the required provider standards for this service is described in SMA IRIS program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Day 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 throughout 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)*:

- ☒ **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: Statutory Service
Service Name: Day Services

Provider Category:

Agency

Provider Type:

Day Service program operated by agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code §§ DHS 61.41, 61.75

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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

Alternate Service Title (if any):

Live-in Caregiver

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
07 Rent and Food Expenses for Live-In Caregiver	07010 rent and food expenses for live-in caregiver
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 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 is intended 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.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

Legally Responsible Persons, Relative, or Legal Guardian cannot serve as allowable providers of live-in caregiver's services.

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 of Medicaid services).

Excludes training provided to a participant intended to improve the participant's ability to independently perform routine daily living tasks, which may be provided as Daily living skills training.

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

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.
Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.
Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

PPrevocational 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 within paid employment in integrated community settings. Prevocational services should be provided in the most integrated setting preferred by the participant, and may be provided in a variety of community locations. Participants receiving prevocational services must have integrated employment related goals with clearly defined benchmarks in their participant-centered services and support plan; the general habilitation activities must be designed to support such employment goals. Competitive integrated employment is considered to be the successful outcome of prevocational services.

These services should involve strategies that enable the participant to attain the highest possible wage and level of work in the most integrated setting that aligns with the participant's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. These services 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. Participants who receive prevocational services during some days or parts of days may also receive supported employment, educational, or day services at other times.

Project SEARCH is a covered service under this category.

Prevocational services occur over a defined period of time and with specific outcomes to be achieved, as determined by the participant and their IRIS Consultant through an ongoing participant-centered planning process and only until integrated community employment can be obtained. Employment related outcomes are a part of the participant-centered planning process, which is a participant-directed process and must include identifying the participant's long-term employment goals. 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. 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 determine what actions have successful or unsuccessful and develop a new action plan.

Participation in prevocational services is not a required pre-requisite for supported employment services.

Prevocational service providers offering compensated work must be in accordance with applicable Federal laws and OSHA health and safety regulations, which prohibit unpaid contract work or engaging in training that involves doing unpaid contract work.

The cost of transportation for a participant to get to and from prevocational service sites may be included in the reimbursement paid to the prevocational service 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.

Personal care provided to a participant by their personal care worker employee during the receipt of prevocational services may be included in the reimbursement paid to the prevocational service provider, or may be covered and reimbursed under the waiver service personal care, but not both. All providers of personal care shall ensure that the provider qualifications for personal care are met.

The SMA 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.

This service category excludes the following:
- Services provided in sheltered workshop settings, where individuals are supervised for the primary purpose of producing goods or performing services; and
- Services that do not contribute to the participant's work experience, work skills, or work-related knowledge that leads to paid integrated employment in the community.

Prevocational services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category, such as supported employment or day services.

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	Prevocational Provider, Community Rehabilitation Programs (CRPs), or Supported Employment Agency

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, Community Rehabilitation Programs (CRPs), or Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Federally identified 14(c) certificate holder through U.S. Department of Labor (CRP).

Other Standard *(specify):*

1. Providers 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 possesses skills and knowledge that typically would be acquired through:
a. College coursework or 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 of experience in a work situation related to the type of work supervised;
4. 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.
5. Prevocational 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.
6. Information concerning health and special work considerations of participants is clearly communicated in writing to supervisory personnel.
7. Vocational counseling shall be available.
8. The provider must 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 provider must maintain payroll sub-minimum wage certificates and other records for each participant employed in compliance with the Fair Labor Standards Act.
10. The provider must provide the participant with effective and accessible grievance and complaint procedures.
11. The provider must also offer supported employment services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Respite services are services provided for a participant on a short-term basis to ease the participant's family or other primary caregiver(s) from daily stress and care demands. Respite services may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite services may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the participant's own home, or the home of a respite service provider.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

The receipt of Respite services precludes the participant from receiving other waiver services such as Adult Day Care, Nursing Services, and Supportive Home Care on the same day the participant receives Respite Services, unless clear documentation exists that service delivery occurred at distinct times from Respite Services regardless of how the Respite payment is structured.

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

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	Supportive Home Care Agency
Agency	1-2 Bed Adult Family Home, Residential Care Apartment Complex (RCAC)
Agency	Personal Care Agency
Individual	Individual Respite Provider
Agency	Hospital, Nursing Home, Community-Based Residential Facility, 3-4 Bed Adult Family Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA IRIS program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

1-2 Bed Adult Family Home, Residential Care Apartment Complex (RCAC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified 1-2 bed Adult Family Home – Certified as 1-2 Bed AFH by SMA and Wis. Admin. Code Ch. DHS 82 for Barrett Homes;
Residential Care Apartment Complex (RCAC) - Wis. Admin. Code Ch. DHS 89

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA IRIS program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

Individual Respite Provider

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA IRIS program policy.

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Hospital, Nursing Home, Community-Based Residential Facility, 3-4 Bed Adult Family Home

Provider Qualifications
License *(specify):*

Hospital: Wis. Admin. Code Ch. DHS 124
Nursing Home: Wis. Admin. Code Ch. DHS 132 and Ch. DHS 134
Community-based Residential Facility: Wis. Admin. Code Ch. DHS 83
3-4 Bed Adult Family Home - Wis. Admin. Code Ch. DHS 88

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

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

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

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

Service Definition *(Scope):*

Supported Employment –Individual is the provision of ongoing supports and services to participants who need intensive on-going support to obtain and maintain an individual job in competitive integrated employment. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

This service can be provided through different models and includes vocational/job-related discovery or assessment, participant-centered employment planning, work incentive benefits counseling, job placement, job supports, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, training and planning, asset development, career advancement services, and tools/equipment needed to work effectively. Other workplace supports include services not specifically related to job skill training, but that enable the participant to successfully integrate into the job setting.

This services also includes supports to establish or maintain self-employment, which includes aiding the participant to identify potential business opportunities; assistance in the development of a business plan, including identifying potential sources of business financing and developing a business; identification of the supports that are necessary in order for the participant to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

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.

Personal Care provided to a participant by their personal care worker 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 ensure that the provider qualifications for personal care are met.

The SMA 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.

This service category excludes the following:
- Supports for the performance of volunteer work;
- Payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business; and
- 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.

Supported Employment- Individual services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. A service covered here may not duplicate any service that is provided under another waiver service category, such as Vocational Futures Planning and Support or other vocational services, if billed concurrently.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	On-the-Job Support Person
Agency	Supported Employment Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

On-the-Job Support Person

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Participants assure that providers have the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service or similar services.

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:

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:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05010 private duty nursing
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):*

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

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

Exclusion includes services available through the Medicaid State Plan.

Participants aged 18-21 must receive this service through the State Plan per EPSDT.

The Statewide IRIS-SDPC oversight agency provides review of the need for nursing services to ensure the participant's needs exceed the State Plan benefit limitations. Results of the analysis serve as the prior authorization for this service. The SMA reviews all prior authorizations.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency-directed Registered Nurse/LPN

Provider Qualifications

License *(specify):*

Wis. Stat. § 441

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Individual RN or LPN
Provider Qualifications
License *(specify):*

Wis. Stat. § 441
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.
Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
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-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Fiscal Employer Agent Services are financial management services provided to all participants by Fiscal Employer Agents.

Fiscal Employer Agents assist the participant and/or legal representative to exercise employer authority by facilitating employment of participant-hired workers by the participant, or common law employer. As the participant's employer agent, the responsibilities performed include:
(A) Assistance with completion of required documentation for newly hired workers including verification of citizenship or legal authority to work status and all other federal and state requirements,
(B) Verification that workers and other providers selected by the participant meet program provider qualifications including reviewing criminal and caregiver history and ensuring Medicaid provider agreements are signed and maintained,
(C) Collection and processing of worker timesheets consistent with the participant's ISSP, and
(D) Operation of a payroll service including withholding garnishments and taxes from workers' pay, providing workers' compensation insurance, filing and paying federal and state taxes, utilizing a SMA-approved EVV system to evaluate and provide service compensation (for applicable services), and distribution of payroll checks.

Fiscal Employer Agents also assist the participant and/or legal representative to exercise budget authority by managing and directing the disbursement of funds contained in the participant's budget. This includes:
a. Tracking of the participant's budget and expenditure activity,
b. Receipt and disbursement of funds for the payment of waiver services authorized in the participant's ISSP, including the processing and payment of invoices for goods and services, and
c. Preparation and provision of periodic reports on budget and expenditure activity to the participant, the SMA, and other entities specified by the SMA.

Fiscal Employer Agents also assist the participant to maintain enrollment by collecting required IRIS participant Medicaid post eligibility cost share payments, when applicable.

Fiscal Employer Agent Services do not include the recruitment, training and supervision of workers, and provision of emergency backup staff. This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan. Fiscal Employer Agents cannot also provide any other Wisconsin long-term care waiver service to the same participant.

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

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

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

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):*

Certificate *(specify):*

Agencies must be certified by the State Medicaid Agency as Fiscal Employer Agents.

Other Standard *(specify):*

Certified Fiscal Employer Agents must have a current contract with the State Medicaid Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA).

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

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

To assist the participant and/or legal representative with IRIS Consultant Services, ICA staff carries out activities which include:
A. Providing comprehensive IRIS program orientation and skills training regarding self-direction, provider and participant-hired worker selection, and participant spending and individual budget management;
B. Providing assistance with regards to the self-directed planning process and its application;
C. Creation and long-term maintenance of the participant Individual Support and Service Plan (ISSP) and associated service authorizations;
D. Monitoring and effectively assuring participant health and welfare;
E. Performance, as needed, of routine level of care reevaluations and maintenance of long-term care and Medicaid eligibility;
F. Explanation of participant rights and the appeals and grievance processes;
G. Facilitating the liaison between the participant and/or legal representative and the participant's financial management services provider;
H. Providing insights to the participant about problem solving, conflict resolution, hiring, managing, and terminating participant-hired workers; and
I. Recognizing, remediating, and reporting critical events.

IRIS Consultant Services does not include direct coordination of services or the hiring, management, scheduling, training, or termination of participant-hired workers or other service providers.

This service may not duplicate services otherwise provided through the Medicaid State Plan or provided under another waiver service category.

Providers of IRIS Consultant Services cannot also provide other Wisconsin long-term care HCBS waiver services to the same participant.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: IRIS Consultant Services

Provider Category:

Agency

Provider Type:

Indian Health Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA).

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: IRIS Consultant Services

Provider Category:

Agency

Provider Type:

IRIS Consultant Agency (ICA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies must be certified by the State Medicaid Agency as IRIS Consultant Agency.

Other Standard *(specify):*

Certified IRIS Consultant Agency must have a current contract with the State Medicaid Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA).

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Assistive technology is an item, piece of equipment, software or application, service dog, or product system – whether acquired commercially, modified, or customized – that is used to increase, maintain, or improve functional capabilities of participants. This service category also includes assistive technology typically referred to as communication aids. This includes extended warranties, cost of maintenance, ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology.

This category also includes assistive technology services which are services that directly assist a participant in the selection, acquisition, or use of assistive technology, such as:
(A) Services consisting of purchasing, leasing/renting, or otherwise providing for the acquisition of assistive technology for participants;
(B) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology;
(C) Coordination and use of necessary therapies, interventions, or services with assistive technology, such as therapies, interventions, or services associated with other services in the ISSP;
(D) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
(E) 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 service dogs defined as a dog that is individually trained by reputable provider experienced in providing structured training for service dogs to do work or perform tasks for the participant that are directly related to the participant's disability. Costs are limited to the following:
(A) Purchase of a service dog;
(B) Post-purchase training that is necessary to partner a service dog with the participant owner; and
(C) Ongoing maintenance costs of a service dog that include preventative, acute, and primary veterinary care and items necessary for the service dog to perform its task or work.
Service dog costs must be consistent with program policy.

Acquisition of all assistive technology including assessments is subject to program policy consistent with this service definition. Assistive technology may be purchased, new or used, or leased to the participant. All assistive technology must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Assistive technology and services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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	Qualified Accessibility Assessor
Individual	Independent Practice Veterinarian

Provider Category	Provider Type Title
Individual	Qualified Health Professional
Individual	Service Dog Trainer or Provider
Agency	Service Dog Training or Provider Agency
Agency	Qualified Accessibility Assessor Agency
Agency	Authorized Durable Medical Equipment and Medical Supply Vendor
Agency	Qualified Health Professional Agency
Agency	Veterinary Clinic
Agency	Other Assistive Technology Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Qualified Accessibility Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Possession of extensive knowledge and experience in assistive technology and accessibility; and
• Reputable agency that is independent of all contractors and vendors and has no personal or financial tie to the requested assistive technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Independent Practice Veterinarian

Provider Qualifications

License *(specify):*

• Wis Statute 89.06

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Qualified Health Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Admin 107.24

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Service Dog Trainer or Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable and experienced.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Service Dog Training or Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable and experienced.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Qualified Accessibility Assessor Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Possession of extensive knowledge and experience in assistive technology and accessibility; and
• Reputable agency that is independent of all contractors and vendors and has no personal or financial tie to the requested assistive technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:

Authorized Durable Medical Equipment and Medical Supply Vendor

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Admin Code 105.40 & Wis Admin 107.24

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:

Qualified Health Professional Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Admin 107.24

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Veterinary Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Statute 89.06

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Other Assistive Technology Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Reputable vendor;
- Items purchased must meet a reasonable buyer expectation of quality and performance; and
- Must meet and be installed according to all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Involvement Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other

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

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

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

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

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

Service Definition *(Scope):*

Community Involvement Support enables the participant to meet their long-term care goals and to attain or maintain community involvement to the same degree of access as individuals not receiving these services. This service category covers two distinct types of support related to community integration:

1. The participant's costs related to allowable community integration activities; and/or
2. Required support staff's associated costs to attend a community-integrated event with a participant.

Participant's costs related to community integration activities must occur in environments that also engage individuals who are non-disabled. This service covers only the participant's direct expense related to the following:

- Health club memberships
- Camps

Supports or expenses not specifically described above may be covered, if approved by the SMA.

The second subcategory assists the participant with engagement in community-integrated events, through the coverage of associated expenses for support staff to accompany a participant, specifically when a participant's attendance is dependent on staff accompaniment. This is limited to the worker's expense only; the participant portion of the expense is the responsibility of the participant.

This service must contribute to the community functioning of the participant and may not be recreational or diversional in nature.

Community Involvement Support may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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	Participant-Hired Worker
Agency	Camps
Agency	Fitness Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Involvement Support

Provider Category:

Individual

Provider Type:

Participant-Hired Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Participants assure that providers have the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service or similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Involvement Support

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

American Camp Association (ACA) accreditation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Involvement Support

Provider Category:

Agency

Provider Type:

Fitness Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DHS Admin. Code Ch. 100.178

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation 2

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Same as Community Transportation - added for budget break out purposes in Appendix J.

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

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

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

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	See Community Transportation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation 2

Provider Category:
Individual
Provider Type:

See Community Transportation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

See Community Transportation

Verification of Provider Qualifications

Entity Responsible for Verification:

See Community Transportation

Frequency of Verification:

See Community Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Transportation is the transport of a participant to and from a waiver service, place of employment, or community service, activity, or resource. The cost of community transportation is covered in accordance with Internal Revenue Service policy as outlined in the participant's Individualized Services and Support Plan (ISSP). Community Transportation is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable) and does not replace them. Transportation service may only be funded through the waiver when the services are not provided by a legally responsible third-party, such as school, private insurance, or a public entity. Whenever possible, family, neighbors, friends, community agencies, or local government programs that can provide this service without charge will be prioritized and utilized.

Community transportation may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Mass Transit Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Wis. Stat. § 85.20
Wis. Stat. § 85.23

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:
Individual
Provider Type:

Individual Participant-hired Worker

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Valid driver's license appropriate to the type of transportation being provided & adequate insurance coverage including liability auto insurance.

Verification of Provider Qualifications
Entity Responsible for Verification:

Participant and Fiscal Employer Agent

Frequency of Verification:

Prior to service rendered and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:
Agency
Provider Type:

Taxi or Common Motor Carrier

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Wis. Stat. § 194

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Specialized Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 85.21
Wis. Stat. § 85.22

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultative Clinical and Therapeutic Services for Caregivers

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the participant's treatment/support plans and are necessary to improve the participant's independence and inclusion in their community.

The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans, consultation with providers and potential providers, and monitoring of the participant and the provider in the implementation of the plans. This may be provided in the individual’s home or in the community, as described in the participant’s service plan.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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	Counseling/Therapy Organization
Individual	Individual Counselor or Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Agency

Provider Type:

Counseling/Therapy Organization

Provider Qualifications

License *(specify):*

Wis. Stat. § 448
DHS Admin. Code Ch. 61.35

Certificate *(specify):*

Wis. Stat. § 448
Wis. Stat. § 440.312
DHS Admin. Code Ch. 61.35

Other Standard *(specify):*

Meets Industry Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

At the time of authorization/purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Individual

Provider Type:

Individual Counselor or Therapist

Provider Qualifications

License *(specify):*

Wis. Stat. Chapter 448
DHS Admin. Code Ch. 61.35

Certificate *(specify):*

Wis. Stat. Chapter 448
Wis. Stat. Chapter 440.312
DHS Admin. Code Ch. 61.35

Other Standard *(specify):*

Meets Industry Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

At time of authorization/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:
09 Caregiver Support	09020 caregiver counseling and/or training

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

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

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

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

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

Service Definition *(Scope):*

Consumer education and training services are designed to help participants develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over services and supports.

Self-advocacy skills enable participants to communicate wants and needs, make informed decisions, and develop trusted supports with whomever they can share concerns.

The consumer education and training service includes education and training for participants, their caregivers, and legal representatives that is directly related to developing 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.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq) or other relevant funding sources.

Excludes education/training costs exceeding $2500 per participant annually.

Excludes all forms of college tuition.

Excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events.

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	Education and Training Agency
Individual	Personal Assistant, Teacher

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Education and Training Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Personal Assistant, Teacher

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:
11 Other Health and Therapeutic Services	11020 health assessment
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
Category 3:	**Sub-Category 3:**

11 Other Health and Therapeutic Services	11040 nutrition consultation

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 is the provision of professional, treatment-oriented services, resources, or interventions to maintain or improve participant health, welfare, or functioning in the community. This service addresses a participant's identified personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse treatment needs and is recommended by a qualified health care or mental health professional.

These services include aging or disability adjustment and adaptation counseling, interpersonal therapy, recreational therapy, music therapy, art therapy, aquatic therapy, massage therapy, nutritional counseling, medical counseling, behavioral counseling, weight counseling, and grief counseling. Costs directly associated with any counseling or therapies received are included in this service. Services not specifically described above may be covered, if approved by the SMA.

This service category excludes the following:
- Inpatient services
- Services provided by a physician
- Attendant costs, to assist participants in attending counseling and therapeutic sessions

Counseling and therapeutic services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Counseling/Therapy Organization
Individual	Individual Counselor or Therapist

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/Therapy Organization
Provider Qualifications
License *(specify):*

Wis. Stat. § 448
DHS Admin. Code Ch. 61.35
Certificate *(specify):*

Wis. Stat. § 448
Wis. Stat. § 440.312
DHS Admin. Code Ch. 61.35
Other Standard *(specify):*

Meets Industry Standards.
Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.
Frequency of Verification:

Annually.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Individual Counselor or Therapist
Provider Qualifications
License *(specify):*

Wis. Stat. § 448
DHS Admin. Code Ch. 61.35
Certificate *(specify):*

Wis. Stat. § 448
Wis. Stat. § 440.312
DHS Admin. Code Ch. 61.35

Other Standard *(specify):*

Meets Industry Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*

Home delivered meals are meals provided to participants who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor and transportation to deliver one or two meals a day.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

This service does not include payment for meals at federally subsidized nutrition sites.

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	Restaurants
Agency	Aging Network Agency
Agency	Hospitals or Nursing Homes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Restaurants

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. ATCP 75

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Aging Network Agency

Provider Qualifications

License *(specify):*

Wis. Stat. § 46.82(3)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Hospitals or Nursing Homes

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 124
Wis. Admin. Code Ch. DHS 132
Wis. Admin. Code Ch. DHS 134

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: 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:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**

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

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

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

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

Service Definition *(Scope):*

Home modifications are physical adaptations to the private residence of a participant or participant's family that ensure the health, welfare, and safety of the participant and enable the participant to function with greater independence in the home. These are generally permanent fixtures and/or changes to the physical structure of the home. This service category also includes cost of materials, services, permits and inspections, maintenance, and extended warranties necessary for a home modification.

Home modifications and services include:
- Accessible alerting systems for smoke/fire/carbon monoxide;
- Adaptive door bells, locks, and/or security items, systems, or devices;
- Adaptive lighting;
- Bathroom adaptations for bathing, showering, toileting, and personal care needs;
- Cameras;
- Fences;
- Flush entries and leveled thresholds;
- Heating, cooling, or ventilation systems;
- Independent assessments of requested home modifications as deemed necessary by program policy (cost does not impact participant budget);
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the health, welfare, and safety of the participant;
- Kitchen counter, sink, and other cabinet modifications (including brackets for appliances);
- Outside railing to safely access the home;
- Plumbing or electrical adaptations related to approved modifications;
- Raised electrical switches and sockets;
- Ramps from street, sidewalk, or house;
- Slip-resistant flooring;
- Stair gliders and stair lifts;
- Surface protection;
- Swing-clear and expandable offset door hinges;
- Track lift systems;
- Vertical lifts; and
- Widened doorways, landings, and hallways.

Modifications not specifically described above may be covered if approved by the SMA. Modifications may be made up to 180 days prior to leaving the institutional setting and enrolling in the waiver but cannot be paid for until the participant is enrolled with a plan start date.

Acquisition of all modifications, including independent assessments, is subject to program policy consistent with this service definition. Modifications to rental properties require additional assurances.

This service category excludes:
- Modifications or improvements that are of general home maintenance and upkeep and are not specifically related to home modifications;
- Modifications made to living arrangements that are owned or leased by agency providers of other waiver services;
- Modifications that do not meet standards of manufacture, design, and installation; and
- Modifications that add to the total square footage of the home, except when necessary to complete a modification and shown to be the most cost effective option.

All modifications are required to comply with applicable local and state housing or building codes and are subject to inspections required by the municipality responsible for administering the codes. Home modifications may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

- [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	Qualified Health Professional
Agency	Qualified Accessibility Assessor Agency
Individual	Carpenter, Electrical Contractor, Electrician, Elevator Contractor, General/Dwelling Contractor, HVAC Contractor, Plumber, Professional Engineers
Agency	Carpenters, Electrical Contractors, Electricians, Elevator Contractors, General/Dwelling Contractor, HVAC Contractor, Plumbers, Professional Engineers
Agency	Qualified Health Professional Agency

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:

Qualified Health Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Admin 107 & industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency
Provider Type:

Qualified Accessibility Assessor Agency

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Possession of extensive knowledge and experience in assistive technology and accessibility; and
• Reputable agency that is independent of all contractors and vendors and has no personal or financial tie to the requested assistive technology.

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase.

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, Electrical Contractor, Electrician, Elevator Contractor, General/Dwelling Contractor, HVAC Contractor, Plumber, Professional Engineers

Provider Qualifications
License *(specify):*

Must obtain required state license.

Certificate *(specify):*

Must obtain required state certificate.

Other Standard *(specify):*

Must obtain required state registration and adhere to industry set standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Agency

Provider Type:

Carpenters, Electrical Contractors, Electricians, Elevator Contractors, General/Dwelling Contractor, HVAC Contractor, Plumbers, Professional Engineers

Provider Qualifications

License *(specify):*

Must obtain required state license.

Certificate *(specify):*

Must obtain required state certification.

Other Standard *(specify):*

Must obtain required state registration and adhere to industry set standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Agency

Provider Type:

Qualified Health Professional Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis Admin 107 & industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Housing counseling is the provision of information and assistance for participants who are looking to acquire and maintain safe, affordable, and accessible housing in the community. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the participant lives with his or her family.

Services include:
- Counseling and assistance in identifying housing options;
- Identifying financial resources and determining affordability;
- Identifying preferences of location and type of housing;
- Locating available housing;
- Identifying and assisting in access to financing;
- Explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint; and
- Planning for ongoing management and maintenance.

Housing counseling may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free.

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

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

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

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 that meets provider qualifications

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:

Agency that meets provider qualifications

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Must have expertise in housing issues;
- Must have housing counseling or assistance as a part of its mission or regular activities; and
- Must not have a direct or indirect financial interest in the property or housing the participant selects.

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase, and annually, if applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Individual Directed Goods and Services refers to services, equipment, or supplies that addresses or enhances the participant's opportunity to achieve their long-term support need, but is not already coverable under another service category. The service, equipment, or supply must not be captured under an exclusion of another service category.

Each service, equipment, or supply selected must clearly address a long-term support need documented in the ISSP and meet the additional following requirements:
* The participant is reasonably unable to obtain the good or service from another source; and
* At least one of the following:
o The item or service must decrease the need for other Medicaid services (Medicaid State Plan or waiver services); or
o Promote or maintain inclusion in the community; or
o Increase or maintain the participant's safety in the home environment.

Individual Directed Goods and Services are purchased from the participant-directed budget. Any service, equipment or supply included under this service definition is subject to review by the SMA, prior to service authorization and utilization.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

Experimental or prohibited treatments are 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	Family, Friend, Neighbor, Supportive Home Care Worker
Agency	Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Family, Friend, Neighbor, Supportive Home Care Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

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: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

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:

Interpreter Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17020 interpreter
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):*

Interpreter services are provided to participants who are Deaf or Hard of Hearing or who have hearing, speech, or vision impairments and require interpretation to communicate.

This service category does not cover interpreter services provided by a spouse, relative, or guardian. Interpreter services may only be funded when it is not the responsibility of the service provider, IRIS Consultant Agency, Fiscal Employer Agent, or another party to provide this service or it is not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category. Waiver funds may not be used to purchase this service if it is provided to the general public for free.

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

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

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

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	Interpreter, Facilitator, or Translator
Agency	Interpretation agency that employs licensed Sign Language Interpreters for the Deaf or Hard of Hearing
Individual	Licensed Sign Language Interpreter for the Deaf or Hard of Hearing
Agency	Interpretation, Facilitatation, or Translation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:
Individual

Provider Type:

Interpreter, Facilitator, or Translator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and Fiscal Employer Agent

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:

Agency

Provider Type:

Interpretation agency that employs licensed Sign Language Interpreters for the Deaf or Hard of Hearing

Provider Qualifications

License *(specify):*

Wis. Stat. 440.032

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:

Individual

Provider Type:

Licensed Sign Language Interpreter for the Deaf or Hard of Hearing

Provider Qualifications

License *(specify):*

Wis. Stat. 440.032

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Interpreter Services

Provider Category:

Agency

Provider Type:

Interpretation, Facilitatation, or Translation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
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):*

Personal Emergency Response System (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service may include devices and services necessary for operation of PERS when those devices and services are otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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)*:

- ☒ **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 (PERS)

Provider Category:
Agency

Provider Type:

PERS Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL Standards for electronic devices or FCC regulations for telephonic devices.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

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:

Relocation - Community Transition Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Relocation – Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institution, family home, or a provider-operated living setting to a community living setting in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those that are necessary to enable the participant to establish a basic household excluding room and board.

These include:
a. Security deposits that are required to obtain a lease on an apartment or home;
b. Essential household furnishings;
c. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and
d. Moving expenses.

Relocation expenses not specifically described above may be covered if approved by the SMA. Relocation expenses may be made up to 180 days prior to leaving the institutional setting and enrolling in the waiver but cannot be paid for until the participant is enrolled with a plan start date.

This service category does not cover the furnishing of living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Explicit exclusions include regular rental or mortgage expenses, food, regular utility charges, service agreements or extended warranties for appliances or home furnishings, and household appliances or items that are intended for purely diversional/recreational purposes.

Relocation expenses may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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	Real Estate Agency
Agency	Home Furnishing Vendor
Agency	Moving Company
Agency	Public Utilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation - Community Transition Service

Provider Category:
Agency
Provider Type:

Real Estate Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards.
Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent
Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation - Community Transition Service

Provider Category:
Agency
Provider Type:

Home Furnishing Vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation - Community Transition Service

Provider Category:

Agency

Provider Type:

Moving Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation - Community Transition Service

Provider Category:

Agency

Provider Type:

Public Utilities

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to 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 Services (1-2 Bed AFH)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other

Category 3: 02 Round-the-Clock Services

Sub-Category 3: 02031 in-home residential habilitation

Category 4: 02 Round-the-Clock Services

Sub-Category 4: 02021 shared living, residential habilitation

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

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

Service Definition *(Scope):*

Residential services are a combination of individually tailored supports, services, treatment, and care provided within a community-integrated residential setting above the level of room and board. Residential services also include collaboration with health care, vocational, or day service providers. The scope of residential services may include performing personal care or supportive home care; however, such activities may not comprise the entirety of the service.

The residential service provider and participant must maintain an agreement which specifies the nature and scope of the services provided. Participants may purchase individual services from separate providers. In these cases, residential service providers must also coordinate with those external service providers. Supportive home care may only be provided by an external party when the care takes place outside of the residential setting.

All services performed by the provider are included in the residential provider's rate. The cost of room and board is excluded from this service category.

The residential provider must immediately report to the local Adult Protective Services unit and/or local law enforcement regarding any incident, situation, or condition that endangers the health or safety of the participant living in the residential setting. All providers of residential services must also communicate with the certifying or licensing agency, the participant's ICA, and applicable providers, within confidentiality laws, about any critical incidents that occur in the residential setting, as soon as practicable.

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

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

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

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	Certified 1-2 Bed Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services (1-2 Bed AFH)

Provider Category:
Individual
Provider Type:

Certified 1-2 Bed Adult Family Home

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certified by the SMA.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Residential Services (Other)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02023 shared living, other

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

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

Service Definition *(Scope):*

Residential services are a combination of individually tailored supports, services, treatment, and care provided within a community-integrated residential setting above the level of room and board. Residential services also include collaboration with health care, vocational, or day service providers. The scope of residential services may include performing personal care or supportive home care; however, such activities may not comprise the entirety of the service.

The residential service provider and participant must maintain an agreement which specifies the nature and scope of the services provided. Unless the residential setting is required to provide a service, the participants may purchase individual services from separate providers. In these cases, residential service providers must also coordinate with those external service providers. Supportive home care may only be provided by an external party when the care takes place outside of the residential setting.

All services performed by the provider are included in the residential provider's rate. The cost of room and board is excluded from this service category.

The residential provider must immediately report to the local Adult Protective Services unit and/or local law enforcement regarding any incident, situation, or condition that endangers the health or safety of the participant living in the residential setting. All providers of residential services must also communicate with the certifying or licensing agency, the participant's ICA, and applicable providers, within confidentiality laws, about any critical incidents that occur in the residential setting, as soon as practicable.

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

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

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

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Residential Care Apartment Complex
Agency	Licensed Adult Family Homes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Certified Residential Care Apartment Complex

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 89

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Licensed Adult Family Homes

Provider Qualifications

License *(specify):*

Wis. Admin. Code § DHS 88

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Specialized medical equipment and supplies include items or devices necessary to maintain the participant's health, manage a medical or physical condition, improve or maintain functioning, or enhance independence. The costs of maintenance and warranty for such medical equipment and supplies are also included. This service category excludes those items that are not of direct medical or remedial benefit to the participant.

Items or devices under this service category are in addition to medical supplies and equipment available under the state plan. All specialized medical equipment and supplies require a qualified health care professional's order.

Items not regulated by the federal Food and Drug Administration (FDA) as nutritional or dietary supplements are excluded unless specifically covered under the Medicaid state plan.

All specialized medical equipment and supplies must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission. This service category may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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	Other Vendor
Agency	Authorized Durable Medical Equipment and Medical Supply Vendor
Agency	Licensed Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Other Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable vendor that meets industry standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Authorized Durable Medical Equipment and Medical Supply Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Admin. Code § DHS 105.40
Wis. Admin. Code § DHS 107.24

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Licensed Pharmacy

Provider Qualifications

License *(specify):*

Wis. Stat. 450

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Support Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
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 to fulfill identified long-term care needs and outcomes by providing the participant with flexible and individualized support.

Support brokers must be knowledgeable of the IRIS program, of the typical kinds of needs of persons in the participant's target group, and of other local community-integrated services and resources available to the participant. The participant and the IRIS consultant agencies are responsible to assure that a support broker selected by the participant has the appropriate knowledge.

Support brokers are subject to criminal background checks and must be independent of any other waiver service provider.

This service may not duplicate services otherwise provided through the Medicaid State Plan or provided under another waiver service category including ICA services or FEA Services.

Participant employer authority and budget authority responsibilities may not be delegated to this service.

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

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

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

☐ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker
Agency	Support Broker Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:
Individual
Provider Type:

Individual Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified support broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant can decide the amount and type of training they require of the Support Broker.

Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:
Agency
Provider Type:

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

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified support broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant can decide the amount and type of training they require of the support broker.

Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.
Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Supported Employment - Group

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supported Employment - Group are services and training activities provided in regular business, industry and community settings for group of two (2) to eight (8) workers receiving supported employment. Supported employment must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

This service includes vocational/job-related discovery or assessment, participant-centered employment planning, benefits support, job placement, job supports, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, training and planning, asset development, career advancement services, and tools/equipment needed to work effectively. Other workplace supports include services not specifically related to job skill training, but that enable the waiver participant to successfully integrate into the job setting.

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.

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 ensure that the provider qualifications for personal care are met.

The SMA 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.

This service category excludes the following:
- Supports for the performance of volunteer work;
- Payment for supervision, training, support, or adaptations typically available to other non-disabled workers filling similar positions in the business; and
- 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.

Supported Employment- Group services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

Federal financial participation (FFP) 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.

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 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):*

Other Standard *(specify):*

Providers must 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.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supportive Home Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08050 homemaker
Category 4:	**Sub-Category 4:**
08 Home-Based Services	08060 chore

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

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

Service Definition *(Scope):*

Supportive home care (SHC) is the direct and indirect assistance with daily functions and individualized needs, to promote improved functioning and safety in a participant's home and community.

SHC services are comprised of supports or tasks such as:
- Companion or attendant supports necessary for participant safety at home and in the community. This may include observation or indirect assistance with the following: assure appropriate self-administration of medications, meal preparation, bill payment, communication, schedule and/or attend appointments, completion of activities detailed in occupational or physical therapy treatment plans, arrangement and/or usage of transportation, and personal assistance in non-employment related community activities.
- Chore services that assist the participant to maintain their home environment in a clean, sanitary, and safe manner. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event are also covered.

The scope of SHC may include performing incidental personal care, including activities of daily living or instrumental activities of daily living. However, such activities may not comprise the entirety of the service. When personal care is available to the participant through the Medicaid State Plan, it must be utilized prior the use of any incidental personal care under this service category.

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 participant would not be able to retain a preferred supportive 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 participant.

The participant shall determine the amount of the per diem retainer payment, not to exceed 75% of the authorized rate amount, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the participant:

Medically- Related
- Hospitalization;
- Nursing home or ICF-I/ID admission ;
- Receipt of medical or rehabilitative care entailing at least an overnight absence; or
- Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

Non-Medically Related
- Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
- Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;
- Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or
- Recreational activities unaccompanied by the worker entailing at least an overnight absence.

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made. However, retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

This service category excludes the following:
- Live-in Caregiver services;
- Representative payee services; and
- Payroll bonuses.

Supportive Home Care may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supportive Home Care Agency, Home Health Care Agency
Individual	Individual Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency, Home Health Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:
Individual
Provider Type:

Individual Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Participants assure that providers have the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service or similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:

Training Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

This service is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to participants.

Training includes instruction about treatment regimens and other services that are included in the participant's Individual Support and Service Plan (ISSP), use of equipment specified in the ISSP, and guidance to safely maintain the member in the community.

Training must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the ISSP and must directly relate to the individual's role in supporting the participant.

This service includes, but is not limited to, online or in-person training; conferences; or resource materials on the specific disabilities, illnesses, or conditions that affect the member. The purpose of the training is for the caregiver to learn more about member's condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided on how to effectively care for a member with dementia.

Training includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the ISSP.

This service may not duplicate services otherwise provided through the Medicaid State Plan or under another waiver service category.

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

This service may not be provided in order to train paid caregivers.

Excludes payment for lodging and/or meal expenses incurred while attending a training event or conference.

Excludes teaching self-advocacy, which is covered under Consumer Education and Training 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	Training/Service Agency
Individual	Professional Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training Services for Unpaid Caregivers

Provider Category:

Agency

Provider Type:

Training/Service Agency

Provider Qualifications

License *(specify):*

This training must be provided by license, certified, or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

Certificate *(specify):*

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licenses mental health professionals, or licensed therapists.

Other Standard *(specify):*

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licenses mental health professionals, or licensed therapists.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training Services for Unpaid Caregivers

Provider Category:

Individual

Provider Type:

Professional Services

Provider Qualifications

License *(specify):*

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licenses mental health professionals, or licensed therapists.

Certificate *(specify):*

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licenses mental health professionals, or licensed therapists.

Other Standard *(specify):*

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licenses mental health professionals, or licensed therapists.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Vehicle modifications are physical adaptations to the vehicle that is the participant's primary means of transportation. Vehicle modifications accommodate the specialized needs of a participant and enable the participant to function with greater independence in the community. This service category also includes the cost of materials, services, inspections, maintenance, and extended warranties necessary for a vehicle modification.

Vehicle modifications and services include:
- Customized devices necessary for the participant to be transported safely in the community, including tie-downs and wheelchair docking systems;
- Driver control devices, including hand controls and pedal adjusters;
- Independent assessments of requested vehicle modifications as deemed necessary (does not impact participant budget);
- Inspections required for a modification;
- Interior alterations to seats, head and leg rests, and belts;
- Modifications needed to accommodate a participant's sensitivity to sound, light or other environmental conditions;
- Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle;
- Raising the roof or lowering the floor to accommodate wheelchairs;
- Vehicular lifts, platforms, carriers, and curbsiders.

Modifications not specifically described above may be included if approved by the SMA. Acquisition of all modifications, including independent assessments, is subject to program policy consistent with this service definition.

This service category excludes:
- Modifications to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
- Modifications to vehicles that are owned or leased by agency providers of waiver services;
- Purchase or lease of a vehicle, (however, this service category can be used to fund the portion of a new or used vehicle purchase that directly relates to the cost of accessibility adaptations;) and
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

All vehicle modifications must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Vehicle modifications may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Motor Vehicle Modifier
Agency	Qualified Vehicle Modification Assessor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:

Motor Vehicle Modifier

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Motor vehicle repair businesses must:
a. Register as a "vehicle modifier" with the National Highway Traffic Safety Administration (49 CFR 595.6);
b. Meet requirements outlined in 49 CFR section 595.7; and
c. Install equipment according to the manufacturer's requirements and instructions.

Verification of Provider Qualifications
Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:

Qualified Vehicle Modification Assessor

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Has met one of the following:
a. Driver rehabilitation specialist certification (ADED Association for Driver Rehabilitation Specialists);
b. Is an occupational therapist specializing in driver rehabilitation and community mobility (WI Ch. 4 OT Practice & Supervision);
c. Five years of full time experience in the field of driver rehabilitation; or
d. Four year undergraduate degree in a health related field with
i. One year full time experience in the degree area of study;
ii. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
iii. Supervision by:
- A certified driver rehabilitation specialist; or
- An occupational therapist with a specialty certification in driving and community mobility; or iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to 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:

Vocational and Futures Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development

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

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

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

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

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

Service Definition *(Scope):*

Vocational Futures Planning and Support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that provides assistance for participants to obtain, maintain, or advance in employment or self-employment/microenterprise.

VFPS includes the development of an employment plan is based on:
a. An individualized determination of strengths, needs; and interests;
b. Analysis of the participant's barriers to work, including an assistive technology pre-screen or in-depth assessment;
c. Identification of the assets the participant brings to employment;
d. Benefits analysis and support;
e. Resource team coordination;
f. Career exploration and employment goal validation;
g. Job seeking support, with an emphasis on competitive, integrated employment opportunities; and,
h. Job follow-up and long-term support.

When this service is provided, the participant's case management record must contain activity reports, completed by the appropriate VFPS Team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the ongoing support and provided to the participant.

VFPS may only be covered by the waiver when not covered by the State Plan or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. Additionally, VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17)). VFPS may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category. Waiver funds may not be used to purchase this service if it is provided to the general public for free.

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

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

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

☐ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational and Futures Planning Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vocational and Futures Planning

Provider Category:

Agency

Provider Type:

Vocational and Futures Planning Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All VFPS team members shall be qualified professionals that 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent.

Frequency of Verification:

Prior to purchase and annually, if applicable.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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) In accordance with SMA IRIS program policy, all paid caregivers are required to pass a criminal and caregiver background checks before being allowed to provide services to participants.

b) The scope of the required criminal and caregiver background checks is described in the SMA IRIS program policy.

c) The IRIS Fiscal Employer Agents (FEA) are required by contract to ensure that all persons working as paid caregivers pass a criminal and caregiver background checks before being allowed to provide services to participants. 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. SMA 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 Wis. Stat. § 146.40 and Wis. Admin. Code §§ DHS 13, maintains a registry of caregivers as an official record of persons found to have abused or neglected a client or misappropriated a client's property. The ICAs and FEAs, as well as all other entities that are licensed by, certified by, or registered with the SMA to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse, neglect, or misappropriation committed by any person who is employed by or under contract with the entity if the person is under the control of the entity.

b) Positions for which abuse registry screenings must be conducted include all waiver service providers, paid or unpaid, listed on the ISSP who have regular, direct contact with waiver participants and all persons employed by or under contract with an entity that is licensed or certified by or registered with the SMA to provide direct care or treatment services to clients.

c) The SMA's contract with the FEAs requires FEAs to ensure that all persons working as caregivers pass required registry checks. 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	
Certified 1-2 Bed Adult Family Home	
Certified Residential Care Apartment Complex	
Licensed Adult Family Homes	

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: Facility Specifications

Facility Type:

Certified 1-2 Bed Adult Family Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Counseling	☐
Counseling and Therapeutic Services	☐
Prevocational Services	☐
Home Modification	☐
Day Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Relocation - Community Transition Service	☐
Consumer Education and Training	☐
Vocational and Futures Planning	☐
Respite	☐
Interpreter Services	☐
Community Transportation 2	☐
Residential Services (1-2 Bed AFH)	☒
Daily Living Skills Training	☐
Adult Day Care	☐
Support Broker Services	☐
Supported Employment - Group	☐
Supported Employment - Individual	☐
Nursing Services	☐
IRIS Consultant Services	☐
Vehicle Modifications	☐
Training Services for Unpaid Caregivers	☐
Individual Directed Goods and Services	☐
Assistive Technology	☐
Personal Emergency Response System (PERS)	☐
Home Delivered Meals	☐
Fiscal Employer Agent Services	☐
Community Transportation	☐

Waiver Service	Provided in Facility
Residential Services (Other)	☐
Specialized Medical Equipment and Supplies	☐
Live-in Caregiver	☐
Community Involvement Support	☐
Supportive Home Care	☐

Facility Capacity Limit:

1 or 2 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Certified Residential Care Apartment Complex

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Counseling	☐
Counseling and Therapeutic Services	☐
Prevocational Services	☐
Home Modification	☐
Day Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Relocation - Community Transition Service	☐
Consumer Education and Training	☐
Vocational and Futures Planning	☐
Respite	☐
Interpreter Services	☐
Community Transportation 2	☐
Residential Services (1-2 Bed AFH)	☐
Daily Living Skills Training	☐
Adult Day Care	☐
Support Broker Services	☐
Supported Employment - Group	☐
Supported Employment - Individual	☐
Nursing Services	☐
IRIS Consultant Services	☐
Vehicle Modifications	☐
Training Services for Unpaid Caregivers	☐
Individual Directed Goods and Services	☐
Assistive Technology	☐
Personal Emergency Response System (PERS)	☐
Home Delivered Meals	☐
Fiscal Employer Agent Services	☐
Community Transportation	☐
Residential Services (Other)	☒
Specialized Medical Equipment and Supplies	☐
Live-in Caregiver	☐
Community Involvement Support	☐
Supportive Home Care	☐

Facility Capacity Limit:

No limit (See c.ii.)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Adult Family Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Counseling	☐
Counseling and Therapeutic Services	☐
Prevocational Services	☐
Home Modification	☐
Day Services	☐

Waiver Service	Provided in Facility
Consultative Clinical and Therapeutic Services for Caregivers	☐
Relocation - Community Transition Service	☐
Consumer Education and Training	☐
Vocational and Futures Planning	☐
Respite	☐
Interpreter Services	☐
Community Transportation 2	☐
Residential Services (1-2 Bed AFH)	☐
Daily Living Skills Training	☐
Adult Day Care	☐
Support Broker Services	☐
Supported Employment - Group	☐
Supported Employment - Individual	☐
Nursing Services	☐
IRIS Consultant Services	☐
Vehicle Modifications	☐
Training Services for Unpaid Caregivers	☐
Individual Directed Goods and Services	☐
Assistive Technology	☐
Personal Emergency Response System (PERS)	☐
Home Delivered Meals	☐
Fiscal Employer Agent Services	☐
Community Transportation	☐
Residential Services (Other)	☒
Specialized Medical Equipment and Supplies	☐
Live-in Caregiver	☐
Community Involvement Support	☐
Supportive Home Care	☐

Facility Capacity Limit:

4 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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.*

a) The spouse of a participant may be paid to provide personal care and/or supportive home care identified as necessary and included on the participant's Individual Support and Service Plan (ISSP) if: 1) the participant's preference is for the spouse to provide the service; 2) the spouse meets the provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the FEA and the spouse for providing this service; and 3) the spouse will either i. provide an amount of service that exceeds the normal care giving responsibilities for a spouse who does not have a disability, or ii. find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b) The spouse may be paid only for services that are above and beyond the usual spousal responsibilities. The ICA is responsible to ensure that the purchase of service meets all of the following criteria intended to ensure that the provision of services by a spouse is in the best interest of the participant: 1) the service to be provided meets identified needs and outcomes on the participant's Individual Support and Service Plan (ISSP) and assures the health, safety, and welfare of the participant; 2) purchase of services from the spouse is cost-effective in comparison to purchase of services from another provider; and 3) potential conflicts of interest for the provider are identified and monitored by the ICA. ICA review also assures the participant is able to fully participate in the self-direction process.

c) ICAs are responsible to monitor and document that the services purchased from the spouse are actually delivered in accordance with the participant's Individual Support and Service Plan (ISSP). ICAs conduct Fraud Allegation Review and Assessment (FARA) and if necessary, mitigate associated risks, when concerns are raised about potential payment for unworked hours to the individual(s). ICAs also conduct announced and unannounced visits or other mitigation strategies. The SMA and its contracted external quality review organization (EQRO), monitor ICAs oversight of all service providers including legally responsible caregivers. In situations wherein the spouse is the one committing the fraud, the participant may be dis-enrolled from the IRIS program.

☒ **Self-directed**

☒ **Agency-operated**

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.

a) For the purposes of this waiver, a relative is defined as a person related, by blood, adoption or marriage, to the participant. Legal guardian is defined in state statute.

b) Services are rendered by relatives/legal guardians when:
1. The service is identified as necessary and included on the participant's Individual Support and Service Plan (ISSP);
2. The participant's preference is for the individual to provide the service;
3. There is a properly executed provider agreement between the FEA and the individual providing this service;
4. The individual meets the provider qualifications and standards for the service;
5. For spouses, the spouse may be paid only for services that that exceeds the normal care giving responsibilities for a spouse who does not have a disability or find it necessary to forego paid employment in order to provide the service

c) Additionally:
1. ICAs are responsible to monitor and document that the services purchased from the relative/legal guardian are actually delivered in accordance with the participant's Individual Support and Service Plan (ISSP). ICAs conduct Fraud Allegation Review and Assessment (FARA) and if necessary, mitigate associated risks, when concerns are raised about potential payment for unworked hours to the individual(s). ICAs also conduct announced and unannounced visits or other mitigation strategies. The SMA and its compliance contractor, monitor ICAs oversight of all service providers including relatives/legal guardians. In situations wherein the relative/legal guardian is the one committing the fraud, the participant may be dis-enrolled from the IRIS program as a result.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

a) All willing providers who demonstrate evidence of meeting eligibility requirements for provider qualifications and/or standards for the desired Appendix C-1/C-3 service, are eligible to serve IRIS participants. The SMA contracts with the IRIS Consultant Agencies (ICAs) and Fiscal Employer Agents (FEAs) and require that those organizations be familiar with provider enrollment procedures, timelines, and responsibilities relative to the verification of provider qualifications and standards.

b) IRIS participants or legally representative, identify the agencies or participant-hired worker applicants that can provide services. The participant's ICA provides the necessary tools, resources, information, and support to assist participants in locating providers. Additionally, participants can also retain the services of a Support Broker to help locate providers.

c) ICAs provide participants the necessary supports and services in support of self-direction by assisting the identified providers or participant-hired workers to accurately and thoroughly complete provider enrollment and qualification verification, including all required criminal and caregiver background checks. The SMA's case management system maintains information on providers, including participant-hired workers that are already registered and have had their qualifications including applicable criminal and caregiver background checks verified. In these cases, the provider is immediately available to be selected during the development of the participant's ISSP in the SMA's case management system. Additionally, at the request of the participant, ICAs and Aging and Disability Resource Centers (ADRCs) can provide a lists of providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Active participant-hired workers (PHW) must have the appropriate criminal background and caregiver registry checks as verified by the Fiscal Employer Agent (FEA). Numerator/Denominator: Number and percent of active participant-hired workers with appropriate criminal background and caregiver registry checks over Number of active participant-hired workers checked.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA case management system (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 monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
Active providers (non-participant-hired worker) must meet the provider verification requirements as verified by the Fiscal Employer Agent (FEA).
Numerator/Denominator: Number of active providers (non-participant-hired workers) who met the provider verification requirements over Number of active providers (non-participant hired worker).

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Case Management System (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:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Participants must have a completed IRIS Participant Education Manual: Acknowledgement (F-01947) form in WISITS. Numerator/Denominator: Number and percent of participants who have a completed IRIS Participant Education Manual: Acknowledgement (F-01947) form over Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA case management system (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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **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.

To ensure waiver and program compliance by contracted ICAs and FEAs, the SMA developed performance indicators that aligns with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures. Contractor oversight operations also provide valuable discovery information.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Quarterly, the SMA meets with each contractor to review the following:

- Remediation activities for Record Review performance indicators below the CMS required threshold;
- Participant Satisfaction Survey results;
- Review of all substantiated cases of abuse, neglect, misappropriation and exploitation cases; and
- Review of the contractor Performance Improvement Plans (PIPS) promulgated by the contractor to increase performance and address areas for improvement.

Annually, the SMA conducts the “Contractor Recertification Site Visit” with each contractor. Following the site visit, the SMA provides the contractor with the outcome of the Annual Recertification Visit.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The site visits also seeks to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Program Oversight Tracking document.

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

ii. Remediation Data Aggregation

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

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

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

☐ **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.

IRIS Individual Budget Allocations (IBAs) are established through a model based on historic cost data. The SMA's contracted actuaries develop target group specific regression models to determine which attributes from the SMA's Long-Term Care Functional Screen (LTCFS) are most predictive of a participant's costs as well as the amount of funding predicted by each attribute. An IRIS participant's IBA is calculated by seeing which attributes the member has on the LTCFS, and adding up the funding the regression model has associated with those attributes. Further adjustments, such as for regional cost variance, are applied to the IBA as appropriate to maintain an equitable and cost-effective funding model. This calculation is completed automatically as part of the LTCFS system. The SMA updates the IBA calculation annually.

All services in Appendix C-1/C-3 are funded by this individual budget allocation with the exception of IRIS Consultant Services and Fiscal Employer Services that are requirements of participation of the IRIS program and are therefore not charged to the participant's budget.

If the participant's IBA is insufficient to meet the needs of the participant, a budget amendment (BA) or one-time expense (OTE) request can be made to the SMA. The SMA reviews all BA/OTE requests and determines if those requests are fully approved, partially approved, or denied.

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 LTCFS will be administered. Any change in budget will be considered prior to determining the need for a BA or OTE. Participants may exercise their State Fair Hearing rights in cases where BA or OTE requests are denied. Participants who reside in adult family homes or RCACs are not eligible for BA or OTE requests. Exceptions are considered by the SMA for those participants for whom their budget is reduced following an annual LTCFS 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 SMA has assessed and determined that the following settings meet the requirements of 42 CFR § 441.301(c)(4):
(a) Participant's private residences; whether owned or rented, including when voluntarily shared with family, friends, or chosen residence mates; that are not regulated residential settings for persons with disabilities.
(b) Places of integrated, competitive employment.
(c) 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.

The SMA 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 participant's choice and are 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 participant's preference; provide opportunities for regular interaction in daily activities with non-participants; facilitate participant 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 SMA has done the following:
(a) Included requirements in the SMA-FEA/ICA contract to ensure the ongoing assessment of settings in which waiver services are provided; and
(b) Informed participants, through the participant materials, of the settings requirements and how to report any concerns in regard 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.

a) Participants receive information and support relating to directing and being actively engaged in the service plan development process, at a minimum, during orientation and quarterly thereafter. The participant also has the freedom to request information and support from the IRIS Consultant (IC), IRIS Consultant Agency (ICA), or Fiscal Employer Agent (FEA) at any other time.

To help the participant direct and be actively engaged in the service plan development process the participant is educated and provided supports related:
- To the self-directed planning process;
- 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;
- Differences between participant-hired worker and agency providers;
- Strategies for managing an individual budget;
- Processes for changing supports and services.

b) 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The self-directed Individual Support and Service Plan (ISSP) reflects the participant's chosen lifestyle, culture, and functional and social needs for successful community living. The goal of the self-directed planning process is for the participant to have his or her long-term support needs met and to achieve a meaningful life in the community.

a) Upon enrollment and under the guidance of the IRIS Consultant (IC), the initial Individual Support and Service Plan (ISSP) is developed during a face-to-face meeting between the IC and the participant (and/or legal representative) with the optional support of any individual of the participant’s choosing, during the 60-day IRIS program orientation period. The IC facilitates the completion of the requisite paperwork and back-office processing related to the completion of the ISSP. The participant’s start date in the IRIS program is the date of implementation of the initial ISSP.

b) Information used in level of care assessments for new enrollees using the state’s automated Long-Term Care Functional Screen (LTCFS) is gathered by Aging and Disability Resource Center (ADRC) screeners during a face-to-face meeting with the participant.

The SMA, using information from the resulting LTCFS, identifies the participant’s long-term care needs relative to the participant’s abilities to complete activities of daily living (ADLs), instrumental activities of daily living (IADLs) as well as any medical or behavior needs. If behavioral needs are identified, a behavioral support plan (BSP) is also created. Additionally, an IRIS participant needs assessment is conducted to further refine and address the participant's identified long-term care needs.

To create the participant's initial ISSP, the IC uses the results of the LTCFS, the IRIS participant needs assessment, and any created behavioral support plan, in conjunction with exploratory discussions with the participant to comprehensively assess and identify the participant’s needs and long-term care outcomes, strengths, preferences, informal supports, and identifies any ongoing participant conditions that require a course of treatment or regular care monitoring.

c) Participants are first informed about the services available under the waiver at the Aging and Disability Resource Center (ADRC) or the Tribal Aging and Disability Specialist (TADRS) during enrollment options counseling. Upon enrollment and during program orientation, participants are also provided with SMA-approved materials which describe the services available under the waiver. Periodically, but at a minimum, at least quarterly, ICs meet with participants to formally review, reassess, and update, if necessary, the ISSP. At these reassessment meetings, the ICs, if requested, provide information about the services available under the waiver. Also, SMA-approved IRIS program materials along with overall information about the IRIS program and the available services offered, are readily available on the IRIS program website.

d) The participant's ISSP is developed using a self-directed planning process that assesses, identifies and documents the participant’s long-term care needs and outcomes; the services and supports, consistent with the assessment, that will be sufficient to assure the participant’s health, safety, and well-being and which are satisfactory to the participant in supporting his or her outcomes; and will encourage the active involvement of the participant and his or her natural and community supports.

To ensure that the ISSP is understandable to the participant (and/or legal representative), it is written in plain language and in a manner that is accessible to participants with disabilities (through the provision of auxiliary aids and services at no cost to the participant) and participants with Limited English Proficiency (through the provision of language services at no cost to the participant).

ICAs are required to ensure that the ISSPs developed by their ICs meet the needs of the participant. Accordingly, the SMA conducts record reviews that evaluate a sample of participant ISSPs to ensure that the ISSPs as created 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) The IRIS participant (and/or legal representative) receives information and individualized assistance from an IRIS Consultant (IC). The amount of support from the IC varies based upon the participant's needs, but at a minimum, the IC assures that the participant's long-term care needs are assessed, outcomes developed, related services and supports identified, and there exists no immediate or long-term health and safety risks for the participant.

The IC provides the necessary tools, resources, and information to locate and retain providers. The participant is responsible for identifying and retaining either participant-hired workers (PHW) or agency providers or a combination of

both. The IC in tandem with coordination from the Fiscal Employer Agent (FEA), ensures that the ISSP and subsequent service authorizations, and other back office processes are in place to support the participant. The participant is responsible for communicating any change of condition to the IC so that level of care reassessments can be coordinated and subsequent changes made to the ISSP to address the changes in condition. ICs, at a minimum, are required to meet the participant quarterly to discuss and if necessary, revise the ISSP. However, the participant can at any time contact the IC about waiver and other services and support coordination matters.

f) The IC and participant collaboratively are responsible for development of the ISSP. During the ISSP development process the IC uses the results of the LTCFS, the IRIS participant needs assessment, and any created behavioral support plan, in conjunction with exploratory discussions with the participant to comprehensively assess and identify the participant's needs and long-term care outcomes, strengths, preferences, informal supports, and identifies any ongoing participant conditions that require a course of treatment or regular care monitoring.

ICs are required to ensure participants have the resources and information needed to implement the ISSP. The participant is responsible for implementing the ISSP, monitoring, and reporting service delivery. Additionally, ICs are required to complete periodic phone and/or face-to-face visits with the participant to monitor implementation of the ISSP, check on the participant's overall health and safety, and review and revise the ISSP if required. If participants are concerned about the implementation of the ISSP, they can contact their IC at any time.

g) Periodically, but at a minimum, at least quarterly, ICs meet with participants to review, reassess, and update, if necessary, the ISSP. As part of this process the IC reviews and reassesses the long-term care needs and outcomes of the participant and if necessary, conducts another LTCFS, and updates the ISSP accordingly. The participant and IC collaborate to ensure the new ISSP is an accurate and current reflection of the participant's needs and long-term care outcomes. Additionally, the ISSP must be reviewed and updated whenever the participant's preferences change, there is a significant change in the condition of the participant, the ISSP no longer meets the participant's needs or associated outcomes, or at the participant's (and/or legal representative) request.

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.

Participants and their ICs collaborate to identify and discuss the risks that may arise with IRIS participant direction of supports and services. Both work together to develop and implement strategies to mitigate those risks. This is also documented in the needs assessment component of the ISSP, completed during the development of the ISSP and throughout the participant's time in IRIS.

One mitigation strategy is the completion of a comprehensive back-up plan. ICs and participants are required to develop a back-up plan that outlines in the absence of the participant's primary caregiver, there is a back-up caregiver that is able to provide requisite care and maintain the participant's health and safety. Back-up plans must contain the following components:

a. Medical needs;
b. Behavior needs;
c. Medication and medical equipment needs;
d. General overview of the participant's daily schedule;
e. Contact information for emergency back-up providers;
f. Contact information for service providers including medical providers and the IRIS Consultant; and
g. Other pertinent participant-specific information.

The participant and the IRIS Consultant continuously review the accuracy and effectiveness of the back-up plan, and participants are responsible for notifying the IC of any changes that may impact the 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.

IRIS participants select their own service providers. During development of the ISSP and throughout the participant's time in the program, ICs are the main resource for service provider and vendor information. They are required to have localized knowledge and provide participants with the tools, resources, and information consistent with each participant's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The participant and IC complete the ISSP, and the ICA has the responsibility of approving each ISSP day-to-day. If any changes occur, it is also the ICAs responsibility to work with the participant to modify and then approve the plan. As described in Appendix C, select services may require SMA approval prior to being a part of an approved ISSP, but it is still the ICAs responsibility to approve each plan.

The SMA contracts with an External Quality Review Organization (EQRO) to review ISSPs. The EQRO reviews a sample (95% confident interval) of each ICA's total ISSPs from the past year on a quarterly basis. The random sample is reviewed to ensure that those ISSPs:

- Address all of the participant's long-term care needs, including mitigation of health and safety risks (see performance measure at the end of this appendix);
- Have participant-driven long-term care outcomes;
- Have adequately supported long-term care outcomes; and
- Have complete service authorizations including service or support type, scope, amount, description, and frequency (see performance measure at the end of this appendix).

If any negative findings arise from this review, the SMA is notified and the ICA must remediate the findings (non-compliant ISSPs) immediately. In addition, the SMA and ICA discuss performance on these review indicators at quarterly meetings.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update 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):*

- [x] **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.

The main method of ISSP monitoring comes in the form of regularly meetings and conversations between the participant and IRIS Consultant (IC). Jointly, they are responsible for monitoring the implementation of the ISSP to ensure that specified supports and services continue to meet the participant's needs, are furnished in accordance with the service plan, and are accessible to the participant. The participant and IC meet frequently for thorough, face-to-face consultations during the initial ISSP planning and implementation phase. After this phase, at a minimum, ICs contact participants on a monthly basis and meet face-to-face every 90 days.

Regular meetings also provide the opportunity for the IC to monitor the participant's back-up plan and health and safety. ICs may mitigate risk of threats to health and safety by connecting participants with resources for addressing their own health and safety risks. If a threat to health or safety arises, ICs report such critical incidents to appropriate parties, which may include Adult Protective Services or law enforcement. This is further defined in Appendix G. If the participant refuses, or is unable, to address his or her own health and safety, or refuses the assistance of the IRIS Consultant, the IRIS Consultant has the responsibility to recommend involuntary disenrollment.

In addition to regular meetings between ICs and participants, the SMA has developed performance indicators for monitoring the ongoing implementation of the ISSP. The EQRO review, on a quarterly basis, a random sample (95% confidence interval) of each ICA's ISSPs to ensure that each ISSP:
a. Continues to address all of the participant's long-term care needs, including mitigation of health and safety risks (see performance measure at the end of this appendix);
b. Continues to have participant-driven long-term care outcomes;
c. Continues to have adequately supported long-term care outcomes; and
d. Continues to have complete service authorizations including service or support type, scope, amount, description, and frequency (see performance measure at the end of this appendix).

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 States quality improvement strategy, provide information in the following fields to detail the States 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:
Participants must have Individual Support and Service Plans (ISSP) that address all participant needs including health and safety risks. Numerator/Denominator: Number of participant records reviewed that address all participant needs over Number of participant records reviewed.

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

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

		95%
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants 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:
Participant Individual Support and Service Plans (ISSP) must be updated at least once every 365 days. Numerator/Denominator: Number of participant records with an ISSP that was updated in the last 365 days over Number of participant records reviewed.

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

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

☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
Participant records must have complete service authorizations that identify the type, scope, amount, description, and frequency of services. Numerator/Denominator: Number and percent of records with complete service authorizations (type, scope, amount, description, and frequency of services) over Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA case management system (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: Office of Inspector General (OIG)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Participant records must demonstrate that participants were offered a choice of waiver services and providers. Numerator/Denominator: Number and percent of participants who have a completed "IRIS Participant Education Manual: Acknowledgement (F-01947)" form over Total number of participant records reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

To ensure waiver and program compliance by contracted ICAs and FEAs, the SMA developed performance indicators that aligns with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures. Contractor oversight operations also provide valuable discovery information.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

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

Annually, the SMA conducts the “Contractor Recertification Site Visit” with each contractor. Following the site visit, the SMA provides the contractor with the outcome of the Annual Recertification Visit.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The site visits also seeks to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Program Oversight Tracking document.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. 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.

IRIS (Include, Respect, I Self-direct) waiver offers participants the opportunity to fully self-direct their long-term care needs. All participants exercise budget authority in directing their waiver supports and services, excluding IRIS Consultant (IC) Services and Fiscal Employer Agent Services (FEA), which assist participants with budget authority and employer authority, if elected. Specifically, IRIS provides participants (and/or legal representatives; this is implied throughout the waiver) with the opportunity to:
a. Direct long-term care service delivery which allows for decision making regarding which long-term care supports and services are furnished and which service providers provide them;
b. Exercise employer authority by assisting participants with acting as employers of individuals who furnish waiver supports and services; and
c. Exercise budget authority by supporting participants with making decisions over how their Medicaid funded budget is spent.

IRIS participants are able to take advantage of these opportunities by:
a. Determining who else, family members, friends, legal representatives, qualified professionals, etc., they would like to be a part of decision making during their time in the program and the extent of those individuals' participation;
b. Deciding which IRIS Consultant Agency (ICA) and Fiscal Employer Agent (FEA) to utilize while in the program and having the ability to change this choice throughout their time in the program;
c. Taking a leadership role during development of the participant-centered Individualized Support and Service Plan (ISSP);
d. Being provided with sufficient, relevant information and support to facilitate informed decisions;
e. Determining outcomes (goals) from assessed long-term needs and preferences as well as strategies for attaining those outcomes;
f. Selecting services that best meet outcomes, preferences, and abilities;
g. Determining the amount, frequency, and duration of services and supports;
h. Selecting service providers and negotiating rates;
i. Choosing to serve as an employer of record and hire and supervise individual hired workers;
j. Creating strategies to identify, assess, and manage potential risks; and
k. Creating individual backup plans for situations that might jeopardize the participant's health and welfare.
l. Exercising decision making over all aspects of waiver service delivery (excluding IC and FEA services) and accepting the responsibility for directly managing them in an ongoing basis; and
m. Having the ability to modify their ISSP, goals, strategies, services, and service providers throughout their time as a program participant.

Because IRIS requires full participant direction (or self-direction), the SMA contracts with organizations to provide those services that are required to assist participants with self-direction and participation in the program. Specifically:
a. Information and assistance in support of participant direction: This service is provided by agencies certified by the SMA as IRIS Consultant Agencies (ICAs). Resources, information, and services are provided to participants to assist the participant with identifying immediate and long-term needs and outcomes, developing options to meet those needs and outcomes, and gaining access to needed waiver, State Plan, and community services and supports regardless of funding source.
b. Financial management services: This service is provided by agencies certified by the SMA as FEAs. FEA services assist the participant with exercising employer authority by acting as the participant's fiscal employer agent and budget authority by assisting with managing and directing the disbursement of funds.
The SMA also contracts with independent advocacy agencies to provide participants with a route to address concerns regarding IRIS or self-direction. This is further discussed in Appendix E-1-k.

In summary, IRIS not only supports the participant to achieve long-term care outcomes but also supports the participant to live the life he or she chooses. IRIS is structured to afford participants the opportunity to freely determine all aspects of program participation including identifying needs and preferences, choosing goods, supports, and services, directing all aspects of service delivery including setting rates and selecting providers, having the ability to hire individual workers, and monitoring service quality. All of these opportunities are discussed throughout Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Additional allowable living settings include:
- Home of a friend,
- Certified Residential Care Apartment Complexes (RCAC),
- Certified 1-2 Bed AFH, and
- Licensed 3-4 Bed Adult Family Homes (AFH).

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

◉ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Prior to selection of IRIS, a prospective participant is given information about the various Wisconsin adult long-term care programs for which they are eligible at an Aging and Disability Resource Center (ADRC). ADRCs are public entities that are tasked with helping individuals make informed decisions in regards to their long-term care. ADRCs present an unbiased overview of information on the various benefits and public programs including information about participant direction opportunities in IRIS and other adult long-term care programs. A prospective participant who express interest in IRIS are provided IRIS-specific informational documents. This includes plain language scorecards that display performance on select customer service indicators of ICAs and FEAs.

Once a prospective participant selects IRIS and is referred to the program, the ICA welcomes the participant and then provides the participant with a robust orientation to the program within 30 days. This orientation includes walking the participant through a participant-friendly IRIS education document. This document outlines information and policies, including responsibilities and liabilities with being an IRIS participant. These topics include, at a minimum, participant rights, participant direction services and supports (ICAs and FEAs), ISSP development, budget management, health and safety monitoring, conflicts of interest, the complaint and grievance process, and employer authority expectations and tasks. The participant attests that the document was reviewed and received.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Housing Counseling	☐	☒
Counseling and Therapeutic Services	☐	☒
Prevocational Services	☐	☒
Home Modification	☐	☒
Day Services	☐	☒

Waiver Service	Employer Authority	Budget Authority
Consultative Clinical and Therapeutic Services for Caregivers	☐	☒
Relocation - Community Transition Service	☐	☒
Consumer Education and Training	☐	☒
Vocational and Futures Planning	☐	☒
Respite	☒	☒
Interpreter Services	☐	☒
Community Transportation 2	☐	☒
Residential Services (1-2 Bed AFH)	☐	☒
Daily Living Skills Training	☒	☒
Adult Day Care	☐	☒
Support Broker Services	☒	☒
Supported Employment - Group	☐	☒
Supported Employment - Individual	☒	☒
Nursing Services	☐	☒
Vehicle Modifications	☐	☒
Training Services for Unpaid Caregivers	☐	☒
Individual Directed Goods and Services	☒	☒
Assistive Technology	☐	☒
Personal Emergency Response System (PERS)	☐	☒
Home Delivered Meals	☐	☒
Community Transportation	☒	☒
Residential Services (Other)	☐	☒
Specialized Medical Equipment and Supplies	☐	☒
Live-in Caregiver	☒	☒
Community Involvement Support	☐	☐
Supportive Home Care	☒	☒

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:

In IRIS, participants are required to exercise budget authority but have the choice of exercising employer authority, where the participant is the common law employer of his or her worker(s). In order to support the IRIS participant in exercising both authorities, FMS are provided as a waiver service (Fiscal Employer Agent Services) by non-governmental, vendor organizations that are certified. These certified vendor organizations are titled Fiscal Employer Agents (FEAs). There is no limit to the number of FEAs in the IRIS program.

Certification is managed by the SMA and meets requirements set forth in 45 CFR § 92.42. Through the certification process, the SMA ensures that interested vendor organizations have the capability to perform tasks in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 as well as other SMA desired tasks and responsibilities. Once certified, FEAs enter into a contract with the SMA and sign a Medicaid provider agreement. FEA contracts have two year terms, and FEAs are recertified annually. Throughout the vendor organizations time as an FEA, the SMA provides oversight and technical assistance to ensure FEAs continue to satisfactorily uphold contract-outlined responsibilities and tasks.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The SMA pays FEAs a per enrolled participant rate on a monthly basis.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

Conducts caregiver background and criminal history checks. Verifies provider qualifications. Checks Federal exclusions monthly.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

Specify:

Collects required IRIS participant Medicaid post eligibility cost share payments, when applicable.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FEA services are monitored in a variety of ways. More on review of waiver service expenditures (FEA responsibility) is described in Appendix I. Oversight includes:
a. On a weekly basis, FEAs submit expenditure data to be processed and disbursed to waiver service providers. The SMA reviews the weekly data for calculation errors. In addition, a small random sample of expenditure data is reviewed to ensure individual expenses are not over the budget and match the service authorized in selected participant’s ISSP.

b. On a monthly basis, the SMA reviews performance on the performance measures expressed in this waiver, other measures not expressed in the waiver, including customer service measures. This review is done by the External Quality Review Organization (EQRO) and results are communicated to the SMA quarterly.

c. On a quarterly basis, the SMA meets with each FEA to review performance on the above items, discuss challenges and concerns regarding the FEA’s responsibilities, and identify opportunities for technical assistance. If a Conditional Certification Improvement Plan (CCIP) is in place, the SMA and FEA would discuss the FEA’s progress on meeting the CCIP requirements. This meeting provides for the opportunity to discuss anything related to IRIS and the FEA’s role, including discussing participant experience from the perspective of the FEA.

d. On an annual basis, the SMA conducts a recertification visit at each FEA. This is similar to the quarterly meetings but is more extensive. The visit ensures that the FEA is upholding contract requirements and continues to meet provider qualifications.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

In order to support the IRIS participant in exercising both authorities, information and assistance are provided as an element of the IRIS Consultant Services waiver service. This service is provided by SMA certified non-governmental, vendor organizations, or IRIS Consultant Agencies (ICA). ICAs employ IRIS Consultants (ICs) to work individually with IRIS participants and to provide services and supports appropriate to the level of participant direction the participant elects. How the IRIS Consultant Service assists participants with exercising budget and employer authority is described in the "IRIS Consultant Services" definition in Appendix C-1/C-3.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Housing Counseling	☐
Counseling and Therapeutic Services	☐
Prevocational Services	☐
Home Modification	☐
Day Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Relocation - Community Transition Service	☐
Consumer Education and Training	☐
Vocational and Futures Planning	☐
Respite	☐
Interpreter Services	☐
Community Transportation 2	☐
Residential Services (1-2 Bed AFH)	☐
Daily Living Skills Training	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Care	☐
Support Broker Services	☒
Supported Employment - Group	☐
Supported Employment - Individual	☐
Nursing Services	☐
IRIS Consultant Services	☒
Vehicle Modifications	☐
Training Services for Unpaid Caregivers	☐
Individual Directed Goods and Services	☐
Assistive Technology	☐
Personal Emergency Response System (PERS)	☐
Home Delivered Meals	☐
Fiscal Employer Agent Services	☐
Community Transportation	☐
Residential Services (Other)	☐
Specialized Medical Equipment and Supplies	☐
Live-in Caregiver	☐
Community Involvement Support	☐
Supportive Home Care	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The SMA contracts with a private, non-profit agency (Disability Rights Wisconsin; participants ages 18-59) and an independent, governmental board (Board on Aging and Long Term Care, participants ages 60 and above) to act as long-term care ombudsmen. As necessary, they investigate participant complaints and problems about IRIS and self-direction, provide information to participants about their rights, and refer participants to other resources, as appropriate. They also represent participants at hearings and during disputes. Ombudsmen may also consult and work with the SMA to ensure the participant's concerns are fully addressed.

Contact information and the types of information and services ombudsmen can provide are detailed on participant program documents. This information is also provided on the SMA's website. ICAs are also expected to furnish this information to participants during program enrollment and as needed throughout the participant's time in the program.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Only persons who elect to self-direct are eligible for IRIS, so if a participant voluntarily dis-enrolls from IRIS, the participant has the option to explore alternative Wisconsin long-term care programs.

If a participant wants to voluntarily dis-enroll, the participant is directed to return to the Aging and Disability Resource Center (ADRC) to go through enrollment counseling to select a different long-term care program. ADRCs communicate the participant's decision to the ICA, and, until the participant is officially enrolled in the other long-term care program, the ICA ensures the participant's health and welfare and continued IRIS supports and services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Because the waiver targets only participants who elect to direct their services, the following are reasons a participant may be involuntarily disenrolled from IRIS:

1. Failure to utilize IRIS funding (not spending funds in the budget);
2. Loss of financial eligibility, including falling into cost share arrears;
3. Loss of functional eligibility, including expiration of long-term care functional screen;
4. Mismanagement of Budget Authority responsibilities (misappropriation of funds);
5. Mismanagement of Employer Authority responsibilities;
6. Unable to contact for an extended period of time;
7. Health and safety cannot be assured;
8. Substantiated fraud;
9. Movement to an ineligible living setting; and
10. Noncompliance with IRIS program requirements outside of reasons above.

In cases of involuntary disenrollment, the participant is notified of the decision, provided a Notice of Action, and provided information on how to engage the State Fair Hearing process if the participant wishes to appeal the decision. The ADRC is then made aware of the involuntary disenrollment and given the official disenrollment date. Up until the participant is officially disenrolled, the ICA ensures the participant's health and welfare and continued IRIS supports and services.

In the case that the participant engages in the State Fair Hearing process to appeal the disenrollment decision, the ICA ensures continued health and welfare along with services and supports until there is a reaffirmed disenrollment date, if that is the result.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		27175
Year 2		29376
Year 3		31555
Year 4		33734
Year 5		35912

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Agency with Choice

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An IRIS participant's budget estimate relies on data from Wisconsin's Long-Term Care Functional Screen (LTCFS). Developed by the SMA, the LTCFS provides an automated and objective way to identify the long-term care needs of elders and people with physical or intellectual/developmental disabilities and determine the degree of assistance required to address those needs. Specifically, the LTCFS looks at a person's ability to complete both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). It also looks at a person's cognition, behavior(s), diagnoses, medically-oriented tasks and employment; as well as indicators for mental health issues, substance use issues and other conditions that put a person at risk of institutionalization in a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The screen was developed with input from stakeholders, consumers and clinical practitioners. Several studies to test its validity and reliability were also completed.

The SMA contracted actuaries to develop the regression model that predicts the total cost of an IRIS participant's needed long-term supports and services as determined by the participant's LTCFS results. The model was developed using past, corresponding IRIS services and supports expenditure and LTCFS data. After a participant goes through the LTCFS, that individual's information is inputted into the model and results in the participant's individual budget estimate. This budget estimate is what is used to allocate supports, services, and goods in the participant's ISSP during the self-directed planning process. This is applied consistently to each IRIS participant.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants are informed of the budget estimate by the IRIS Consultant Agency (ICA) during orientation. Participants use this budget amount to develop their ISSP. In addition, the participant is notified of the budget estimate each time the Long-term Care Functional Screen is administered, annually and as a result of a change in condition, if the situation arises.

If the costs of the participant's long-term support, services, and goods exceeds the budget estimate, the participant may seek additional funding through two methods:
1. A budget amendment request: A participant may request to increase their budget amount if the participant identifies that he or she requires an ongoing support or service that does not fit within the current budget. The participant's IRIS Consultant (IC) assists the participant with preparation and submission of the request to the SMA for review. The SMA reviews the request for the additional support or service for allowability, appropriateness, and cost efficiency. If the request is approved, the budget amount is increased for the rest of the support and services plan year. Both the budget increase and requested support or service are documented in the participant's ISSP. In cases where the SMA has denied or partially approved the request, the participant receives a Notice of Action and has the opportunity to request an independent review by the SMA or appeal the decision through the State Fair Hearing process.

2. A one-time expense request: When a participant requires a one-time support or service that does not fit within the current budget, the participant may request the SMA to approve a one-time expense. Similar to the budget amendment request process, the participant's IC assists with preparation and submission of the request to the SMA for review. The SMA reviews the request for the additional support or service for allowability, appropriateness, and cost efficiency. If the request is approved, both the budget increase and requested support or service are documented in the participant's ISSP. In cases where the SMA has denied or partially approved the request, the participant receives a Notice of Action and has the opportunity to request an independent review by the SMA or appeal the decision through the State Fair Hearing process.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

FEAs are required to provide participants with a budget statement on a monthly basis. This statement includes an individual accounting of expenditures by service, further broken down by provider, amount paid, and indicators of overspending. If questions or concerns are identified by the participant, contact information is included on the report to assist with questions.

FEAs are also required to provide ICAs and the SMA with a participant-level monthly budget and spending report. ICAs use this information to discuss budget and spending progress with the participant.

If a concern or problematic trend is identified, the participant's IRIS Consultant (IC) is notified and directed to contact the participant as soon as is practicable. The IC is expected to explore the situation and offer assistance and resources to ensure that the participant is able to spend his or her budget appropriately. The IC is also expected to continue to monitor the situation and ensure the participant has adequate support.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

IRIS program participants receive information about opportunities to request a fair hearing at multiple times and in multiple ways, including prior to enrollment, at the time of enrollment, and while enrolled. The opportunities presented to participants are as follows:

- Aging and Disability Resource Centers (ADRCs) or Tribal Aging and Disability Resource Specialists (TADRS) provide information about fair hearings during enrollment counseling and any other time upon request; or
- the regional income maintenance (IM) consortium which determines financial eligibility for Medicaid use standardized Notices of Action (NOA) forms to inform participants of ineligibility that include information about the right to a fair hearing; or
- ICAs provide participants with SMA approved participant education materials which includes fair hearing information, at program orientation, whenever the participant materials are updated, or at a minimum, annually; or
- information is mailed to the participant with every issued notice of adverse benefit determination regarding the IRIS program and includes fair hearing information; or
- The SMA contracts for ombudsman services which provide assistance to participants in filing a request for fair hearing and to assist the participant at the hearing; or
- The SMA contracts with an external quality review organization (EQRO) to provide participants with information and support about the complaints and grievance process which includes information about the fair hearing process; or
- During the adjudications of appeals of “adverse actions,” Administrative Law Judges provides the participant with written information with includes fair hearing information.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When a participant’s request for additional waiver funds either through a Budget Amendment (BA) or One-Time Expense request (OTE) has been denied, the participant has the opportunity to request an “Independent Review” from the SMA. The SMA includes the information about the availability of an independent review in the initial denial correspondence sent to the participant. This initial denial correspondence also contains information about the fair hearing process available to the participant. The participant then has 10 days of the date of the initial denial correspondence to request an independent review from the SMA. As part of the independent review, the participant has the option of submitting additional information for consideration by the SMA during the independent review.

After the independent review, the SMA sends correspondence to the participant explaining the outcome and available options for further review, if necessary. If the SMA affirmed the denial of the request for additional waiver funds or the participant had not requested an independent review within ten days of the initial denial, the ICA sends the participant a Notice of Action (NOA). The NOA informs and provides an explanation of the SMA’s decision and provides information on the participant’s rights to a fair hearing. Throughout the entire “review” process, the participant is informed multiple times of their rights regarding a fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○ **No. This Appendix does not apply**

◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA oversees the complaints/grievance system of the IRIS program, through a contract with an external quality review organization (EQRO). The EQRO provides administration of, and tracks all grievances in a database. This database includes all timeline information and confidential records of participants' complaints/grievances and the resulting outcomes. The SMA receives periodic reports from the EQRO, detailing the complaints/grievances and efforts to mediate a resolution. This report is reviewed by the SMA for consistency and to monitor trends for each contracting ICA/FEA and trends overall.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) IRIS program participants and/or representatives may file complaints/grievances regarding dissatisfaction about any aspect of the care or service provided by the IRIS program. The formal state fair hearing is used primarily for "adverse actions" defined as a denial, reduction, termination or limitation of previously authorized services or when a participant is determined financially or functionally ineligible for the IRIS program.

b) IRIS program participants and/or representatives may report complaints and grievances in a number of ways. Participants can contact the ICA or FEA, SMA staff, IRIS Ombudsman, DHS Secretary's Office, Wisconsin State Legislator, Office of the Governor, or other external advocacy agencies. Additionally, the SMA contracts with an external quality review organization (EQRO) who provides services to assist and mediate complaints/grievances. As part of the contractual services, the EQRO provides a staff monitored email inbox and independent telephone hotline for participants and/or representatives to report complaints/grievances. The EQRO must complete its review of the complaint/grievance within 30 calendar days with the exception of participant-hired worker payments which should be resolved within 3 working days. The SMA and the EQRO reviews and analyzes trends in the data collected by the EQRO with the goal of streamlining the complaints/grievance process or eliminating reoccurring concerns/problems. All complaints/grievances not made to the EQRO and acknowledged by the SMA, are resolved expeditiously.

c) The EQRO monitors, mediates, and evaluates participants' complaints/grievances. In doing so, the EQRO communicates directly with the participant and/or representative, explains the rights afforded to the participant, communicates and provides information and options for recourse, and facilitates a collaborative environment to foster resolution of the participant's complaint/grievance. The EQRO also keeps secured confidential records of participant's complaints/grievances and the resulting outcomes. Periodically, the EQRO provides analysis and summaries of the collected data for the SMA's internal use and overall program integrity. All complaints/grievances not made to the EQRO and acknowledged by the SMA, are resolved expeditiously.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The incident types that the SMA requires to be reported for review and follow-up action include any instances of the following:

- Alleged or confirmed abuse, neglect, exploitation, or misappropriation;
- Illness, injury, or hospitalization that requires emergency medical treatment
- Death of a waiver participant;
- Medication administration errors that require medical attention;
- Unapproved or unplanned use of restrictive measures;
- Law enforcement involvement when the participant is the alleged victim or the alleged perpetrator;
- Significant damage to property, either enacted against or by the participant;
- Damage to a participant's residence due to fire, natural disaster, or other cause;
- Unexpected absence of a participant; and
- Unexpected significant behavior that is not addressed through a behavior support plan.

Participants, and/or their legal representatives, are provided education and expected to report any of the above mentioned incidents to the designated ICA staff no later than one (1) business day after the incident occurred or was discovered. Incidents can be reported by phone, in writing, or through appropriate available channels accessible to the participant.

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.

Referencing the consumer-focused educational and informational resources provided to participants, ICA staff provide training to participants, and/or their legal representatives, regarding the protections against and the identification of abuse, neglect, and exploitation. This training includes how abuse, neglect, and exploitation are reported to the appropriate authorities. This training occurs after enrollment and on an annual basis.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Once they are notified, ICAs are responsible for collecting information regarding incidents and ensuring the participant's immediate health and safety. They are then responsible for reporting each incident and the immediate follow-up activities to the SMA within seven (7) calendar days of notification utilizing the SMA's web-based critical incidents reporting system. The SMA reviews all reported incidents for appropriate follow-up.

Additionally, ICAs complete documentation regarding the applicable follow-up and assurance of ongoing health and safety within thirty (30) calendar days.

If ICAs are notified of any incidents involving alleged abuse, neglect, or exploitation, they are responsible for reporting such incidents to local law enforcement authorities and/or the local adult protective services (APS) agency. Local law enforcement authorities and APS agencies are the entities responsible for investigating allegations of abuse, neglect, and exploitation, pursuant to Wis. Stats. 55.043 and Wis. Stats. 46.90.

If the participant receives services within a SMA certified or licensed setting, the certifying or licensing entity is responsible for reporting any incidents that involve alleged abuse, neglect, or exploitation to local law enforcement authorities and/or local APS agencies. The certifying or licensing entity may perform an investigation of setting compliance, if deemed appropriate by such entity.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for overseeing all incidents submitted through the web-based critical incidents reporting system, which includes individually reviewing all incidents reported and ensuring that the ICAs have met the incident response requirements. Incidents are reviewed as they are submitted.

The information collected through the web-based critical incidents reporting system includes incident types, participant information and demographics, incident setting, and various stages of incident follow-up to assure participant health and safety. The collection of data within the system allows for a clean and efficient compilation and analysis of aggregate incident data to better address incident follow-up and identified trends. This is done through regular contacts with the ICAs, as well as a monthly remediation assurance process, where the SMA selects a sample of incidents for additional review of compliance, specifically regarding remediation activities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

As defined in Wisconsin Administrative Code DHS 94.10 and Wis. Stats. 51.61 (1) (i), any service provider using isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s. 51.61 (1) (i) 2. Stats. Restrictive measures may only be used when imminent risk of harm is present to protect the individual or others from injury, it must be the least restrictive approach possible, and it must be used for the shortest time possible.

The use of manual restraints, protective equipment, restraints for protection, restraints to allow healing, medical restraints, and medical procedure restraints, must be formally requested, evaluated, and approved by the SMA. Requests for restrictive measures must be accompanied by documentation of alternative methods attempted prior to the request for the restrictive measure, a plan for documenting and monitoring the use of the restraint, the education and training plan for personnel, and the plan to reduce and eliminate the use of the restrictive measure. Each request is evaluated by the SMA on a case-by-case basis and must be approved prior to the use or implementation of restraint.

Any unapproved or unplanned use of a physical restraint is considered a critical incident and must be reported to the SMA through the process defined in G-1. Drugs may not be used as restraints (i.e. chemical restraints) pursuant to Wis. Stats. 51.61 (1) (h).

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:

IRIS Consultant Agencies (ICAs) are required to ensure the safe use of restraints in accordance with the approved application. ICAs are required to discuss and review the documented use of approved restraints during each contact with the participant. ICAs also submit all critical incidents related to unapproved or unplanned use of restraints to the SMA, through the process defined in G-1.

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 use of restrictive interventions is limited to isolation, which incorporates both the use of physical or social isolation and isolation by staff withdrawal. As defined in Wisconsin Administrative Code DHS 94.10 and Wis. Stats. 51.61 (1) (i), any service provider using isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s. 51.61 (1) (i) 2. Stats. Isolation may only be used when imminent risk of harm is present to protect the individual or others from injury, it must be the least restrictive approach possible, and it must be used for the shortest time possible.

The use of isolation must be formally requested, evaluated, and approved by the SMA. Requests for the use of isolation must also be accompanied by documentation of alternative methods attempted prior to the request for isolation, a plan for documenting and monitoring the use of isolation, the education and training plan for personnel, and the plan to reduce and eliminate the use of isolation. Each request is evaluated by the SMA on a case-by-case basis and must be approved prior to the use or implementation of isolation.

Any unapproved or unplanned use of isolation is considered a critical incident and must be reported to the SMA through the process defined in G-1.

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:

ICAs are required to ensure the safe use of isolation in accordance with the approved application. ICAs are required to discuss and review the documented use of approved isolation during each contact with the participant. ICAs also submit all critical incidents related to unapproved or unplanned use of isolation to the SMA, through the process defined in G-1.

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).

As defined in Wisconsin Administrative Code DHS 94.10 and Wis. Stats. 51.61 (1) (i), any service provider using isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s. 51.61 (1) (i) 2. Stats. Seclusion may only be used when imminent risk of harm is present to protect the individual or others from injury, it must be the least restrictive approach possible, and it must be used for the shortest time possible.

The use of seclusion must be formally requested, evaluated, and approved by the SMA. Requests for the use of seclusion must also be accompanied by documentation of alternative methods attempted prior to the request for seclusion, a plan for documenting and monitoring the use of seclusion, the education and training plan for personnel, and the plan to reduce and eliminate the use of seclusion. Each request is evaluated by the SMA on a case-by-case basis and must be approved prior to the use or implementation of seclusion.

Any unapproved or unplanned use of seclusion is considered a critical incident and must be reported to the SMA through the process defined in G-1.

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:

ICAs are required to ensure the safe use of seclusion in accordance with the approved application. ICAs are required to discuss and review the documented use of approved seclusion during each contact with the participant. ICAs also submit all critical incidents related to unapproved or unplanned use of seclusion to the SMA, through the process defined in G-1.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Appropriately licensed medical professionals have first-line responsibility for monitoring the participant's medication regimens as part of regular reassessment and prescription. Second-line monitoring of medication regimens is the responsibility of service providers and participants. This includes regularly assessing medication regimens to identify failures to comply with medication regimens, following internal medication administration protocol, and reporting any medication administration concerns or errors to designated ICA staff. Upon initial plan development, ICAs document any medication administration needs identified in the functional screen. ICA staff also additionally request information regarding any reportable incidents, including medication errors, regularly.

If a participant is living in their own home or a family member's home, the participant or legal representative assumes responsibility for the overall ongoing monitoring of the participant's medication regimen.

Providers that are licensed or certified and providing services to participants have the responsibility to ensure the appropriateness of a participant's medication regimen. In accordance with the service provider's respective certifying or licensing authority, the provider has the responsibility to monitor and document appropriate medication administration regimens, including any behavior modifying medications as prescribed by a medical professional.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Participants must report any medication errors that require medical attention to the designated ICA staff within the applicable reporting guidelines defined in the waiver. It is the responsibility of designated ICA staff to report these incidents to the SMA for individual review and verification of appropriate follow-up.

In addition, providers that are licensed or certified by the SMA certifying or licensing entity have monitoring and reporting requirements related to the terms of their credentialing. Oversight of those monitoring and reporting requirements includes onsite reviews and investigation of incidents with those facilities.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Per SMA policy, a participant who has the capacity to self-administer medication and is residing in their own home or a family member's home, does so and their medications remain under their control. If the participant delegates this task to a provider, the participant or legal representative assumes responsibility for training any provider, monitoring the provider, and ensuring quality of medication administration, including reporting any medication administration errors that occur.

If a participant receives services from a certified or licensed provider, the provider must adhere to any medication administration protocols or regulations outlined in applicable certifying or licensing criteria.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication administration errors that require medical attention are reported to the designated ICA staff, which are in-turn reported to the SMA for review and verification of appropriate follow-up.

In addition, providers that are licensed or certified by an SMA credentialing entity also have reporting requirements related to the terms of their credential and must report any instances of medication administration errors to their applicable SMA credentialing authority.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors, including medication errors for which there are no negative impacts to the participant's health.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are required to report any medication errors resulting in the need for medical attention.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Designated ICA staff to report incidents regarding medication errors that result in the need to seek medical attention to the SMA for individual review and verification of appropriate follow-up. During plan development, ICAs also document any medication administration needs identified in the functional screen.

In addition, providers that are licensed or certified by an SMA credentialing entity are monitored by that credentialing entity, which includes onsite reviews and investigation of complaints and medication error-related incidents within those facilities.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Numerator/Denominator: Number of participant records reviewed for which the ICA submitted a critical incident report of remediation activities related to substantiated cases of abuse, neglect, exploitation, and unexplained deaths over Number of participant records with reported cases of abuse, neglect, exploitation, and unexplained deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA case management system (WISITS) and SMA-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 =

		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:
The IRIS Consulting Agency (ICA) is responsible for ensuring participant health and safety by ensuring immediate and ongoing health and safety related to the reported critical incident. Numerator/Denominator: Number of critical incidents reported in which the ICA adequately ensured the health and safety of the participant over Number of participant incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA-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 = 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:
Participants receiving supports using restrictive measures must have an approved restrictive measure application. Numerator/Denominator: Number of participants who have an approved restrictive measure over Number of participants using restrictive measures.

Data Source (Select one):

Record reviews, off-site
If 'Other' is selected, specify:
SMA Restrictive Measure 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: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Participants must receive annual education about accessing a primary care provider, the benefits of receiving influenza and pneumonia vaccines, and identifying symptoms of urinary tract infections. Numerator/Denominator: Number and percent of participants who have a completed "IRIS Participant Education Manual: Acknowledgement (F-01947)" form over Number of participant records reviewed.

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

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

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

To ensure waiver and program compliance by contracted ICAs and FEAs, the SMA developed performance indicators that aligns with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures. Contractor oversight operations also provide valuable discovery information.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

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

Annually, the SMA conducts the “Contractor Recertification Site Visit” with each contractor. Following the site visit, the SMA provides the contractor with the outcome of the Annual Recertification Visit.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The site visits also seeks to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Program Oversight Tracking document.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §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; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's 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 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Discovery and remediation information comes from the continuous measurement of progress on a collection of ICA and FEA performance indicators, referred to as the Record Review process. Developed by the SMA, these indicators demonstrate how the ICAs and FEAs are meeting the waiver assurances (described throughout the waiver) as well as how successfully they are in meeting other program performance and quality requirements. The indicators are divided into five categories: customer satisfaction, health and welfare, ISSP, administrative authority, and best practice. The Record Review is completed quarterly with data from the year prior. The SMA then analyzes the findings and determines remediation strategies and activities.

The SMA pays particular attention to those performance indicators that support the waiver assurances. As a result of the discovery and remediation information as well as information gathered from other sources of ICA and FEA oversight described in Appendix E, the SMA identifies if the poor performance is a result of the practices established by the ICA or the FEA or if it is a systemic issue that needs to be addressed by the SMA through programmatic policy change or waiver amendment.

When the finding is directly related to the performance of the ICAs or FEAs (not individually), the SMA works to develop strategies to enhance performance. When findings are related to a programmatic or systemic issue, the SMA works internally to develop strategies to increase compliance. Sometimes, the SMA meets with external stakeholders to discuss options for improvement strategies. Improvements needed that impact participant health and safety are prioritized followed closely by those that would address program integrity. To determine if the improvement activity or strategy was successful, the SMA continues to monitor the Record Review data.

ICAs and FEAs are also responsible for developing annual Performance Improvement Plans (PIPs) to increase performance and to address potential areas of improvement. The SMA monitors PIPs on a quarterly basis, at a minimum. PIPs must clearly define the desired outcome, target, strategy, and resulting deliverables.

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	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The SMA is responsible for assessing the impact of the system design changes. The SMA also documents system changes in a format that can be shared with internal and external stakeholders. The SMA format consists of:
a. Description of the needed system change;
b. Desired outcome of the system change;
c. Steps to complete the system change; and
d. Method to measure the effectiveness of the system change;
The SMA develops performance indicators related to each system change and incorporates them into the Record Review process. Once the system design has been implemented, the SMA continues to monitor the effectiveness of this change.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated by the SMA's Quality Strategy Steering Committee on an annual basis. The Committee reviews performance on waiver measures and revisits high level goals linked to the SMA vision, mission, and values of adult long-term care programs. The Committee includes representation from the quality, oversight, and compliance teams, who shape the SMA's direction of continuous improvement and operationalization of processes. The Committee evaluates progress on meeting performance goals, decides a course of action to meet goals not met, and monitors high-level effects of system-wide changes.

EQRO Annual Quality Reviews and activities are periodically reviewed as they relate to the overall Quality Improvement Strategy.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

○ **No**
◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

The State uses the NCI Survey as well as an internally developed statewide survey called the Participant Satisfaction Survey. The Participant Satisfaction Survey is meant to capture overall participant satisfaction with his or her ICA and FEA.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) The SMA contracts with IRIS Consultant Agencies (ICAs) and Fiscal Employer Agents (FEAs) and requires each agency to have an annual independent third party financial audit performed by a certified public accounting (CPA) firm. The audit must be in accordance with the Generally Accepted Auditing Standards and GAAP (accrual accounting).

The focus of the audit is expenditure and contract compliance. The annual financial audit includes sampling and testing claims payments, as well as verification of eligibility, authorization, and provision of services. The SMA reviews the results of the independent financial audits. Any findings resulting from the independent third party must be remediated by the contracted agencies. The SMA implements corrective action with the contract agencies as required, including but not limited to updated policies and procedures, additional internal controls, increased frequency of financial reporting, and/or additional reporting specific to the identified weakness.

Additionally, the SMA requires an annual review of the policy and procedure manual of each certified ICA and FEA provider. Internal audit controls used during claims processing are included in the annual review.

In addition to the above annual audit, the SMA conducts audits of the claim file submitted to DHS bi-weekly for provider and participant hired worker payroll claims. This audit includes a sample of 20% of the claims exceeding $2500.00 or more. Every fifth claim is reviewed by the SMA against the source authorization (the participants plan).

The SMA does not require audits of other waiver service providers.

(b) The Bureau of Rate Setting (BRS) within the SMA, provides oversight of the service utilization and payment data reported to the SMA by the Fiscal Employer Agencies (FEAs). The FEAs are the exclusive submitters of data and they only submit payment for services in the amount and at the rate approved under a valid service authorization. Service utilization and payment data is submitted to the SMA through the encounter data reporting system. The encounter system collects data submitted electronically through standard extensible markup language (XML) file format. The encounter reporting system has contingencies in place to detect, reject, and flag potential errors. Any errors are reported to the FEAs who correct and resubmit data until accepted.

All of the participant service claims submitted to the FEAs are audited against the source authorization (the participant's plan) prior to payment. The FEAs check for the accuracy of the claim, including service code and applicable modifiers, unit type, rate, frequency, provider, and authorization period against the same data elements on the authorization of the plan. A service cannot be authorized on a participant's plan unless the participant has sufficient budget authority and identified long-term care needs and outcomes along with a strategy to meet those needs and outcomes through the waiver. Individual consultants do not submit claims. The SMA pulls the participant count by IRIS Consultant Agencies (ICA) from the SMA case management system and reviews the claim file for accuracy. After reviews, the file is then sent to the state's fiscal agent and is validated against the State's MMIS system to ensure that all participants enrolled have maintained their MA eligibility. All participants that have not maintained their MA eligibility are removed from the payment to the ICA.

The SMA also conducts data integrity audits. The audit includes tracing the submittal of encounter data submission claims certified within 30 days to identify service claims found compliant with claim submission standards and source data authorizations (i.e. the ISSP), and claim rate submissions compared to source data authorizations. The audit conducted for claim submission standards includes the review of service, frequency, authorization period, date of service, code, applicable modifiers, unit, and provider. As part of the provider's contractual obligations, they are required to comply with any Corrective Actions required by the state including those resulting from audit findings.

The SMA also audits the claim file submitted bi-weekly for providers and participant hired worker (PHW) payroll claims. This audit includes a sample of 20% of the claims exceeding $2500.00 or more. Every fifth claim is reviewed by the SMA against the source authorization (the participant's ISSP).

To further ensure integrity and to confirm that services have been rendered by providers, the SMA conducts the IRIS Record Review process. Random participant's ISSPs are audited to verify that ICAs, per contractual obligations, have inputted long-term care outcomes and strategies, plan updates, signed education sheets, confirmed services documented on the ISSP meet the needs identified on the Long Term Care Functional Screen (LTCFS), and have completed required phone and in-person contacts. If ICAs are found deficient during this process, corrective actions are required to bring them into compliance.

Also, the FEA certification process includes requirements of the FEA regarding standard operating procedures and internal controls. FEAs are required to have their policy and procedure manual certified by the SMA. The SMA checks that the FEA will comply with the State's claim processing requirements, including put not limited to validation of participant

enrollment, service date, service unit, service amount and qualified provider as reflected on the participant's plan. The SOP must include a control to review 100% of claims submitted against the source data of the authorization. The SMA requires an annual review of the policy and procedure manual of each certified ICA and FEA provider. Internal audit controls used during claims processing are included in the annual review.

Several system level contingencies are also built in the SMA case management system to ensure financial integrity and accountability. These contingencies include:

1) HCBS waiver codes and modifiers are hard coded into the system removing the opportunity for services to be miscoded and compromise the integrity of the encounter data submission. The hard code can only be modified by the SMA case management system administrator;

2) A service cannot be added to an ISSP without an identified long term care outcome, strategy and status (e.g. in progress, maintaining);

3) The plan setup page in the SMA case management system also requires you to identify 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.

4) There is a complete separation between provider set up and adding a provider to an authorization. The FEAs are the only entities allowed to add providers to the SMA case management 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.

5) 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.

6) In addition to the controls in place for providers described above, participant hired workers are also linked directly to the participant they are employed by, eliminating the opportunity for a PHW to be added to an ISSP of a participant they are not authorized to work for.

(c) The SMA ensures the financial integrity of payments that have been made for waiver services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(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:
Waiver service claims must identify a number of units of service that is consistent with the number of units on the approved service authorization. Numerator/Denominator: Number of service claims with the number of units consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA case management system (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:*

Performance Measure:
Waiver service claims must identify a date of service that is consistent with the date of service on the approved service authorization. Numerator/Denominator: Number of service claims with dates of service consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA case management system (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***	☒ ***Annually***	☐ ***Stratified***

Specify:		*Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Waiver service claims must identify the specific provider that is consistent with the provider listed on the approved service authorization. Numerator/Denominator: Number of service claims by a specific provider consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA case management system (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***

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
Waiver service claims must identify a rate of service that is consistent with the rate on the approved service authorization. Numerator/Denominator: Number of service claims with rates consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA case management system (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:*

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

To ensure waiver and program compliance by contracted ICAs and FEAs, the SMA developed performance indicators that align with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA.

Additionally, the SMA requires ICAs and FEAs to have an annual independent third party audit performed by a certified public accounting firm. The audit includes sampling and testing of claims payments, as well as verification of eligibility, authorization, and provision of services. The SMA reviews the results of the independent financial audits.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Any adverse findings resulting from the independent third party audit must be remediated by the ICA or FEA responsible for the violation. Moreover, the SMA implements corrective action with the contract agencies as required, including but not limited to updated policies and procedures, additional internal controls, increased frequency of financial reporting, and/or additional reporting specific to the identified weaknesses. The SMA also requires an annual review of the policy and procedures manual of each certified ICA and FEA provider. Internal audit controls used during claims processing are included in the annual review.

ICA and FEAs are also trained to recognize fraudulent submission of claims and timesheets. If fraudulent activity is suspected, it is reported timely to the SMA. The SMA and ICA and/or FEA collaborate as necessary, to complete the Fraud Allegation Review and Assessment (FARA) processes and report cases of substantiated fraud to the SMA's Office of Inspector General and Department of Justice as appropriate.

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

ii. Remediation Data Aggregation

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

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

IRIS Individual Budget Allocation Algorithm
IRIS Individual Budget Allocations (IBAs) are established through a model based on historic cost data. The SMA's contracted actuaries develop target group specific regression models to determine which attributes from the SMA's LTCFS are most predictive of a participant's costs as well as the amount of funding predicted by each attribute. An IRIS participant's IBA is calculated by seeing which attributes the participant has on the LTCFS, and adding up the funding the regression model has associated with those attributes. Further adjustments, such as for regional cost variance, are applied to the IBA as appropriate to maintain an equitable and cost-effective funding model. This calculation is completed automatically as part of the LTCFS system. The SMA updates the IBA calculation annually.

The total of a participant's service expenses may not exceed the total IBA. If the participant's IBA is insufficient to meet the needs of the participant, a budget amendment (BA) or one-time expense (OTE) request can be made to the SMA. The SMA reviews all BA/OTE requests and determines if those requests are fully approved, partially approved, or denied. Additionally, all documentation of the BA/OTE request and resulting determinations must be part of the participant's record if pay ranges are exceeded.

The cost of IRIS Consultant Agency (ICA) and Fiscal Employer Agent (FEA) services are not funded from a participant's IBA.

Provider Rates
The participant is the primary negotiator for provider rates. As part of the educational information given to participants during their orientation to the program, participants receive education on how to negotiate rates with providers. ICAs assist with rate negotiations, as requested, to ensure that the rate negotiated is usual and customary for the service in that region of the state according to SMA established rate ranges.

The SMA does not establish a mandated fee schedule for services provided by participant hired workers. The nature of the program ensures full budget and employer authority for participants. However, the SMA does develop rate ranges to assist participants in negotiations and for use in internal reviews of BA/OTE requests.

The SMA establishes per unit or per participant per month rate ranges for IRIS waiver services based on actual historical costs, adjusted as necessary for considerations such as geographic variation and cost trends. These rate ranges are shared with the ICAs who in turn educate participants to ensure participants have the tools, resources, and information to negotiate the most cost effective rate with providers.

Once the provider and participant have negotiated an agreed upon rate and the participant's plan has been approved, the FEAs receives a prior authorization for each service generated by the SMA case management system.

There are only two rates set in the IRIS program: the ICA and the FEA rates. These two services are not paid out of the participant's budget because they are required of all participants. Participants negotiate rates for all other services.

ICA and FEA Rate Setting
The SMA contracts directly for and establishes rates for ICA and FEA services. The SMA develops the IRIS Monthly Rate of Service (MROS) to reflect the costs for different sized entities to provide ICA and FEA services. ICA and FEA rates are established using actual historical costs. Rates are reviewed annually to determine whether the rate model needs to be updated with more recent cost and/or staffing data. Full updates will be completed at least every three years.

The MROS needs to be sufficient to support small FEAs and ICAs serving a small number of participants while also reflecting economies of scale as ICAs and FEAs grow in membership. The SMA reviews ICA and FEA historical costs across all of the participating ICAs and FEAs to develop the model. To support this process the SMA requires financial reporting at least quarterly from the ICAs and FEAs. In addition, supplemental information is collected from FEAs and ICAs on staffing models, operating costs, organizational cost structures, and cost allocations.

ICA and FEA costs are separated into functional categories. Each functional category is identified as either a fixed or variable cost component to separate costs that underpin administrative operations versus those that increase and decrease directly with varying enrollment. The model includes a per participant per month (PPPM) funding amount for each variable cost component based on the weighted average from the FEA and ICA financial submissions. An average number of Full Time Equivalent (FTEs) employees for each fixed cost component is developed to reflect tiered size categories based on projected annual participant months and is multiplied by the weighted average cost per FTE based

on the vendor submissions. The total fixed cost funding within any defined size tier is constant until a change in the vendor's projected participant months moves the vendor to a different tier. The fixed cost funding is then converted to a PPPM by dividing the total fixed cost funding by the projected member months for each vendor. The fixed cost PPPM funding will differ for each vendor unless two vendors have the same projected annual participant count. An adjustment using the consumer price index (CPI) is applied to set costs for the desired rate year. The fixed cost PPPM is then added to the variable cost PPPM for a final total PPPM MROS. The SMA reviews funding results and identifies final adjustments required to ensure program stability.

Public Comment on Rate Methodology
The SMA rate determination methodology and rate ranges will change as part of this waiver renewal. As required, the SMA will provide the required period for public comment on how the ICA or FEA rates are established. Each time the methodology changes by which ICA and FEA rates are calculated, the SMA will obtain public comment.

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 SMA uses FEAs for claims adjudication and processing when making payments for waiver services. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired worker payroll claims.

Traditional provider claims are submitted from service 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 are submitted directly to the FEAs 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 FEAs receive the claims from the providers and adjudicate based on the participant's approved authorizations within the Individualized Service and Support Plan (ISSP). Through the adjudication process the FEAs determine if the claims are authorized. The FEAs submit the authorized claims to the SMA for funding. The SMA funds zero balance state-held bank accounts. The providers receive reimbursement for claims through electronic funds transfer. If a claim exceeds the authorization on the ISSP, the amount exceeding the authorization will be pended until the FEA has been able to resolve the issue. If an inaccurate or unauthorized claim has been submitted, the claim will be denied. In either case, the provider is notified of all pended or denied claims. If an FEA receives a claim that is not on the participant's ISSP, the claim will be denied and the provider will be notified.

Participant-hired worker payroll claims are submitted to the FEAs by participant hired workers (PHW). The payroll timesheet system performs a validation against the participant's authorized services on the ISSP and notifies the FEAs of any errors, unauthorized services, or services exceeding the authorization amount for the PHW. After completion of the timesheet validation process, the FEAs conduct their payroll processing procedures to reimburse PHWs for services provided. The FEAs also submit a line item claim to the SMA. The SMA then funds zero balance state-held bank accounts. The PHWs receive reimbursement for claims through electronic funds transfer. Payroll claims that are paid to PHWs in error (keying error from validation to check write) are the responsibility of the FEAs to recoup. Reimbursement from the SMA is only up to the amounts authorized on the ISSP.

The SMA conducts an audit of 20% all claim files submitted where the claim exceeds $2500. Bureau of Financial Services (BFS) staff prepares the documentation required for Federal Financial Participation and complete and certify the CMS-64. Additionally, paid claims are reviewed and analyzed by SMA staff through encounter reporting and the participant record review process.

The SMA utilizes the encounter data reporting system that was established and tested for Family Care for the SDS encounter reporting. The FEAs are the exclusive submitters of SDS reporting in this system. As with Family Care, there are specifications in place to ensure proper encounter reporting, including a data certification.

DHS's Medicaid Management Information System (MMIS) fiscal agent has selected an EVV vendor for Wisconsin. This arrangement allows DHS to maximize integration between the MMIS and EVV system. A general implementation timeline is as follows:
Summer 2020 - Provider, payer, participant, and participant trainings.
Fall 2020 - DHS requires providers to utilize EVV for personal care services.
TBD 2021 - Claims may be denied if EVV is not completed.

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 (PHW) all receive trainings on claims and PHW timesheet submission. The providers receive instruction on proper claim submission protocols from the FEAs as part of the FEA contractual obligations. Participants receive instruction on timesheet (claim) authorization and submission upon enrollment into the IRIS program from the ICAs, as part of the ICA contractual obligations. Participant hired workers receive instruction from the participants and the ICAs on proper timesheet (claim) submission at the time they identified as a qualified PHW.

Provider claims and PHW payroll claims are validated by the FEAs through the prior authorizations the FEAs received from the SMA case management system. The prior authorizations include 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 FEAs are 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 (ISSP) 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:

Providers do not have the option of receiving payments directly from the SMA. All service claims except payment for ICA and FEA services are submitted to the FEAs.

a) The SMA makes payments directly from state-held bank accounts upon receipt of appropriate payment files from the FEAs.

b) Payments are processed through the FEA claims adjudication systems. The FEA claims adjudication systems receive a prior authorization from the SMA case management system. The FEAs assure that payments to providers are in accordance with prior authorizations generated from participant's ISSPs. Services that are not part of an ISSP or that exceed the approved use of the participant's individual budget are denied.

c) The FEAs submit paid claims through the SMA encounter reporting system and certify that the submitted claims are true and accurate. To ensure financial integrity and accountability, the SMA audits the FEAs. During the audit, the FEAs' certified paid claims are checked against participants' authorized individualized budgets and there is a determination 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 is required, according to the terms of the contract with the SMA.

d) The draw of federal funds and claiming occurs based upon the information entered in the SMA 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 SMA contracts with Fiscal Employer Agents (FEAs) for Financial Management Services (FMS) for waiver participants. Appendix C describes FEA services in detail. The SMA uses FEAs for claims adjudication and processing when making payments for waiver services. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired worker payroll claims.

Traditional provider claims are submitted from service 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 are submitted directly to the FEAs 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 FEAs receive the claims from the providers and adjudicate based on the participant's approved authorizations within the Individualized Service and Support Plan (ISSP). Through the adjudication process the FEAs determine if the claims are authorized. The FEAs submit the authorized claims to the SMA for funding. The SMA funds zero balance state-held bank accounts. The providers receive reimbursement for claims through electronic funds transfer. If a claim exceeds the authorization on the ISSP, the amount exceeding the authorization will be pended until the FEA has been able to resolve the issue. If an inaccurate or unauthorized claim has been submitted, the claim will be denied. In either case, the provider is notified of all pended or denied claims. If an FEA receives a claim that is not on the participant's ISSP, the claim will be denied and the provider will be notified.

Participant-hired worker payroll claims are submitted to the FEAs by participant hired workers (PHW). The payroll timesheet system performs a validation against the participant's authorized services on the ISSP and notifies the FEAs of any errors, unauthorized services, or services exceeding the authorization amount for the PHW. After completion of the timesheet validation process, the FEAs conduct their payroll processing procedures to reimburse PHWs for services provided. The FEAs also submit a line item claim to the SMA. The SMA then funds zero balance state-held bank accounts. The PHWs receive reimbursement for claims through electronic funds transfer. Payroll claims that are paid to PHWs in error (keying error from validation to check write) are the responsibility of the FEAs to recoup. Reimbursement from the SMA is only up to the amounts authorized on the ISSP.

The SMA conducts an audit of 20% all claim files submitted where the claim exceeds $2500. Bureau of Financial Services (BFS) staff prepares the documentation required for Federal Financial Participation and complete and certify the CMS-64. Additionally, paid claims are reviewed and analyzed by SMA staff through encounter reporting and the participant record review process.

The SMA utilizes the encounter data reporting system that was established and tested for Family Care for the SDS encounter reporting. The FEAs are the exclusive submitters of SDS reporting in this system. As with Family Care, there are specifications in place to ensure proper encounter reporting, including a data certification.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ( ) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- (●) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

County departments of human service, social services and community programs provide certain services in some counties. These services may be selected by participants in IRIS and are reimbursed by the FEAs as authorized by the participant. These services could include:

Adult Family Home
Supportive Home Care
Day Services
Prevocational Services
Supported Employment
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.

- ◉ ***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.***
- ○ ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly

expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Residential settings other than the personal home of the participant specified in Appendix C where the State furnishes waiver services are required to break out the 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 his or her own resources to pay for the cost of room and board.

Actual Cost Methodology
This method requires calculation of actual room and board costs for community residential facility providing residential waiver services to participants. Facility-specific costs are split between care and supervision on the one hand and room and board on the other. Total costs attributable to room and board are divided by the number of residents licensed or certified for the living arrangement to get a room and board rate.

A. Costs Attributable to Room and Board 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. Costs attributable to Care and Supervision. The following are allowable elements in residential provider rates for which FFP can be claimed:
- *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 care and supervision. For example, a live in manager of a facility may have time apportioned for supervision and support, as well as building and ground maintenance.*

Providers that uses this method for identifying the portion of the facility rate attributable to room and board are responsible for maintaining documentation to verify the accuracy of these calculations, and for updating this information annually.

Flat Rate Methodologies

These methods use a standard rate as the room and board cost for every residential care facility, or depending on the method, the rate can vary by county and type of residential facility.

A. SSI-E Payment Standard - SSI–E or the SSI Exceptional Expense Supplement represents the highest combined federal and state SSI payment amount in Wisconsin. Eligibility for the supplement is based on qualifying for SSI and either residing in community residential care or needing at least 40 hours a month of supportive services in one's personal home. The flat rate equals the SSI-E payment amount ($900.77 in 2014) minus a personal needs allowance set at either $80 or $100 a month (must be the same for all participants in community residential care facility). This flat rate method is used regardless of whether the participant receives SSI or her/his income comes from other sources. Since the SSI-E amount changes annually, providers must update this room and board flat rate annually. Providers using this method with a $100 personal needs allowance would have a flat room and board rate of $800.77 in 2014.

B. HUD Fair Market Rate (FMR) Method - This method uses HUD FMR rental amounts as a proxy for housing costs. HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly. Providers using this method use the prior year's HUD FMR efficiency rent for owner–occupied Adult Family Homes; the one bedroom rent for corporate Adult Family Homes and Community-Based Residential Facilities; and the two bedroom rent for Residential Care Apartment Complexes. The board portion is set at a flat amount equal to the maximum Supplemental Nutrition Assistance Program (SNAP, called FoodShare in Wisconsin), allocation for one person plus a small amount for ancillary costs not included in the FMR or FoodShare figures. Figures are updated yearly.

The SMA permits providers to choose from among the actual cost and two flat rate methods because each has strengths and drawbacks. The actual cost method is the most accurate when based on accurate data and calculations and reimburses real costs needed to sustain the facility and attract residential providers to serving participants. However, the yearly calculations may be administratively burdensome and as a cost-based method, it lacks incentives to control room and board costs which frequently may exceed what participants can afford to pay.

Flat rate methods provide more control over room and board rates. They are simple to calculate, transparent, and predictable for providers to make decisions about working with the IRIS Program. Participants and potential participants know prior to enrollment and/or admission to the facility what their financial obligation will be. However, flat rate methods may establish an amount which does not cover every facility's costs and participants may pay more or less than the "real" room and board cost of the facility where they reside. These methods produce a reasonable proxy measure that is simpler to calculate and verify but at the expense of possible departures from actual costs.

Since each provider uses one method, there is consistency. The flat rate methods are based on widely used, available proxy data generated externally for other purposes and so verification is not necessary. If a provider uses actual costs, an audit will be required to verify the data used in the calculations and to make that material available to the SMA as part of any fiscal review.

EFFECTIVE FEBRUARY 1, 2021:

The waiver participant's room and board obligation is the lesser of:
- *HUD FMR rental amounts based on residential type plus the maximum Supplemental Nutrition Assistance Allocation for one person; or*
- *The participant's available income for room and board using procedures specified by the SMA.*

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 ICAs 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 an 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	24373.22	20858.83	45232.05	80936.26	3415.19	84351.45	39119.40
2	25096.69	21577.74	46674.43	83502.77	3532.06	87034.83	40360.40
3	25817.24	22297.59	48114.83	86130.20	3648.98	89779.18	41664.35

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)
4	26543.66	23024.72	49568.38	89045.33	3777.13	92822.46	43254.08
5	27308.18	23771.06	51079.24	91576.46	3888.14	95464.60	44385.36

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	27175	17590	9585
Year 2	29376	18846	10530
Year 3	31555	20053	11502
Year 4	33734	21225	12509
Year 5	35912	22364	13548

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 waiver. Additional capacity is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. The waiver is available statewide as of 7/1/2018; two counties that have not reached entitlement. Some of these counties have waitlists from the legacy waivers. In counties that have people on a waitlist, projected enrollment is based on the number of people on the waitlist multiplied by the proportion of eligible individuals that have chosen to enroll in the waiver. The historical statewide average, about 29%, is assumed in most counties; however, a 50% selection rate is assumed in Dane County where the waiver selection has been higher.

Persons on a waitlist are assumed to be enrolled evenly over a period not to exceed 36 months. The State has typically enrolled persons from waitlists in expanding counties evenly over 36 months since May 2009. However, remaining counties with few people on a waitlist may exhaust their waitlists sooner. Counties are required to submit a transition plan for State approval, which includes a requirement that the waitlist population be enrolled evenly.

The number of unduplicated participants served during the year is calculated by adding the number of participants 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 participant count to calculate the number of participants projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected participant 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 and methodology for these estimates is as follows:*

The Factor D estimate is generally based on actual SFY2019 waiver service costs as reported in certified encounter data. This is the most recent period of complete encounter data with the waiver (WI.0484) available statewide. Alternate data sources were used for the following services:

--Costs for Fiscal Employer Agent Services and IRIS Consultant Services are based on payments made according to the monthly rate of service and trended forward using trend factors found in the State budget. These services are assumed to be utilized by all participants.

--Live-in Caregiver has low utilization with minimal encounter data available. In this case, encounter data from the Family Care waiver (WI.0367) was used, which is a similar population.

Average cost per unit is calculated by dividing projected total costs each year by projected total units each year for each service. Total costs and total units are pulled from SFY2019 encounter data and grouped by service and level of care (Nursing Facility and ICF-IID). The total costs and units for each service in each level of care are divided by SFY2019 participant months in each level of care to arrive at the average service cost PPPM and average units PPPM bases. To calculate projected total cost for each waiver year, the SFY2019 base service costs PPPM are trended forward using trend factors found in the State budget. To calculate total units, the SFY2019 base average units PPPM for each level of care are multiplied by the projected member months for each year and level of care. No trend factors are applied to average units PPPM as utilization patterns are assumed to remain constant. Total service costs and total units by service line for each level of care are added together to combine levels of care. Combined total service costs are divided by combined total units to arrive at average cost per unit.

The number of users for each service is calculated by multiplying the user percentage for each service by the projected unduplicated participants for each waiver year. The user percentage is based on the total users for each service in SFY2019 encounter data for each level of care divided by the number of unduplicated participants in SFY2019 for each level of care. User percentages are held constant for the projected waiver years as utilization patterns are not expected to change. Total users calculated for each level of care are added by service to arrive at the combined number of users for each service.

Average units per user for each service is calculated by dividing the projected units for each service by the number of users for each service. Derivations for total units and number of service users are described above.

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 SFY2019 service costs paid by the State Medicaid plan for the waiver participants as well as self-directed personal care costs. The portion of Factor D' related to self-directed personal care services is from certified encounter data. 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 participant is trended forward at an annual rate of 3.4% using the Consumer Price Index for Medical Care. The trend for each factor is applied consistently in all five years in the application. Personal Care costs are increased 14.41% effective 1/1/2020 as mandated by the State Budget.

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 SFY2019 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 2.1% 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 waiver population. The average length of stay (ALOS) in the institutional population base data is 259 days. The ALOS for the waiver population ranges from 309 to 312 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 waiver ALOS, which increases Factors G and G' ***for the 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 SFY2019 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 3.4% 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 waiver population. The average length of stay (ALOS) in the institutional population base data is 259 days. The ALOS for the waiver population ranges from 309 to 312 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 waiver ALOS, which increases Factors G and G' for the 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	
Day Services	
Live-in Caregiver	
Prevocational Services	
Respite	
Supported Employment - Individual	
Nursing Services	
Fiscal Employer Agent Services	
IRIS Consultant Services	
Assistive Technology	
Community Involvement Support	
Community Transportation 2	
Community Transportation	
Consultative Clinical and Therapeutic Services for Caregivers	
Consumer Education and Training	
Counseling and Therapeutic Services	
Home Delivered Meals	
Home Modification	
Housing Counseling	
Individual Directed Goods and Services	
Interpreter Services	
Personal Emergency Response System (PERS)	
Relocation - Community Transition Service	
Residential Services (1-2 Bed AFH)	
Residential Services (Other)	
Specialized Medical Equipment and Supplies	
Support Broker Services	
Supported Employment - Group	
Supportive Home Care	
Training Services for Unpaid Caregivers	
Vehicle Modifications	
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:							**2412327.95**
Adult Day Care	☐	hours	326	172.65	42.86	**2412327.95**	
Daily Living Skills Training Total:							**3285865.44**
Daily Living Skills Training	☐	hours	591	297.00	18.72	**3285865.44**	
Day Services Total:							**32032749.23**
Day Services	☐	hours	2962	298.58	36.22	**32032749.23**	
Live-in Caregiver Total:							**3092.21**
Live-in Caregiver	☐	each	3	135.09	7.63	**3092.21**	
Prevocational Services Total:							**5986646.25**
Prevocational Services	☐	hours	925	195.00	33.19	**5986646.25**	
Respite Total:							**21542507.37**
Respite	☐	hours	3191	471.44	14.32	**21542507.37**	
Supported Employment - Individual Total:							**16511101.39**
Supported Employment - Individual	☐	hours	1627	317.23	31.99	**16511101.39**	
Nursing Services Total:							**112654.11**
Nursing Services	☐	hours	70	36.46	44.14	**112654.11**	
Fiscal Employer Agent Services Total:							**31593894.14**
Fiscal Employer Agent Services	☐	months	27175	10.16	114.43	**31593894.14**	
IRIS Consultant Services Total:							**73453111.92**
IRIS Consultant Services	☐	months	27175	10.16	266.04	**73453111.92**	
Assistive Technology Total:							**905849.25**
Assistive Technology	☐	items				**905849.25**	

GRAND TOTAL:	**662342338.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	662342338.18
Total Estimated Unduplicated Participants:	**27175**
Factor D (Divide total by number of participants):	**24373.22**
Services included in capitation:	
Services not included in capitation:	24373.22
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			609	17.88	83.19		
Community Involvement Support Total:							**1869557.41**
Community Involvement Support	☐	each	1827	10.18	100.52	**1869557.41**	
Community Transportation 2 Total:							**13663058.55**
Specialized Transportation 2	☐	trips	3289	246.10	16.88	**13663058.55**	
Community Transportation Total:							**10943131.25**
Community Transportation	☐	miles	5593	3432.59	0.57	**10943131.25**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**288835.05**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	234	13.81	89.38	**288835.05**	
Consumer Education and Training Total:							**296367.55**
Consumer Education and Training	☐	each	156	31.60	60.12	**296367.55**	
Counseling and Therapeutic Services Total:							**3871542.01**
Counseling and Therapeutic Services	☐	hours	1303	60.33	49.25	**3871542.01**	
Home Delivered Meals Total:							**981737.16**
Home Delivered Meals	☐	meals	768	147.27	8.68	**981737.16**	
Home Modification Total:							**2640007.85**
Home Modification	☐	projects	271	1.78	5472.88	**2640007.85**	
Housing Counseling Total:							**5096.87**

GRAND TOTAL:	**662342338.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	662342338.18
Total Estimated Unduplicated Participants:	**27175**
Factor D (Divide total by number of participants):	**24373.22**
Services included in capitation:	
Services not included in capitation:	24373.22
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling	☐	hours	7	13.27	54.87	5096.87	
Individual Directed Goods and Services Total:							1102527.27
Individual Directed Goods and Services	☐	each	845	34.60	37.71	1102527.27	
Interpreter Services Total:							28572.86
Interpreter Services	☐	each	7	171.65	23.78	28572.86	
Personal Emergency Response System (PERS) Total:							1405649.08
Personal Emergency Response System (PERS)	☐	rent/mon	2859	9.34	52.64	1405649.08	
Relocation - Community Transition Service Total:							11379.68
Relocation - Community Transition Service	☐	each	12	1.96	483.83	11379.68	
Residential Services (1-2 Bed AFH) Total:							13867177.67
Residential Services (1-2 Bed AFH)	☐	days	292	287.35	165.27	13867177.67	
Residential Services (Other) Total:							20476671.69
Residential Services (Other)	☐	days	369	302.18	183.64	20476671.69	
Specialized Medical Equipment and Supplies Total:							1289582.98
Specialized Medical Equipment and Supplies	☐	items	1280	53.79	18.73	1289582.98	
Support Broker Services Total:							1924756.58
Support Broker Services	☐	hours	965	23.68	84.23	1924756.58	

GRAND TOTAL:	662342338.18
Total: Services included in capitation:	
Total: Services not included in capitation:	662342338.18
Total Estimated Unduplicated Participants:	27175
Factor D (Divide total by number of participants):	24373.22
Services included in capitation:	
Services not included in capitation:	24373.22
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Group Total:							**1139500.17**
Supported Employment - Group	☐	hours	188	215.47	28.13	**1139500.17**	
Supportive Home Care Total:							**397148892.18**
Supportive Home Care	☐	hours	25455	1045.01	14.93	**397148892.18**	
Training Services for Unpaid Caregivers Total:							**3698.99**
Training Services for Unpaid Caregivers	☐	hours	19	2.53	76.95	**3698.99**	
Vehicle Modifications Total:							**1454236.94**
Vehicle Modifications	☐	each	118	1.27	9703.97	**1454236.94**	
Vocational and Futures Planning Total:							**90559.13**
Vocational and Futures Planning	☐	each	44	3.70	556.26	**90559.13**	

GRAND TOTAL:	**662342338.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	662342338.18
Total Estimated Unduplicated Participants:	**27175**
Factor D (Divide total by number of participants):	**24373.22**
Services included in capitation:	
Services not included in capitation:	24373.22
Average Length of Stay on the Waiver:	309

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2687682.81**
Adult Day Care	☐	hours	355	173.05	43.75	**2687682.81**	
Daily Living Skills Training Total:							**3687592.39**
Daily Living Skills Training	☐	hours	648	298.10	19.09	**3687592.39**	
Day Services Total:							**35982614.57**
Day Services	☐	hours	3249	299.81	36.94	**35982614.57**	
Live-in Caregiver Total:							**3162.34**
Live-in Caregiver	☐	each	3	135.49	7.78	**3162.34**	
Prevocational Services Total:							**6725873.14**
Prevocational Services	☐	hours	1015	195.76	33.85	**6725873.14**	
Respite Total:							**24164789.81**
Respite	☐	hours	3494	473.38	14.61	**24164789.81**	
Supported Employment - Individual Total:							**18559529.05**
Supported Employment - Individual	☐	hours	1786	318.08	32.67	**18559529.05**	
Nursing Services Total:							**126910.03**
Nursing Services	☐	hours	77	36.61	45.02	**126910.03**	
Fiscal Employer Agent Services Total:							**34970424.19**
Fiscal Employer Agent Services	☐	months	29376	10.20	116.71	**34970424.19**	
IRIS Consultant Services Total:							**81309007.87**
IRIS Consultant Services	☐	months	29376	10.20	271.36	**81309007.87**	
Assistive Technology Total:							**1001374.01**
Assistive Technology	☐	items				**1001374.01**	

GRAND TOTAL:	**737240313.12**
Total: Services included in capitation:	
Total: Services not included in capitation:	737240313.12
Total Estimated Unduplicated Participants:	**29376**
Factor D (Divide total by number of participants):	**25096.69**
Services included in capitation:	
Services not included in capitation:	25096.69
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			658	18.01	84.50		
Community Involvement Support Total:							**2096213.57**
Community Involvement Support	☐	each	1996	10.22	102.76	**2096213.57**	
Community Transportation 2 Total:							**15332543.89**
Specialized Transportation 2	☐	trips	3596	247.75	17.21	**15332543.89**	
Community Transportation Total:							**12176390.47**
Community Transportation	☐	miles	6078	3454.06	0.58	**12176390.47**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**324784.98**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	257	13.86	91.18	**324784.98**	
Consumer Education and Training Total:							**332451.53**
Consumer Education and Training	☐	each	171	31.70	61.33	**332451.53**	
Counseling and Therapeutic Services Total:							**4328074.42**
Counseling and Therapeutic Services	☐	hours	1423	60.60	50.19	**4328074.42**	
Home Delivered Meals Total:							**1078540.65**
Home Delivered Meals	☐	meals	825	147.72	8.85	**1078540.65**	
Home Modification Total:							**2903124.68**
Home Modification	☐	projects	292	1.78	5585.51	**2903124.68**	
Housing Counseling Total:							**5196.46**

GRAND TOTAL:	**737240313.12**
Total: Services included in capitation:	
Total: Services not included in capitation:	737240313.12
Total Estimated Unduplicated Participants:	**29376**
Factor D (Divide total by number of participants):	**25096.69**
Services included in capitation:	
Services not included in capitation:	25096.69
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling	☐	hours	7	13.28	55.90	5196.46	
Individual Directed Goods and Services Total:							1230195.46
Individual Directed Goods and Services	☐	each	919	34.86	38.40	1230195.46	
Interpreter Services Total:							28846.77
Interpreter Services	☐	each	7	169.10	24.37	28846.77	
Personal Emergency Response System (PERS) Total:							1555958.59
Personal Emergency Response System (PERS)	☐	rent/month	3074	9.37	54.02	1555958.59	
Relocation - Community Transition Service Total:							12655.69
Relocation - Community Transition Service	☐	each	13	1.97	494.17	12655.69	
Residential Services (1-2 Bed AFH) Total:							15560991.87
Residential Services (1-2 Bed AFH)	☐	days	320	288.44	168.59	15560991.87	
Residential Services (Other) Total:							22969355.20
Residential Services (Other)	☐	days	404	303.42	187.38	22969355.20	
Specialized Medical Equipment and Supplies Total:							1428179.45
Specialized Medical Equipment and Supplies	☐	items	1385	54.13	19.05	1428179.45	
Support Broker Services Total:							2154854.38
Support Broker Services	☐	hours	1055	23.80	85.82	2154854.38	

GRAND TOTAL:	737240313.12
Total: Services included in capitation:	
Total: Services not included in capitation:	737240313.12
Total Estimated Unduplicated Participants:	29376
Factor D (Divide total by number of participants):	25096.69
Services included in capitation:	
Services not included in capitation:	25096.69
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Group Total:							**1278481.48**
Supported Employment - Group	☐	hours	206	216.32	28.69	**1278481.48**	
Supportive Home Care Total:							**441495342.15**
Supportive Home Care	☐	hours	27496	1053.59	15.24	**441495342.15**	
Training Services for Unpaid Caregivers Total:							**3986.78**
Training Services for Unpaid Caregivers	☐	hours	20	2.54	78.48	**3986.78**	
Vehicle Modifications Total:							**1623864.12**
Vehicle Modifications	☐	each	128	1.28	9911.28	**1623864.12**	
Vocational and Futures Planning Total:							**101320.30**
Vocational and Futures Planning	☐	each	48	3.72	567.43	**101320.30**	

GRAND TOTAL:	**737240313.12**
Total: Services included in capitation:	
Total: Services not included in capitation:	737240313.12
Total Estimated Unduplicated Participants:	**29376**
Factor D (Divide total by number of participants):	**25096.69**
Services included in capitation:	
Services not included in capitation:	25096.69
Average Length of Stay on the Waiver:	310

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2980081.41**
Adult Day Care	☐	hours	385	173.32	44.66	**2980081.41**	
Daily Living Skills Training Total:							**4114395.69**
Daily Living Skills Training	☐	hours	707	299.05	19.46	**4114395.69**	
Day Services Total:							**40169561.21**
Day Services	☐	hours	3544	300.89	37.67	**40169561.21**	
Live-in Caregiver Total:							**3234.28**
Live-in Caregiver	☐	each	3	135.78	7.94	**3234.28**	
Prevocational Services Total:							**7508097.54**
Prevocational Services	☐	hours	1107	196.42	34.53	**7508097.54**	
Respite Total:							**26936631.89**
Respite	☐	hours	3803	475.05	14.91	**26936631.89**	
Supported Employment - Individual Total:							**20714058.00**
Supported Employment - Individual	☐	hours	1948	318.75	33.36	**20714058.00**	
Nursing Services Total:							**141755.04**
Nursing Services	☐	hours	84	36.75	45.92	**141755.04**	
Fiscal Employer Agent Services Total:							**38392684.51**
Fiscal Employer Agent Services	☐	months	31555	10.22	119.05	**38392684.50**	
IRIS Consultant Services Total:							**89259363.44**
IRIS Consultant Services	☐	months	31555	10.22	276.78	**89259363.44**	
Assistive Technology Total:							**1100511.53**
Assistive Technology	☐	items				**1100511.53**	

GRAND TOTAL:	**814663088.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	814663088.16
Total Estimated Unduplicated Participants:	**31555**
Factor D (Divide total by number of participants):	**25817.24**
Services included in capitation:	
Services not included in capitation:	25817.24
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			707	18.14	85.81		
Community Involvement Support Total:							**2333566.46**
Community Involvement Support	☐	each	2167	10.25	105.06	**2333566.46**	
Community Transportation 2 Total:							**17102029.41**
Specialized Transportation 2	☐	trips	3909	249.29	17.55	**17102029.41**	
Community Transportation Total:							**13452496.59**
Community Transportation	☐	miles	6564	3473.62	0.59	**13452496.59**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**363248.70**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	281	13.90	93.00	**363248.70**	
Consumer Education and Training Total:							**369621.71**
Consumer Education and Training	☐	each	186	31.77	62.55	**369621.71**	
Counseling and Therapeutic Services Total:							**4806257.38**
Counseling and Therapeutic Services	☐	hours	1545	60.83	51.14	**4806257.38**	
Home Delivered Meals Total:							**1177562.75**
Home Delivered Meals	☐	meals	881	148.02	9.03	**1177562.75**	
Home Modification Total:							**3176104.71**
Home Modification	☐	projects	313	1.78	5700.73	**3176104.71**	
Housing Counseling Total:							**6044.75**

GRAND TOTAL:	**814663088.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	814663088.16
Total Estimated Unduplicated Participants:	**31555**
Factor D (Divide total by number of participants):	**25817.24**
Services included in capitation:	
Services not included in capitation:	25817.24
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling	☐	hours	8	13.27	56.94	6044.75	
Individual Directed Goods and Services Total:							1364564.19
Individual Directed Goods and Services	☐	each	994	35.11	39.10	1364564.19	
Interpreter Services Total:							33242.70
Interpreter Services	☐	each	8	166.28	24.99	33242.70	
Personal Emergency Response System (PERS) Total:							1710206.71
Personal Emergency Response System (PERS)	☐	rent/month	3284	9.39	55.46	1710206.71	
Relocation - Community Transition Service Total:							13992.22
Relocation - Community Transition Service	☐	each	14	1.98	504.77	13992.22	
Residential Services (1-2 Bed AFH) Total:							17366672.48
Residential Services (1-2 Bed AFH)	☐	days	349	289.36	171.97	17366672.48	
Residential Services (Other) Total:							25558755.60
Residential Services (Other)	☐	days	439	304.50	191.20	25558755.60	
Specialized Medical Equipment and Supplies Total:							1570154.67
Specialized Medical Equipment and Supplies	☐	items	1489	54.44	19.37	1570154.67	
Support Broker Services Total:							2394929.14
Support Broker Services	☐	hours	1146	23.90	87.44	2394929.14	

GRAND TOTAL:	814663088.16
Total: Services included in capitation:	
Total: Services not included in capitation:	814663088.16
Total Estimated Unduplicated Participants:	31555
Factor D (Divide total by number of participants):	25817.24
Services included in capitation:	
Services not included in capitation:	25817.24
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Group Total:							**1429502.90**
Supported Employment - Group	☐	hours	225	217.06	29.27	**1429502.90**	
Supportive Home Care Total:							**487208089.26**
Supportive Home Care	☐	hours	29512	1061.66	15.55	**487208089.26**	
Training Services for Unpaid Caregivers Total:							**4490.81**
Training Services for Unpaid Caregivers	☐	hours	22	2.55	80.05	**4490.80**	
Vehicle Modifications Total:							**1788308.66**
Vehicle Modifications	☐	each	138	1.28	10124.03	**1788308.66**	
Vocational and Futures Planning Total:							**112871.85**
Vocational and Futures Planning	☐	each	52	3.75	578.83	**112871.85**	

GRAND TOTAL:	**814663088.16**
Total: Services included in capitation:	
Total: Services not included in capitation:	814663088.16
Total Estimated Unduplicated Participants:	**31555**
Factor D (Divide total by number of participants):	**25817.24**
Services included in capitation:	
Services not included in capitation:	25817.24
Average Length of Stay on the Waiver:	311

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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**3282935.52**
Adult Day Care	☐	hours	415	173.48	45.60	**3282935.52**	
Daily Living Skills Training Total:							**4562292.72**
Daily Living Skills Training	☐	hours	767	299.81	19.84	**4562292.72**	
Day Services Total:							**44618160.29**
Day Services	☐	hours	3848	301.80	38.42	**44618160.29**	
Live-in Caregiver Total:							**3304.56**
Live-in Caregiver	☐	each	3	135.99	8.10	**3304.56**	
Prevocational Services Total:							**8345128.23**
Prevocational Services	☐	hours	1203	196.96	35.22	**8345128.23**	
Respite Total:							**29870701.19**
Respite	☐	hours	4122	476.44	15.21	**29870701.19**	
Supported Employment - Individual Total:							**23013246.55**
Supported Employment - Individual	☐	hours	2116	319.22	34.07	**23013246.55**	
Nursing Services Total:							**157113.54**
Nursing Services	☐	hours	91	36.86	46.84	**157113.54**	
Fiscal Employer Agent Services Total:							**41946312.91**
Fiscal Employer Agent Services	☐	months	33734	10.24	121.43	**41946312.91**	
IRIS Consultant Services Total:							**97523536.69**
IRIS Consultant Services	☐	months	33734	10.24	282.32	**97523536.69**	
Assistive Technology Total:							**1201062.46**
Assistive Technology	☐	items				**1201062.46**	

GRAND TOTAL:	**895423832.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	895423832.44
Total Estimated Unduplicated Participants:	**33734**
Factor D (Divide total by number of participants):	**26543.66**
Services included in capitation:	
Services not included in capitation:	26543.66
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
			755	18.26	87.12		
Community Involvement Support Total:							**2583461.84**
Community Involvement Support	☐	each	2342	10.27	107.41	**2583461.84**	
Community Transportation 2 Total:							**18981494.73**
Specialized Transportation 2	☐	trips	4230	250.69	17.90	**18981494.73**	
Community Transportation Total:							**14781445.06**
Community Transportation	☐	miles	7056	3491.46	0.60	**14781445.06**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**403069.43**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	305	13.93	94.87	**403069.43**	
Consumer Education and Training Total:							**408245.53**
Consumer Education and Training	☐	each	201	31.83	63.81	**408245.53**	
Counseling and Therapeutic Services Total:							**5312075.61**
Counseling and Therapeutic Services	☐	hours	1670	61.03	52.12	**5312075.61**	
Home Delivered Meals Total:							**1277801.89**
Home Delivered Meals	☐	meals	937	148.23	9.20	**1277801.89**	
Home Modification Total:							**3459214.62**
Home Modification	☐	projects	334	1.78	5818.50	**3459214.62**	
Housing Counseling Total:							**6152.64**

GRAND TOTAL:	**895423832.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	895423832.44
Total Estimated Unduplicated Participants:	**33734**
Factor D (Divide total by number of participants):	**26543.66**
Services included in capitation:	
Services not included in capitation:	26543.66
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
Housing Counseling	☐	hours	8	13.26	58.00	6152.64	
Individual Directed Goods and Services Total:							1505367.38
Individual Directed Goods and Services	☐	each	1070	35.34	39.81	1505367.38	
Interpreter Services Total:							33478.93
Interpreter Services	☐	each	8	163.28	25.63	33478.93	
Personal Emergency Response System (PERS) Total:							1868629.76
Personal Emergency Response System (PERS)	☐	rent/mon	3490	9.40	56.96	1868629.76	
Relocation - Community Transition Service Total:							15390.36
Relocation - Community Transition Service	☐	each	15	1.99	515.59	15390.36	
Residential Services (1-2 Bed AFH) Total:							19237267.85
Residential Services (1-2 Bed AFH)	☐	days	378	290.10	175.43	19237267.85	
Residential Services (Other) Total:							28361765.04
Residential Services (Other)	☐	days	476	305.40	195.10	28361765.04	
Specialized Medical Equipment and Supplies Total:							1717748.12
Specialized Medical Equipment and Supplies	☐	items	1594	54.73	19.69	1717748.12	
Support Broker Services Total:							2647779.18
Support Broker Services	☐	hours	1239	23.99	89.08	2647779.18	

GRAND TOTAL:	895423832.44
Total: Services included in capitation:	
Total: Services not included in capitation:	895423832.44
Total Estimated Unduplicated Participants:	33734
Factor D (Divide total by number of participants):	26543.66
Services included in capitation:	
Services not included in capitation:	26543.66
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
Supported Employment - Group Total:							**1592408.42**
Supported Employment - Group	☐	hours	245	217.67	29.86	**1592408.42**	
Supportive Home Care Total:							**534631643.54**
Supportive Home Care	☐	hours	31523	1069.36	15.86	**534631643.54**	
Training Services for Unpaid Caregivers Total:							**4996.98**
Training Services for Unpaid Caregivers	☐	hours	24	2.55	81.65	**4996.98**	
Vehicle Modifications Total:							**1945945.08**
Vehicle Modifications	☐	each	147	1.28	10341.97	**1945945.08**	
Vocational and Futures Planning Total:							**124655.80**
Vocational and Futures Planning	☐	each	56	3.77	590.45	**124655.80**	

GRAND TOTAL:	**895423832.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	895423832.44
Total Estimated Unduplicated Participants:	**33734**
Factor D (Divide total by number of participants):	**26543.66**
Services included in capitation:	
Services not included in capitation:	26543.66
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 concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							3596494.90
Adult Day Care	☐	hours	445	173.62	46.55	3596494.90	
Daily Living Skills Training Total:							5037933.31
Daily Living Skills Training	☐	hours	829	300.55	20.22	5037933.31	
Day Services Total:							49369765.53
Day Services	☐	hours	4162	302.68	39.19	49369765.53	
Live-in Caregiver Total:							4499.72
Live-in Caregiver	☐	each	4	136.19	8.26	4499.72	
Prevocational Services Total:							9238752.04
Prevocational Services	☐	hours	1302	197.49	35.93	9238752.04	
Respite Total:							32977517.10
Respite	☐	hours	4450	477.80	15.51	32977517.10	
Supported Employment - Individual Total:							25468617.89
Supported Employment - Individual	☐	hours	2290	319.68	34.79	25468617.89	
Nursing Services Total:							174876.23
Nursing Services	☐	hours	99	36.97	47.78	174876.23	
Fiscal Employer Agent Services Total:							45637098.88
Fiscal Employer Agent Services	☐	months	35912	10.26	123.86	45637098.88	
IRIS Consultant Services Total:							106104596.85
IRIS Consultant Services	☐	months	35912	10.26	287.97	106104596.85	
Assistive Technology Total:							1306923.87
Assistive Technology	☐	items				1306923.87	

GRAND TOTAL:	980691383.18
Total: Services included in capitation:	
Total: Services not included in capitation:	980691383.18
Total Estimated Unduplicated Participants:	35912
Factor D (Divide total by number of participants):	27308.18
Services included in capitation:	
Services not included in capitation:	27308.18
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
			804	18.38	88.44		
Community Involvement Support Total:							**2851619.07**
Community Involvement Support	☐	each	2521	10.30	109.82	**2851619.07**	
Community Transportation 2 Total:							**20974329.16**
Specialized Transportation 2	☐	trips	4559	252.09	18.25	**20974329.16**	
Community Transportation Total:							**16172231.49**
Community Transportation	☐	miles	7555	3509.18	0.61	**16172231.49**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**445800.04**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	330	13.96	96.77	**445800.04**	
Consumer Education and Training Total:							**450362.06**
Consumer Education and Training	☐	each	217	31.89	65.08	**450362.06**	
Counseling and Therapeutic Services Total:							**5846006.77**
Counseling and Therapeutic Services	☐	hours	1798	61.22	53.11	**5846006.77**	
Home Delivered Meals Total:							**1381120.83**
Home Delivered Meals	☐	meals	991	148.42	9.39	**1381120.83**	
Home Modification Total:							**3752740.36**
Home Modification	☐	projects	355	1.78	5938.82	**3752740.36**	
Housing Counseling Total:							**7039.97**

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Services included in capitation:	
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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling	☐	hours	9	13.24	59.08	7039.97	
Individual Directed Goods and Services Total:							1655424.95
Individual Directed Goods and Services	☐	each	1148	35.57	40.54	1655424.95	
Interpreter Services Total:							37919.12
Interpreter Services	☐	each	9	160.26	26.29	37919.12	
Personal Emergency Response System (PERS) Total:							2034898.23
Personal Emergency Response System (PERS)	☐	rent/mon	3692	9.42	58.51	2034898.23	
Relocation - Community Transition Service Total:							17905.76
Relocation - Community Transition Service	☐	each	17	2.00	526.64	17905.76	
Residential Services (1-2 Bed AFH) Total:							21286007.66
Residential Services (1-2 Bed AFH)	☐	days	409	290.83	178.95	21286007.66	
Residential Services (Other) Total:							31339176.03
Residential Services (Other)	☐	days	514	306.28	199.07	31339176.03	
Specialized Medical Equipment and Supplies Total:							1870174.42
Specialized Medical Equipment and Supplies	☐	items	1699	55.01	20.01	1870174.42	
Support Broker Services Total:							2917643.57
Support Broker Services	☐	hours	1335	24.08	90.76	2917643.57	

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Group Total:							**1761853.61**
Supported Employment - Group	☐	hours	265	218.27	30.46	**1761853.61**	
Supportive Home Care Total:							**584704488.97**
Supportive Home Care	☐	hours	33530	1077.10	16.19	**584704488.97**	
Training Services for Unpaid Caregivers Total:							**5543.78**
Training Services for Unpaid Caregivers	☐	hours	26	2.56	83.29	**5543.78**	
Vehicle Modifications Total:							**2123140.39**
Vehicle Modifications	☐	each	157	1.28	10564.99	**2123140.39**	
Vocational and Futures Planning Total:							**138880.64**
Vocational and Futures Planning	☐	each	61	3.78	602.31	**138880.64**	

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