DEPARTMENT OF HEALTH SERVICES DRAFT **STATE OF WISCONSIN**

F-01922 (03/2018)

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: IRIS Adviosry Committee			Attending: **Committee Members:** Rosie Bartel, Linda Bova, Julie Burish, Caitlin Connelly, Martha Chambers, Fil Clissa, John Donnelly, Angie Kieffer, Kathi Miller, Maureen Ryan, Danielle Smith, Sue Urban **DHS Staff:** Amy Chartier, Ann Lamberg, Christine See, Elizabeth Doyle, Grant Cummings, Kyle Novak, Sam Ninnemann, Shelly Glenn, Suzanne Ziehr
Date: July 27, 2021	Time Started: 9:30 am	Time Ended: 3:30 pm	
Location: Zoom Webinar			Presiding Officer: Curtis Cunningham, Assistant Administrator

Minutes

Committee Members Absent

- Dean Choate, Mitch Hagopian

Meeting Call to Order

- Introductions
  - All committee members and DHS staff introduced themselves
  - Live Transcription for Closed Captioning was enabled and common words it may change were explained
- Approval of July minutes
  - Maureen Ryan made motion to approve minutes. Kathi Miller seconded the motion. The minutes were approved unanimously.

Recap on May Meeting Discussion, presented by Curtis Cunningham

- Looking to make the committee meetings more effective
- Had a meeting two (2) months ago with just committee members to discuss
- Went through PowerPoint to summarize what was discussed in May
- ***Committee Suggestions***
  - One thing that happens in the meetings and we provide feedback with initial responses and sometimes we lose track and it doesn't come back around and we don't know what happens with it. We used to do an annual calendar about what we will do in the year so we have input on what is of value and timing. Would like to have a lookout for the next 12 months about what will be worked on and track what goes in, what happened and what comes back.
  - Glad some of the information is on the website, if you read data it doesn't help, need to take it back, use it and talk through with the IAC
  - Previously, on off month committee would get together to prepare what they want to talk about at the meeting. I think it was really constructive. Should consider having ad hoc meetings such as a phone call.

Department Updates, presented by Curtis Cunningham and Amy Chartier

- Budget has been passed

- Managed Care Quality Strategy
  - Public comment period has ended
  - Currently reviewing comments and then will submit to CMS
- Home and Community Based Settings (HCBS) rule
  - Transition plan was posted for public comment. Will be reviewing comment and submitting to CMS
- Hub and Spoke Model is being rolled out
  - Model for Substance Abuse Disorder(SUD) and AODA and Behavioral Health services
- Telehealth rule is moving forward
  - Virtual supports is different than telehealth
- Electronic Visit Verification (EVV)
  - Hard launch set
  - Email and documents being sent out
  - State will not hold PHW paychecks if mistakes are made
    - There will be other consequences if it continues to be an issue
  - Contractors are required to submit validated claims and payments will not be made until they are validated
  - State continues to meet with ICAs and FEAs to discuss monthly
  - ***Committee Suggestions:***
    - There has been a struggle with the mobile app based on the cell provider. Would be beneficial to have an expert at the state for people to go to with these issues to get help
    - Have had situations there aren't answers for. Just because it's a soft launch, doesn't mean you don't have to do it so the users know what issues may be.
    - All the FEAs are trying to use the same language in their messaging
    - thanks Rosie, my RNs provide education and they hear over and over that people will not use it until it is "mandated" we are working with people to explain that if they wait, and they start and hard launch and make errors it could risk their services if they cannot use it correctly. What you say is spot on.
- Monthly Budget Statement
  - Still in process, maybe available the end of August
- Policy Team
  - Karina accepted a new position
  - Kyle will be on maternity leave in August.

IAC Committee Membership for 2022

- Went through process to apply for open seats
- Shared current membership roster and upcoming vacancies
- ***Committee Suggestion:***
  - Will the meetings stay virtual? It helps with having people participate.

Ombudsman Update presented by Kathi Miller

- Have been receiving a lot of questions regarding EVV

Fiscal Updates, presented by Grant Cummings and Elizabeth Doyle

- Individual Budget Allocation (IBA) Overview
  - This will be updated over the next 7-8 months
  - Wanted to provide an overview of what it is and how it works
  - Went through PowerPoint explaining IBA and process to calculate it
    - Use actual participant experience
    - Not using 2020 data since it is thrown off because of COVID-19
    - The IBA is refreshed when there is a new Functional Screen, which may be triggered by a move

        - Will be looking at how to make the system work for everyone without making extra barriers
        - DHS wants members and participants to choose the model that is best for them
        - Targeting some point in winter of 2022 or July 2022 to start using the new model
        - Still early in process, part of which is getting feedback from all stakeholders
        - Will provide an update at September meeting
    - ***Committee Suggestions:***
        - It would be good to go through functional screen
- Monthly Rate of Service (MROS)
    - Information was sent out regarding this prior to the meeting
    - Change in rates occurred
    - Based on review, did not see a need to delay the contractual reduction, effective 7/1/2021
    - Did receive feedback that some more time was needed to meet some contractual requirements
        - Decrease that was to go into effect 1/1/2022 has been delayed until 7/1/2022
    - ***Committee Suggestions***
        - What did the department do to ensure the current level of service is maintained? Not that they go down to the minimum requirement of the contract. Because that would constitute a loss of service for the participant. You're saying its excess profits, how do we know it's not going to come from service and it is coming from the profit?
    - Contract Compliance, If you are seeing changes, need to let the state know to it can be address
    - State has several oversight, contract compliance, and reviews done throughout the year to monitor.

Public Comment

- Kurtis McAully
    - Curtis Cunningham summarized email Kurtis sent committee members. Thank us all for serving on committee. Page 91 of policy manual, one of the listings here is 961.41. There is an asterisk that notes there is a 5 year period - would like an asterisk next to other crimes, such as his personal crime. It would allow him to provide care as a participant hired worker.
- Carol Richards
    - When will the certification process open up to new ICAs and FEAs

Policy Updates and Policy Tracker presented by Amy Chartier

- Went through IRIS Policy Tracker
    - Discussed what policies will be covered and the process
    - Calendar will be updated later with the first 6 months of 2022 as well as October 2021
    - All IRIS policies and work instructions will move through this tracker
    - These initial ones that were changed or tweaked because of the waiver, so they were prioritized
    - Will determine on a case by case basis to see if committees are needed
- Template
    - GovD will go out with what is new/updated and what they are replacing
    - Will be included in What's new IRIS banner on web page
    - Once all completed, will be in a single document and the individual documents will be sunset
    - It is DHS recommendation that ICAs give the Policy manual to participants, but it is ultimately up to the particular ICA if they will
    - This taking the policy manual and work instructions and blending them together

- Once policy and work instructions are complete, the will start on participant facing documents.

FEAs – Enrollment and Transfer Policy, presented by Amy Chartier and Kyle Novak

- Walked through policy
- ***Committee Question:***
  - Limiting choice bullet about how many times can change an FEA. Where in the waiver does it say you can limit it?
  - ***DHS Response***
    - It's not in the waiver. Per policy processing times it only could happen at most 2 times a year. Intention was so that the FEAs had an opportunity to provide their services and not disrupt the IRS process/reporting they need to do.
    - We rarely have people asking multiple times/year, just trying to have it clean, clear, and reasonable for the effort needed to be made by the FEAs

Remote Services Policy, presented by Amy Chartier and Kyle Novak

- Walked through policy
- ***Committee Question:***
  - What about the folks that don't have audio/visual? Can it be just phone
  - ***DHS Response***
    - No, it was determined to meet requirements need to be audio/visual
- ***Committee Question:***
  - I didn't see anything that says these should not replace in person services as the only options. I didn't see anything that is a value statement that these are HCBS services
  - ***DHS Response***
    - This is self-directed and with current state this allows for flexibility
    - We do try to address it in a few places, that provider and participant are in agreement of what the service entails
- This policy will go into effect after the current emergency is over

ARPA Update & 2021-2023 Biennial Budget, presented by Curtis Cunningham

- Went through information found on website: https://www.dhs.wisconsin.gov/arpa/hcbs.htm
- There was a stakeholder engagement meeting to discuss
- Had 2 weeks to put a plan together
- 6 areas to reinvest in
  - Medicaid HCBS Workforce, Provider Capacity, and Fiscal Stability
  - Promoting Quality and Innovation Resources
  - Tribal LTC Services
  - Access to HCBS Information and Services
  - Assisted Living Information, Analysis, and Quality Oversight
- Looking to have portability of training, a career ladder, and registry of training
  - We don't want to professionalize so much to inhibit trusted people from performing services
- Have a registry of workers looking for work that participants can access
- ***Committee Question:***
  - 5% rate increase - does that include IRIS workers? Is it just going to be a 1 time 5% bump?
  - ***DHS Response:***
    - The idea is there would be an increase in funding, IRIS has a different dynamic in that it shows up in a budget for the participant
    - Intent is that the 10% enhanced FMAP will be across many services
- ***Committee Question:***
  - Rate schedules - does this include the IRIS Rates Bands?
  - ***DHS Response:***

        - The rate bands will be reset based on the IBA process. We don't have a rate schedule for Supportive Home Care (SHC) so question is if we want to set one
        - This could look at setting residential rates, day services, Competitive Integrated Employment (CIE), or Supportive employment
    - ***Committee Question:***
        - It all sounds like managed care, but we're HCBS so it should include IRIS too. At what level of each rate band or IRIS caregivers entering
        - ***DHS Response:***
            - This relates to usual and customary that relates to UHC
            - SDPC has a designated rate range
            - Would need to think though how it would be applied
- Independent Living and Informal Care giver resources
    - Current impression is you need to impoverish yourself to get Medicaid services
    - Idea is to do a pilot program to make available some services to individuals not currently eligible for services
    - This would allow people to living in the community and avert coming into full HCBS system
- Access to HCBS Information and Services
    - Aging and Disability Resource Centers (ADRCs) haven't received much increase in funding so their ability to do outreach has been limited
    - Develop a ADRC like system for children's, set up a non-wrong door system for those needed services
- Assisted Living
    - Need to get more data
    - Want to make sure addressing things as much as possible
- Submitted plan to CMS
    - CMS has 30 days to respond or submit questions to state.
    - Need CMS approval to proceed with drawing down the enhanced federal funding
    - If there are changes to the plan or project after approval, needs to go back through CMS approval

Adjourn

- Next meeting topics
    - Tracker won't be posted online but will be reviewed at each meeting
    - Look at things that need to be done by department in the next 12 months to see what else is there - including the policies not on the list (i.e. background checks)
    - Talk about the data that DHS may be able to share
    - Talk about how the data is driven by outcomes

Prepared by: Suzanne Ziehr on 07/27/2021.
These minutes are in draft form. They will be presented for approval by the governmental body on: 09/28/2021

Policy / Content*	Draft Sent to IAC	Discuss at Meeting	Feedback Due (email)	Current Status
EVV	7/6/2021	7/27/21 (Provide update at meeting)	7/13/2021	Published and Posted
Training Standards	7/6/2021	N/A	7/13/2021	Published and Posted
Remote Services	7/15/2021	7/27/2021	8/2/2021	Will be published and posted 12/2021 (Implemtation date of 01/01/2022)
FEA Enrollment				Policy Team Editing
Policy Manual Template				DHS Leadership Review finished
Vulnerable High Risk Participants	8/18/2021	N/A	9/1/2021	
Critical Incidents	9/24/2021	9/28/2021	10/01/2021 (CI Policy)	
SMA Waiver Service Approval Process				
Service Dog Memo			10/11/2021 (SMA and Service Dog)	
Provider Enrollment and Payment Policy	TBD	N/A	TBD	
Budget Amendments and One Time Expenses	11/9/2021	11/23/2021	12/7/2021	
ISSP Signature Requirement	TBD	TBD	TBD	
Provider Agency Agreement	TBD	TBD	TBD	
Room and Board Methodology	TBD	TBD	TBD	

YearlyTopic Items*						
	January	March	May	July	September	November
Committee Membership	X (New members)			X (recruiting)		
IRIS Contract					X	
372 Report					X	
Ombudsman Updates	X					
Participant Survey			X			
Enrollment reports			X			
NCI Data					X	
Self-Direction NCI Data		X				
Review Topics for Next Year						X
Self-Direction NCI Data						X

*Schedules are subject to change

Reporting and Follow-up for Immediate Reportable and Critical Incidents

A. Immediate Reportables

IRIS participant immediate and ongoing health and safety is one of the most important aspects of a self-directed program. Incident reporting is an effective way that IRIS contractors monitor and resolve concerns related to participant health and safety. Due to the impact on participant health and safety, Immediate Reportable Incidents are reported to DHS within 24 hours upon discovery. Incidents related to participant abuse and/or neglect must be referred to Adult Protective Services (APS), and incidents related to caregiver misconduct must be referred to the Division of Quality Assurance (DQA). Both referral processes are outlined below within the Incident Reporting and Follow-up section.

1. Definitions

Immediate Reportable Incidents are cases that involve serious and immediate consequences to the participant. Incident types and cases that fall into this category are described in the following definitions.

a. Participant Missing

When a participant's whereabouts are unknown for 24 hours or more and any of the following circumstances exist:

i. The participant is under guardianship/protective placement.

ii. The participant has been identified as a vulnerable high-risk participant.

iii. The IRIS contractor has reason to believe the participant's health or safety is at risk.

iv. The participant is a potential threat to the community or self.

v. The participant has a significant medical condition that would deteriorate without medications or care.

vi. The participant resides in a residential care apartment complex or an adult family home.

vii. The area in which the participant resides is experiencing potentially life-threatening conditions.

b. Participant Death

When a participant has died under any of the following circumstances, including when a physician refuses to sign the death certificate:

i. Death involving unexplained, unusual, or suspicious circumstances.

ii. Death involving apparent abuse or neglect (979.01(1)).

iii. Apparent homicide.

iv. Apparent suicide.

v. Apparent poisoning.

vi. Apparent accident, whether or not the resulting injury is not the primary cause of death.

c. Participant Injury

When a participant has suffered an injury or accident or caused an injury or accident to someone else under any of the following circumstances:

i. Suspected or confirmed neglect, self-neglect, physical abuse, sexual abuse, or emotional abuse.

1. Neglect
   The failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do-not-resuscitate order under ch. 154, a power of attorney for health care under ch. 155, or as otherwise authorized by law. (Definition Reference: WI Stats. 46.90 (1)(f))

2. Self-Neglect
   A significant danger to an individual's physical or mental health because the individual is responsible for his or her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care. (Definition Reference: WI Stats. 46.90(1)(g))

3. Physical Abuse
   Intentional or reckless infliction of bodily harm. (Definition Reference: WI Stats. 46.90(1)(fg))

4. Sexual Abuse
   Sexual abuse means a violation of WI Statute 940.225 (1), (2), (3), or (3m). (Definition Reference: WI Stats. 46.90(1)(gd))

5. Emotional Abuse
   Language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed. (Definition Reference: WI Stats. 46.90(1)(cm))

ii. The participant has been poisoned.

iii. Adult Protective Services, law enforcement, or a court of law have investigated and/or are involved.

d. Participant Admittance

Upon learning a participant has been admitted to a state institution for mental disease or intensive treatment program. A list of both county and privately operated institutions for mental disease in Wisconsin can be found in section 27.11 of the Medicaid Eligibility Handbook.

e. Participant Restraint

The intentional and unreasonable confinement of a participant in a locked room, involuntary separation of a participant from his or her living area, use on a participant of physical restraining devices, or the provision of unnecessary or excessive medication to a participant, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint. (Definition reference: WI Stats 46.90 (1)(i))

2. Procedures

Upon discovery of an Immediate Reportable Incident, the IRIS contractor is required to ensure the participant's immediate and ongoing health and safety. This includes confirming that the incident has been resolved and that the participant's individual support and service plan (ISSP) has sufficient supports and services to meet the participant's needs.

IRIS contractors are required to report Immediate Reportable Incidents to DHS within 24 hours of discovery and must document Immediate Reportable Incidents in DHS's centralized case management system within seven calendar days. Additionally, the IRIS contractor must complete follow-up activities within 30 calendar days of the incident to assure the participant's ongoing health and safety.

Immediate Reportable Incident Reporting and Follow-up Process

Step	Responsible Partner(s)	Detail
1	Participant	The participant or guardian, legal representative, or provider report all incident types to the IRIS consulting agency (ICA) within 24 hours of the incident.
2	IRIS Consulting Agency (ICA)	The ICA will ensure the participant's immediate health and safety by verifying that the ISSP sufficiently meets the participant's support needs.
3	ICA	The ICA will report Immediate Reportable Incidents to DHS within 24 hours of notification by sending the incident description to DHSIRISQuality@dhs.wisconsin.gov. Incident description must include: · Date incident occurred

Step	Responsible Partner(s)	Detail
		· Date Incident was reported to the ICA · Participant Medicaid identification (MA ID) number · Summary of incident events · Summary of ICA actions to ensure participant health and safety
4	ICA	The ICA will complete the incident reporting panel within DHS's centralized case management system within seven business days of being notified of the incident.

Referrals to Adult Protective Services (APS)

Step	Responsible Partner(s)	Detail
1	ICA	The ICA reports all incidents of abuse and neglect, to the county APS unit within 24 hours of discovery. Active situations wherein the participant's health and safety is at risk must be reported immediately. The DHS website has the contact information for each county's APS helpline: www.dhs.wisconsin.gov/aps/index.htm.
2	ICA	The ICA maintains communication with the APS unit to determine if the incident is substantiated. The ICA will work with the participant to ensure their ISSP meets their support needs and ensures their health and safety.
3	ICA	The ICA will document all communications related to the incident in the incident reporting panel within DHS's centralized case management system.

Referrals to Division of Quality Assurance (DQA)

Step	Responsible Partner(s)	Detail
1	ICA	The ICA reports all critical incidents concerning caregiver misconduct such as a caregiver abused, neglected, or misappropriated the funds of a participant who resides in: • Community-Based Residential Facility (CBRF)* • 3-4 Bed Adult Family Home • Adult Day Care Program • Residential Care Apartment Complex Referral to DQA – Office of Caregiver Quality using the Incident Report of Caregiver Misconduct and Injuries of Unknown Source Form (F-62447). This report is emailed to DHSCaregiverIntake@wisconsin.gov. A copy of this report is attached to the documents console within DHS's centralized case management system.

		*A CBRF is not an eligible living setting in the IRIS program, but CBRFs can be used as short-term respite.
2	ICA	The ICA reports all non-caregiver misconduct incidents that occur involving participants who reside in, or otherwise reside in: • CBRF • 3-4 Bed Adult Family Home • Adult Day Care Program • Residential Care Apartment Complex Report to DQA – Bureau of Assisted Living regional offices. A map that shows the regions and provides contact information for each regional office is found at http://www.dhs.wisconsin.gov/rl_dsl/Contacts/ALSregImap.htm. These incidents are reported by faxing the Incident Report – Medicaid Waiver Programs Form (F-22541) to the regional office. The confirmation of the receipt of the fax is attached to the documents console within DHS's centralized case management system.

WISITS

Step	Responsible Partner(s)	Detail
1	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
2	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
3	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
4	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]

B. Critical Incidents

IRIS participant immediate and ongoing health and safety is one of the most important aspects of a self-directed program. Incident reporting is an effective way that IRIS contractors monitor and mitigate concerns related to participant health and safety. Incidents related to financial exploitation must be referred to Adult Protective Services (APS), and incidents related to caregiver misconduct must be referred to the Division of Quality Assurance (DQA). Both referral processes are outlined below in the Incident Reporting and Follow-up section

1. Definitions

Critical incidents are defined as those incidents that place the participant's immediate or ongoing health or welfare at risk. Incident types and cases that fall into this category are described in the following definitions.

a. Financial Exploitation

Financial exploitation means any of the following (Definition Reference: WI Stats. 46.90(1)(ed)):

i. Obtaining an individual's money or property by deceiving or enticing the individual, or by forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent.

ii. Theft, as prohibited in s. 943.20.

iii. The substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities.

iv. Unauthorized use of an individual's personal identifying information or documents, as prohibited in s. 943.201.

v. Unauthorized use of an entity's identifying information or documents, as prohibited in s. 943.203.

vi. Forgery, as prohibited in s. 943.38.

vii. Financial transaction card crimes, as prohibited in s. 943.41

b. Treatment Without Consent

Administration of medication to an individual who has not provided informed consent or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance. (Definition Reference: WI Stats. 46.90(1)(h))

c. Unreasonable Confinement or Restraint

The intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by DHS if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint. (Definition Reference: WI 46.90(1)(i))

d. Participant Injury

Injury, illness, or hospitalization that requires immediate emergency medical attention.

e. Participant Falls

Any type of participant fall is considered a critical incident.

f. Emergency Medical Attention

Existing medical condition that requires emergency medical attention.

g. Participant Death

All other deaths that do not meet the Immediate Reportable Incident criteria.

h. Missing Participant

Any instance that does not meet the immediate reportable criteria above.

i. Law Enforcement Involvement

i. Unplanned involvement of law enforcement and/or the criminal justice system.

ii. Any time law enforcement personnel are called as a result of an incident that jeopardized the health, safety, or welfare of a participant.

j. Property Damage

i. Significant damage to property, either enacted against or by the participant that places the participant's welfare at risk.

ii. Damage to the participant's residence due to fire, natural disaster, or other cause with significant impact to the participant.

k. Medication Errors

i. Participant received the wrong medication.

ii. Participant received the wrong dose of medication.

iii. Medication was administered to the participant incorrectly.

iv. Medication was administered to the participant at the wrong time.

2. Procedures

Upon discovery of a Critical Incident, the IRIS contractor is required to ensure the participant's immediate and ongoing health and safety. This includes confirming that the incident has been resolved and that the participant's individual support and service plan (ISSP) has sufficient supports and services to meet the participant's needs.

IRIS contractors are required to report Critical Incidents in DHS's centralized case management system within seven calendar days. Additionally, the IRIS contractor must complete follow-up activities within 30 calendar days of the incident to assure the participant's ongoing health and safety.

Critical Incident Reporting and Follow-up Process

Step	Responsible Partner(s)	Detail
1	Participant	The participant or guardian, legal representative, or provider reports all incidents to the ICA within 24 hours of the incident.
2	ICA	The ICA will ensure participant's immediate health and safety by verifying that the ISSP sufficiently meets the participant's support needs.
3	ICA	The ICA will complete the incident reporting panel within DHS's centralized case management system within seven business days of being notified of the incident.

Referrals to Adult Protective Services (APS)

Step	Responsible Partner(s)	Detail
1	ICA	The ICA reports all incidents of financial exploitation of funds to the county APS unit within 24 hours. Active situations wherein the participant's health and safety is at risk must be reported immediately. The DHS website has the contact information for each county's APS helpline: www.dhs.wisconsin.gov/aps/index.htm.
2	ICA	The ICA maintains communication with the APS unit to determine if the incident is substantiated. The ICA will work with the participant to ensure their ISSP meets their support needs and ensures their health and safety.
3	ICA	The ICA will document all communications related to the incident in the incident reporting panel within DHS's centralized case management system.

Referrals to Division of Quality Assurance (DQA)

Step	Responsible Partner(s)	Detail
1	ICA	The ICA reports all critical incidents concerning caregiver misconduct such as a caregiver abused, neglected, or misappropriated the funds of a participant who resides in: • Community-Based Residential Facility (CBRF)* • 3-4 Bed Adult Family Home • Adult Day Care Program • Residential Care Apartment Complex Re to DQA – Office of Caregiver Quality using the Incident Report of Caregiver Misconduct and Injuries of Unknown Source Form (F-62447). This report is emailed to DHSCaregiverIntake@wisconsin.gov. A copy of this report is attached to the documents console within DHS's centralized case management system. *A CBRF is not an eligible living setting in the IRIS program, but CBRFs can be used as short-term respite.
2	ICA	The ICA reports all non-caregiver misconduct incidents that occur involving participants who reside in, or otherwise reside in: • CBRF • 3-4 Bed Adult Family Home • Adult Day Care Program • Residential Care Apartment Complex Report to DQA – Bureau of Assisted Living regional offices. A map that shows the regions and provides contact information for each regional office is found at

		http://www.dhs.wisconsin.gov/rl_dsl/Contacts/ALSreglmap.htm. These incidents are reported by faxing the Incident Report – Medicaid Waiver Programs Form (F-22541) to the regional office. The confirmation of the receipt of the fax is attached to DHS's centralized case management system.

WISITS

Step	Responsible Partner(s)	Detail
1	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
2	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
3	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]
4	[Fill in responsible partners. One per line]	[Provide text describing what is done at this step. Can include bullet points if desired]

State Medicaid Agency (SMA) Review Guidelines and Review Tool

The State Medicaid Agency[1] (SMA) review tool will assist IRIS consultant agencies (ICA) and participants with SMA review requests. The review tool serves to streamline the SMA review process in a way that promotes participant self-direction and program-wide consistency. Further, the review tool aims to improve the SMA review process by outlining the SMA documentation requirements.

SMA review and approval is required for the following services:

- Relocation—community transition services
- Counseling and therapeutic services
- Home modifications
- Vehicle modifications
- Community involvement support
- Individual directed goods and services

The SMA review tool ensures that ICA staff follow a consistent process when working with participants to prepare and submit requests for service authorizations. The SMA review tool includes a series of questions that will assist ICAs and participants with the narrative portion of the SMA review submission. After the ICA and the participant complete any required forms and use the SMA review tool to write the narrative portion of the SMA review, the ICA will submit the request to the SMA via SharePoint. The SMA review process is the mechanism by which the SMA will approve or deny certain service authorization requests.

SMA Review Process

SMA review requests are submitted via a SharePoint site. When a new ICA is certified, SMA staff meet with the ICA to define the SMA review process, including the identification of the participant's need, the completion of the paperwork, the use of the SharePoint sites, the decision-making process, and the independent review and Medicaid Fair Hearing appeal processes.

When a SMA review request is marked as "Pending Review," it is ready for SMA review. The SMA's quality assurance staff will review requests that are "Pending Review." The review analyzes the request and recommends one of the following: approval, request for further information, or denial. When the SMA review results in a service authorization, the SMA approval will indicate the approved service, number of units, rate, provider, and authorization period. In cases where the request is denied, the participant has the option to request an Independent Review. The IRIS Policy and Operations Section Manager conducts the Independent Review. The IRIS Policy and Operations Section Manager

[1] The State Medicaid Agency is the Wisconsin Department of Health Services.

reviews the recommendation and issues a final approval or denial. If the request is denied or the participant chooses not to request an Independent Review, the IRIS participant can request a Medicaid Fair Hearing.

If a participant re-requests the same service within 120 calendar days of the original SMA review decision, a second SMA review request is not required unless there has been a change in the participant's condition or circumstances.

When a re-request is received within 120 days, the ICA staff must:

- Ask the participant what change(s) prompted the re-request.
- Ask the participant to identify a change in condition or circumstances.
    - If a change in condition has occurred, the ICA will complete a new long-term care functional screen and will assist with the submission of an updated SMA review request.
    - If a change in circumstance has occurred, the ICA will assist with the submission of an updated SMA review request.
    - If the ICA determines that no change has occurred since the original review, the ICA will document this in the participant's record. Then, the initial SMA review decision will be upheld, and no additional SMA review request is submitted.

SMA Review Submission Requirements

To ensure that IRIS participants receive all necessary supports, the IRIS program has developed the SMA review process, which will assist participants with requests for services that require SMA review.

As discussed above, participants can request unlisted services in the following categories: relocation—community transition services, counseling and therapeutic services, home modifications, vehicle modifications, and community involvement support. With SMA approval, services in these categories can become a part of the participant's Individual Support and Service Plan (ISSP).

To submit a service approval request for SMA review, the ICA will submit the CREATE FORM and a narrative detailing the requested support, service, or good. The *SMA Review Tool for Service Authorizations* will assist with the development of the narrative.

SMA Review Tool for Service Authorizations

When evaluating whether a participant might benefit from an unlisted service or support, within the categories above, the ICA and the participant must complete the SMA review tool below. The participant's responses should be captured as a narrative and submitted to the SMA via SharePoint.

1. **What is the core issue?**

2. **How does the core issue relate to the participant's long-term care outcomes?**
   - Does the core issue affect the participant's health or safety?
   - Does the core issue affect the participant's independence, activities of daily living (ADLs), or instrumental activities of daily living (IADLs)?

3. **What options address the core issue while supporting the long-term care outcomes?**
   - Identify and consider all potential options, including the requested service or support.
   - Assess the participant's current services and supports.
   - Review previous services and supports to determine what has worked in the past.
   - Explore the role of natural services and supports, like family and friends.
   - Explore community resources, which are services and supports that are readily available to the public.
   - Explore loaner programs and rental versus purchase options.

4. **Review the options to determine the following:**
   - The most effective options to support the participant's long-term care outcome.
   - The most cost-effective option to support the participant's long-term care outcome. Cost-effective means that the option will effectively support an identified long-term care outcome at a reasonable cost and effort.

5. **Evaluate applicable IRIS program policy or guidelines.**

6. **Determine which option will be submitted for SMA review, if needed.**

Identify the qualified provider that the participant wants to hire and determine the provider's payment rate. Rates must be reasonable, usual, and customary. This means that the provider payment rate should be similar to rates paid to other providers in the area. The SMA will deny requests for unqualified providers or payments rates that are not reasonable, usual, or customary.

Tony Evers
Governor

Karen Timberlake
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

Guidelines for Assistive Technology–Service Dogs

A. Definition of a Service Dog:

For the purpose of coverage as an assistive technology benefit, a service dog is a dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability. Emotional support dogs and therapy dogs are not service dogs.

When a participant obtains a service dog as a covered benefit, the participant recognizes that he or she owns the service dog and agrees to be responsible for and liable for the actions of the service dog.

Service Dog Definition: A dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability.

Some (non-exhaustive) examples:

- **Guide Dog:** Guides a person who is blind or visually impaired.
- **Hearing Dog:** Alerts a person who is deaf or hearing impaired to sounds such as door bells, smoke alarms, and alarm clocks.
- **Mobility Dog:** Assists a person in performing tasks, such as opening doors, picking up objects, and pulling wheelchairs; provides stability to a person with the aid of a special harness.
- **Medical Alert Dog:** Notifies a person of a change in body chemistry that may indicate a health concern, such as low or high blood sugar for a person with diabetes, or that a seizure is imminent for a person with epilepsy.
- **Psychiatric Service Dog:** Assists a person with a documented psychiatric disorder such as anxiety or post-traumatic stress disorder (PTSD).

  It is an important distinction of a psychiatric service dog that it performs a specific task to assist its person, as is the case with all service dogs. Some examples follow:

  1. Providing safety checks or room searches for a participant with PTSD.
  2. Blocking a person in a dissociative episode from wandering into danger (for example, traffic).

3. Physically preventing or interrupting impulsive or destructive behaviors, such as self-harm.

In each of these examples, the psychiatric service dog is trained to perform certain tasks directly related to an individual's psychiatric disability and to help the participant accomplish vital tasks the participant would otherwise not be able to perform.

Emotional Support Dog Definition: A dog that provides comfort or emotional support simply by being with a person. While an emotional support dog may be prescribed by a medical professional to help ease a person's anxiety, depression, or phobia, it is not a service dog because it is not trained to perform a specific job or task for an individual with a disability.

Therapy Dog Definition: A dog trained to interact with many people in a clinical setting (hospitals, nursing homes, schools, or other institutional settings), other than its handler, to make those people feel better. A therapy dog is not a service dog because it is not trained to perform a specific job.

B. What is Covered:

1. The purchase of a fully trained service dog as defined above. The fully trained service dog must be purchased from a reputable provider that has experience providing structured training for service dogs. Service dog providers do not have to be Medicaid certified. There are no state or national licensing or accreditation standards that apply to service dog providers. Providers that are members of Assistive Dogs International are considered reputable providers: https://assistancedogsinternational.org/.

   If the provider is not a member of Assistive Dogs International, it is expected that the provider would be able to demonstrate that its program meets or exceeds the following standards:

   a. Screening

      Dogs selected by the provider for training:

      i. Are temperamentally screened for emotional soundness and working ability.

      ii. Are physically screened for the highest degree of good health and physical soundness.

   b. Training

      Dogs are trained using humane training methods providing for the physical and emotional safety of the dog.

   c. Partnering

      i. Dogs are matched to best suit their human partner's needs, abilities, and lifestyle.

ii. Dogs are placed with a person able to provide for the dog's emotional, physical, and financial needs.

iii. Dogs are placed with a person able to provide a stable and secure living environment.

iv. Human partner is provided with a thorough and individualized education process regarding all aspects of service dog partnership.

d. Capabilities

Fully trained service dogs produced by the program are capable of:

i. Responding to commands (basic obedience and skilled tasks) 90% of the time on the first ask in all public and home environments.

ii. Demonstrating basic obedience skills by responding to voice and/or hand signals for sitting, staying in place, lying down, walking in a controlled position near its human partner, and coming to the human partner when called.

iii. Performing their service dog function in public.

iv. [Guide dog] Negotiating obstacles, overhangs, barriers, street crossings, construction work, and public transportation.

v. [Hearing dog] Alerting its human partner through physical contact or by some other behavior, so the human partner is aware when a trained sound occurs.

vi. Performing three or more tasks to mitigate aspects of the human partner's disability unless the mitigation of the human partner's disability requires less than three tasks. (For example when a service dog is trained to mitigate a seizure by lying across the human partner's legs.)

a) The task must be visibly identifiable.

b) The task must directly mitigate the human partner's disability.

A task is trained behavior the dog does on cue (or command) to mitigate its partner's disability. The cue can be verbal, a hand signal, something in the environment, or some behavior exhibited by the partner or another person. Examples of a verbal cue could be "take it," and a hand signal could be pointing at an object to indicate to the dog to retrieve it. A cue in the environment might be a strap on a door, a car in the road, or an alarm clock ringing. The behavior of a person could be falling to the ground, hand shaking, or emitting odor of low blood sugar.

2. Post-purchase training with a reputable provider with experience providing structured training for service dogs. Post-purchase training is necessary to partner a fully trained service dog with its owner (for example, enable the fully trained service dog and the member to work together and for the member to make use of

the assistive technology. Reasonable travel costs (excluding mileage reimbursement) related to this training can be covered under the community transportation benefit because the travel is necessary for the member to access a waiver service.

Food and lodging costs related to the training cannot be covered by the program because 42 CFR § 441.301(a)(2) does not provide federal financial participation for the costs of room and board for home and community-based waiver services. This coverage also includes coverage of a replacement service dog in the event that a dog is determined to not be suitable for a participant as a result of the owner/handler team training (in the same way that the replacement of any other assistive technology is covered when that aid does not work for the participant).

3. Ongoing maintenance costs of a fully trained service dog obtained from a reputable provider with experience providing structured training for service dogs. The coverage is similar to the upkeep, repairs, and adjustments covered for other assistive technology and durable medical equipment. Note: For the ongoing maintenance costs to be covered, it is not necessary that the participant have obtained the service dog through the IRIS program. However, it is necessary that the participant have obtained the service dog from a reputable provider with experience providing structured training for service dogs. Additionally, if a participant's individual support and services included an authorized service dog prior to January 1, 2021, ongoing maintenance costs for the life of that service dog, regardless of who provided the service dog's initial training may be covered.

4. Like any assistive technology, the IRIS consultant and participant must use discretion in determining whether it is cost-effective to maintain the existing assistive technology or replace it.

C. What are Ongoing Maintenance Costs

Ongoing maintenance costs consist of the following:

1. Preventive, acute, and primary veterinary care necessary to maintain or restore the health and functionality of the service dog. This coverage includes, but is not limited to:

    a. Services that maintain or restore the dog's health to an acceptable working condition (for example, treatment for broken bones, poisoning, snake bites, car accidents, lacerations, foreign object ingestion, mass removals, treatable cancer, diabetes, arthritis, allergies, cruciate ligament injuries, skin and ear infections, urinary tract infections, deworming, and epilepsy). Treatable cancer means that there is a high probability of restoring the dog's health to an acceptable working condition.

    b. Physical exams (annual or at the frequency recommended by a veterinarian).

    c. Vaccinations (for example, vaccines for distemper, canine adenovirus-2 [hepatitis and respiratory disease], canine parvovirus-2, rabies, leptospirosis, coronavirus, canine parainfluenza and Bordetella

bronchiseptica [both are causes of "kennel cough"], and Borrelia burgdorferi [causes Lyme disease]).

d. Testing and diagnostics (for example, x-rays, MRIs, CT scans, ultrasounds, blood tests, urinalysis, fecal, and heartworm).

e. Prescription medications (including intravenous fluids and medications) prescribed by a veterinarian and approved by the Food and Drug Administration.

f. Prescription food that is prescribed by a veterinarian to treat a covered condition.

g. Dental care to treat a covered condition.

h. Vitamins and supplements that are prescribed by a veterinarian to treat a covered condition.

i. Medical supplies (for example, bandages, casts, and splints) that are prescribed or ordered by a veterinarian.

2. Equipment and items necessary for the dog to perform its assistive technology function. This includes, but is not limited to:

a. Dog food (similar to batteries or energy for the assistive technology).

b. Leashes.

c. Harnesses.

d. Leads.

e. Vests.

f. Identification patches.

g. Backpacks or saddlebags.

h. City and county annual licenses.

D. What is Not Covered:

1. The purchase, post-purchase training costs, or maintenance costs of any dog that does not meet the definition of a service dog for the purpose of coverage as an assistive technology benefit.

2. The costs of training a dog to become a service dog. Many participants wish to purchase an untrained dog or puppy and then work with a trainer to train the dog to become a service dog (or train the dog on their own). However, coverage is not provided for the training of a dog to become a service dog because there is no guarantee that the dog will become a service dog. A dog that is being trained to be a service dog may never actually become a service dog. The purchase price of a fully trained service dog, which is obtained from a reputable third party provider, presumably reflects the costs associated with the training of the dog (in the same manner in which the price of a wheelchair or any other type of manufactured good reflects the costs of its creation).

3. Veterinary care:
    a. For conditions or diseases that cannot be cured or have a low probability of being cured. Treatment and care for progressive diseases or conditions that are irreversible and render the service dog unable to perform its assistive technology function (for example, hip dysplasia, chronical renal failure, terminal cancer, and canine degenerative myelopathy).
    b. Holistic treatments (for example, acupuncture, chiropractic, laser therapy, and herbal).
    c. Experimental medical procedures and medications. For example, treatment or medication that is not generally accepted in the veterinary medical community as effective or proven, such as clinical trials.
    d. Cosmetic surgeries (for example, ear cropping and tail docking).
    e. Treatment and care related to breeding, pregnancy, whelping, or nursing.
    f. Dental cleanings, unless used to treat a covered illness.
    g. Organ transplants.
4. Equipment and items not necessary for the dog to perform its assistive technology function. These are items that any dog might need and are not specific to service dogs:
    a. Boarding.
    b. Grooming or grooming supplies (for example, non-prescription baths, ear cleanings, non-prescription shampoos, and nail trims).
    c. Non-prescription vitamins and mineral supplements.
    d. Dog Park permits.
    e. Water bowls.
    f. Food dishes.
    g. Blankets.
    h. Toys.
    i. Treats.

If you have questions regarding this memo or need technical assistance, please email DHSIRISQuality@dhs.wisconsin.gov.

WISCONSIN DEPARTMENT of HEALTH SERVICES

2020 Participant Satisfaction Survey

Jie Gu
Program and Policy Analyst
2021

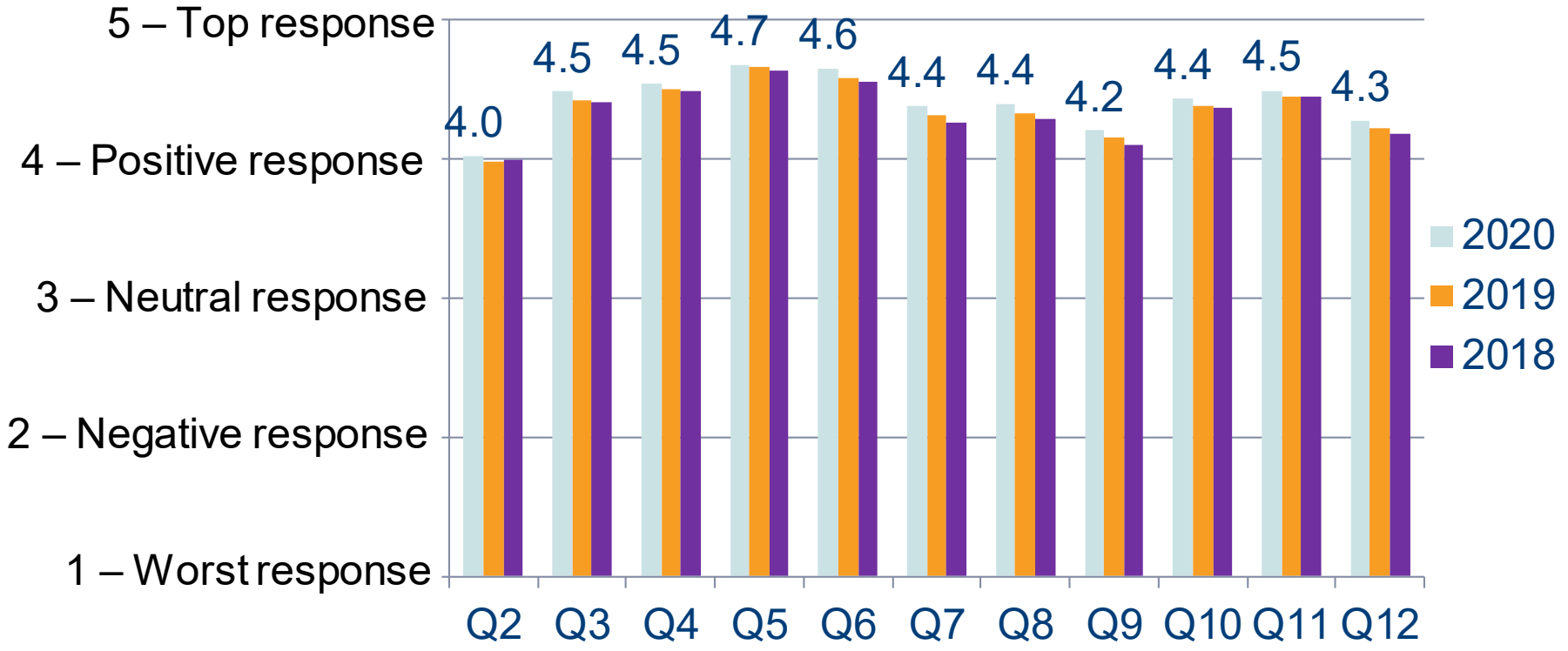
Survey Sample Criteria

Surveys were sent to randomly selected participants meeting the following criteria:

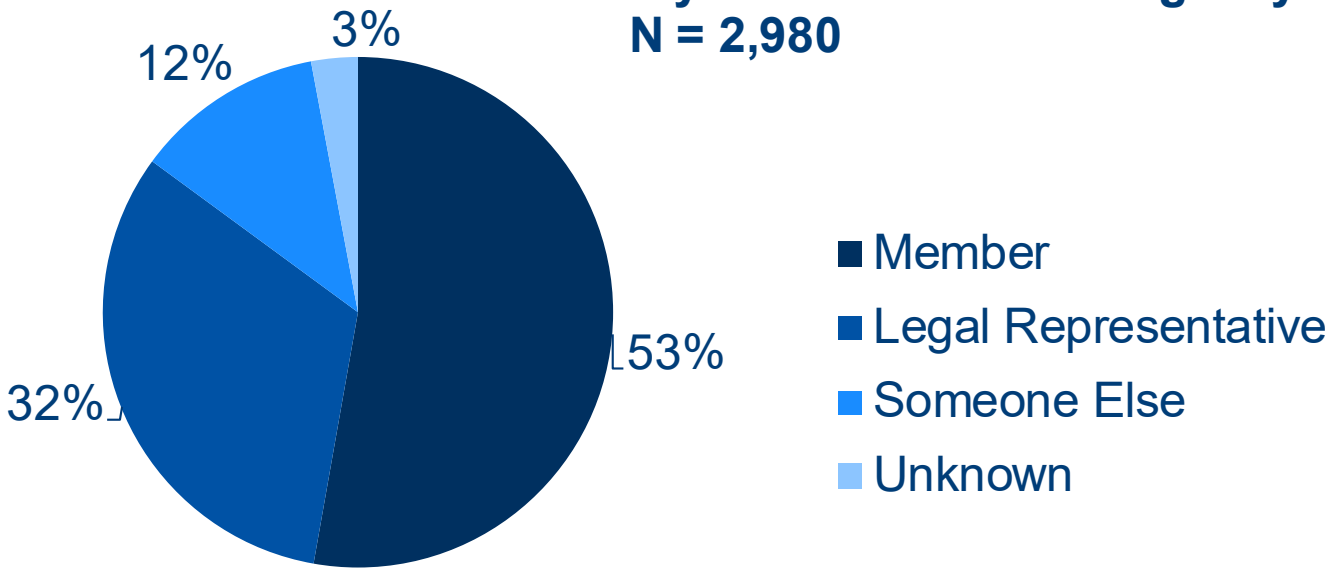
- Current participant
- Having been a participant for 6+ months
- Distributed among all three target groups

2020 IRIS Consultant Agency Participant Satisfaction Survey Analysis

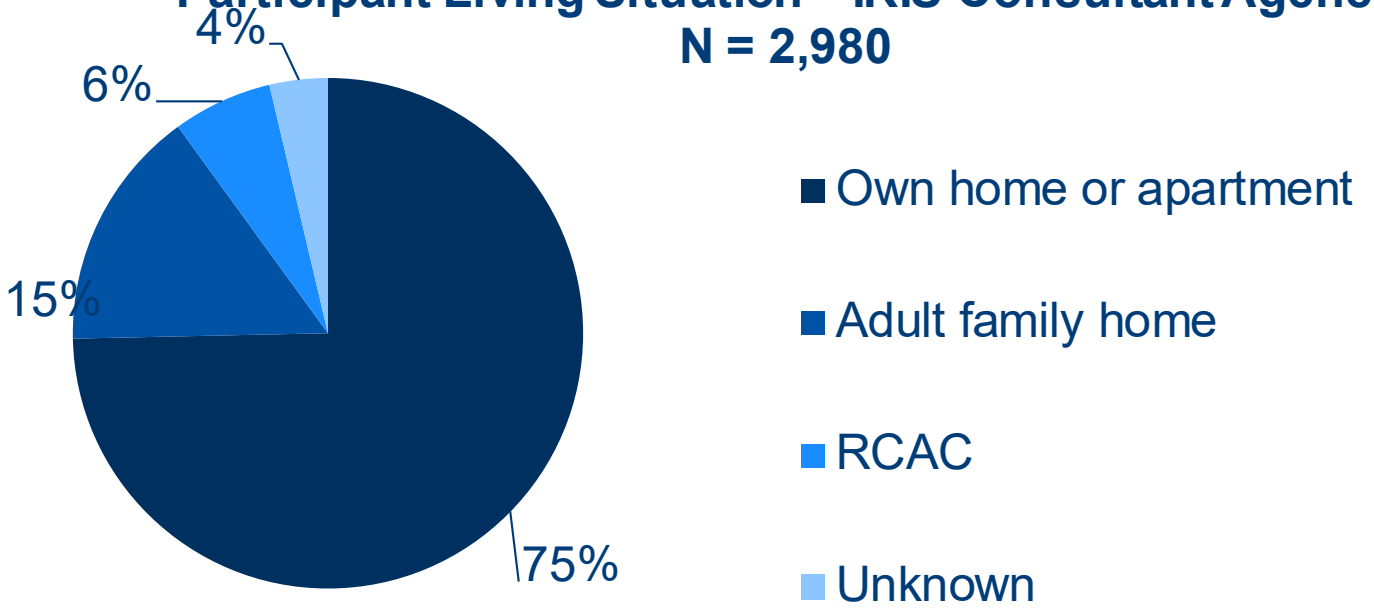
Survey Question Response – IRIS Consultant Agency



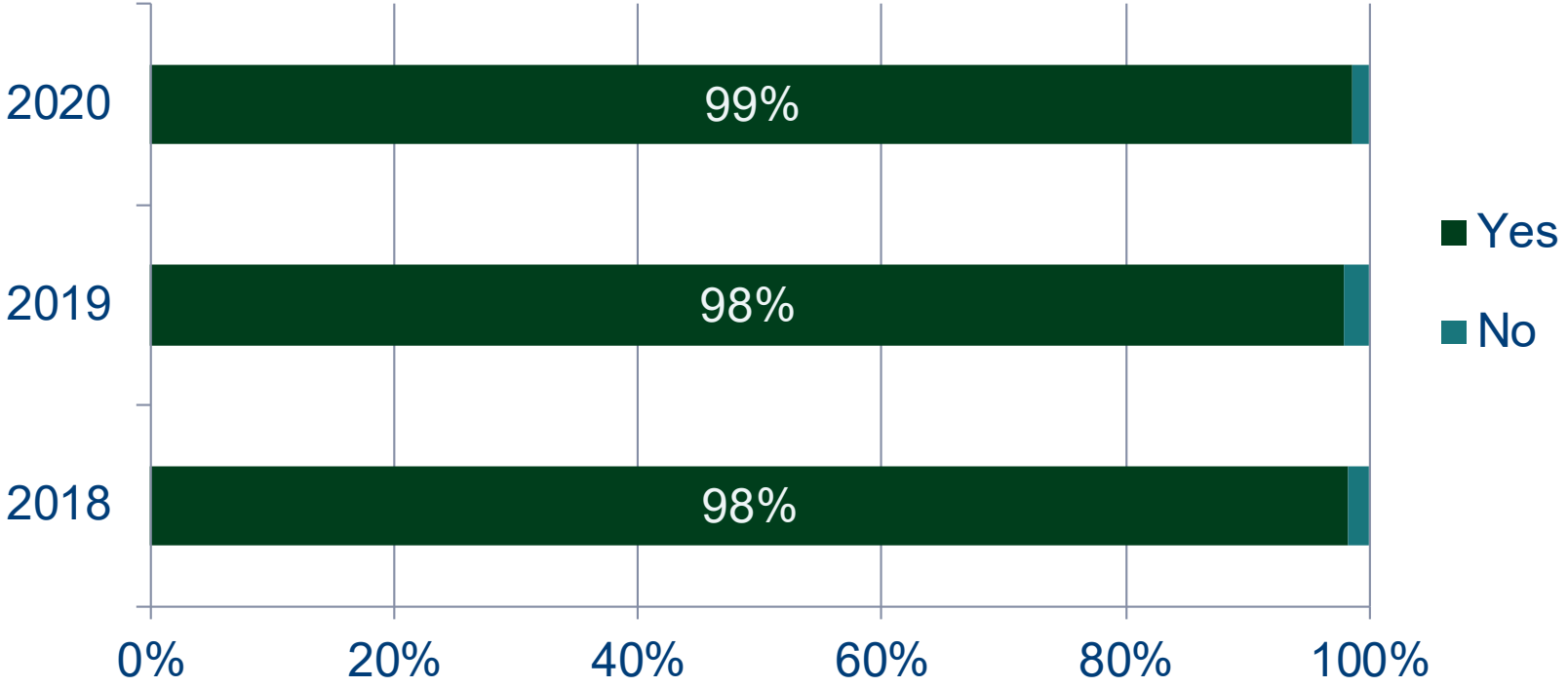
Who Answered Survey – IRIS Consultant Agency
N = 2,980



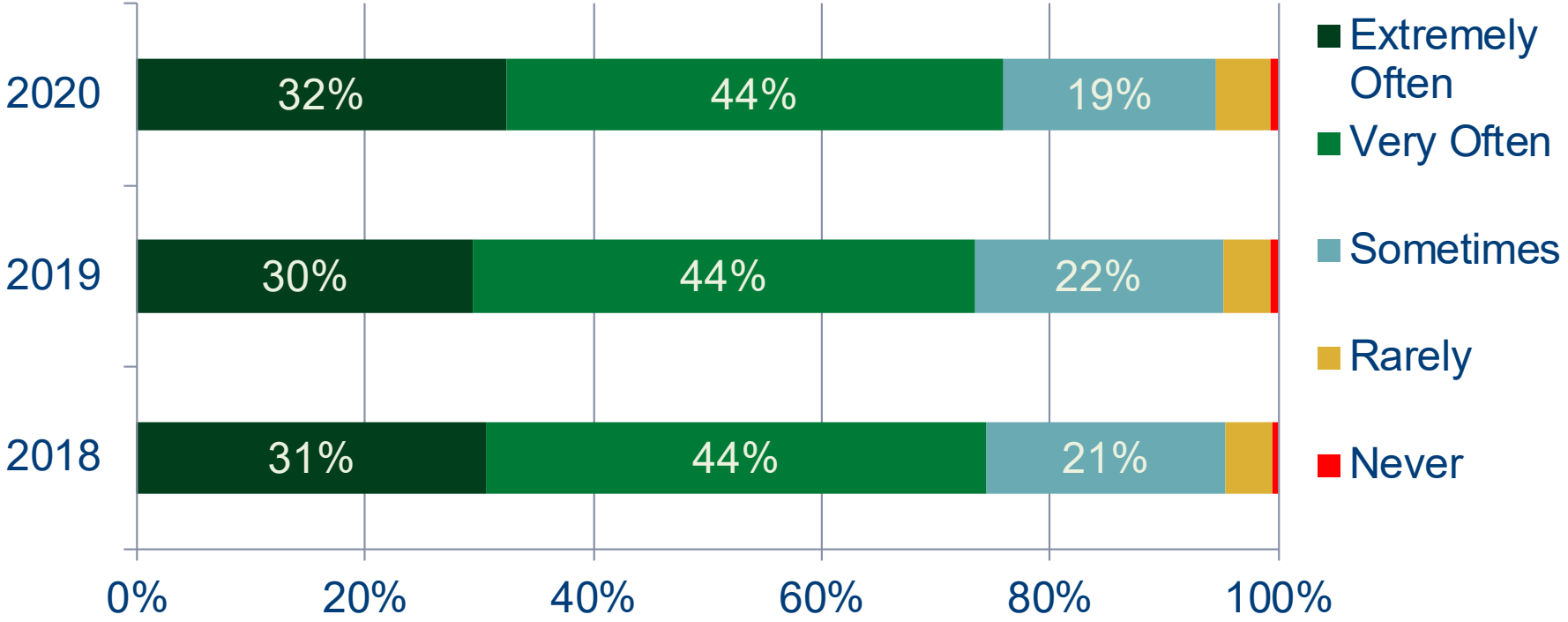
Participant Living Situation – IRIS Consultant Agency
N = 2,980



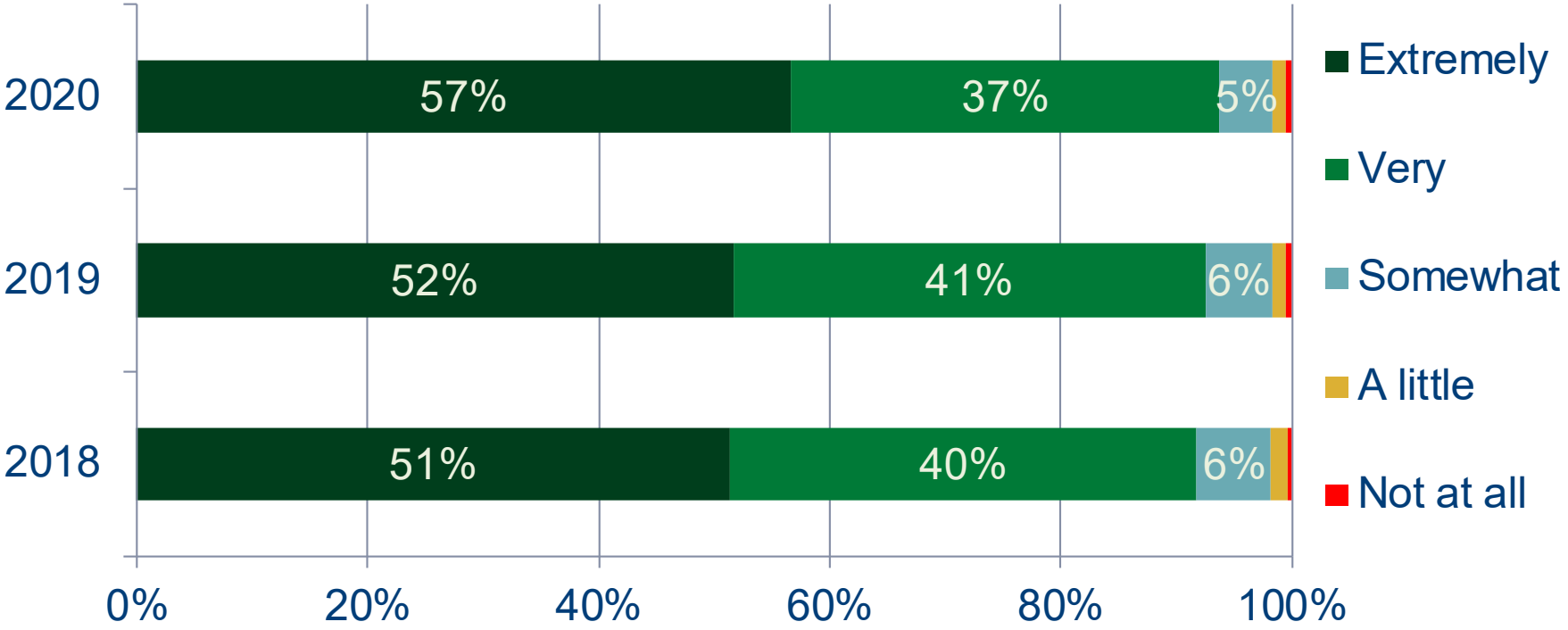
Can you contact your IRIS Consultant when you need to?



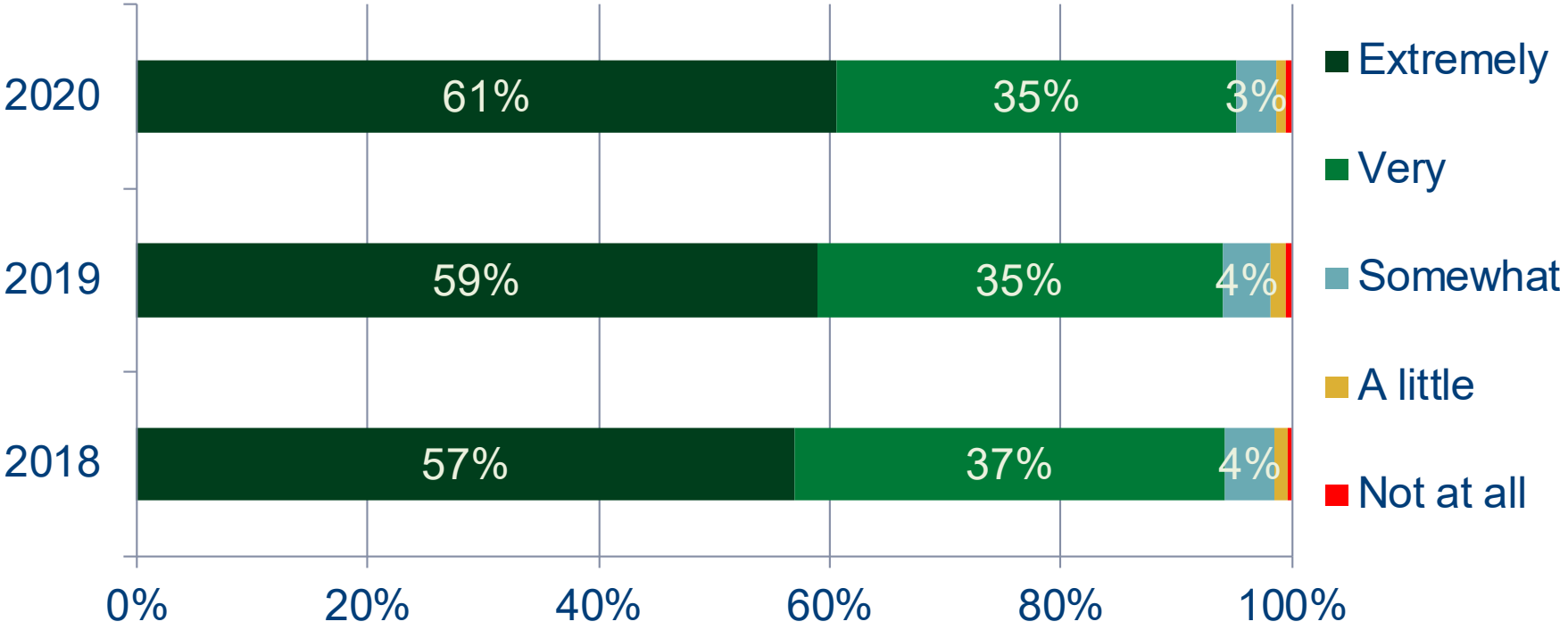
How often do you get the help you need from your IRIS Consultant?



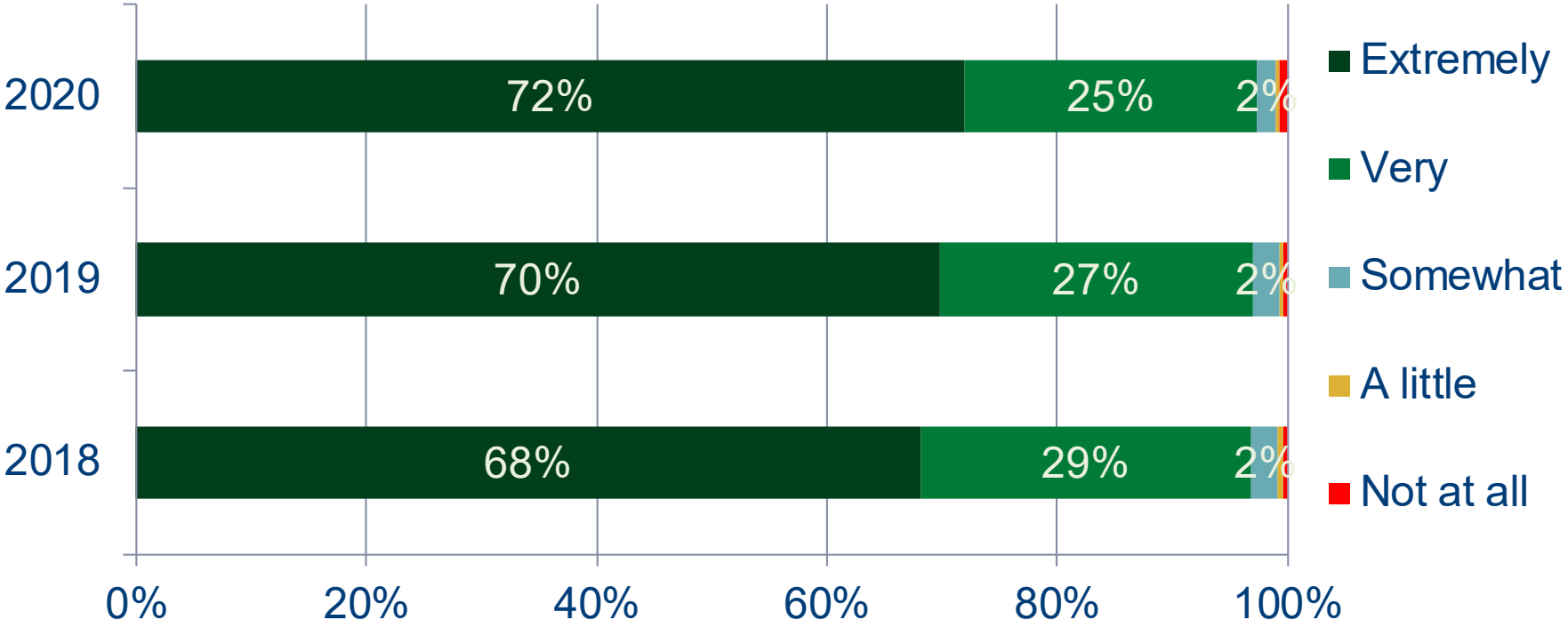
How clearly does your IRIS Consultant explain things to you?



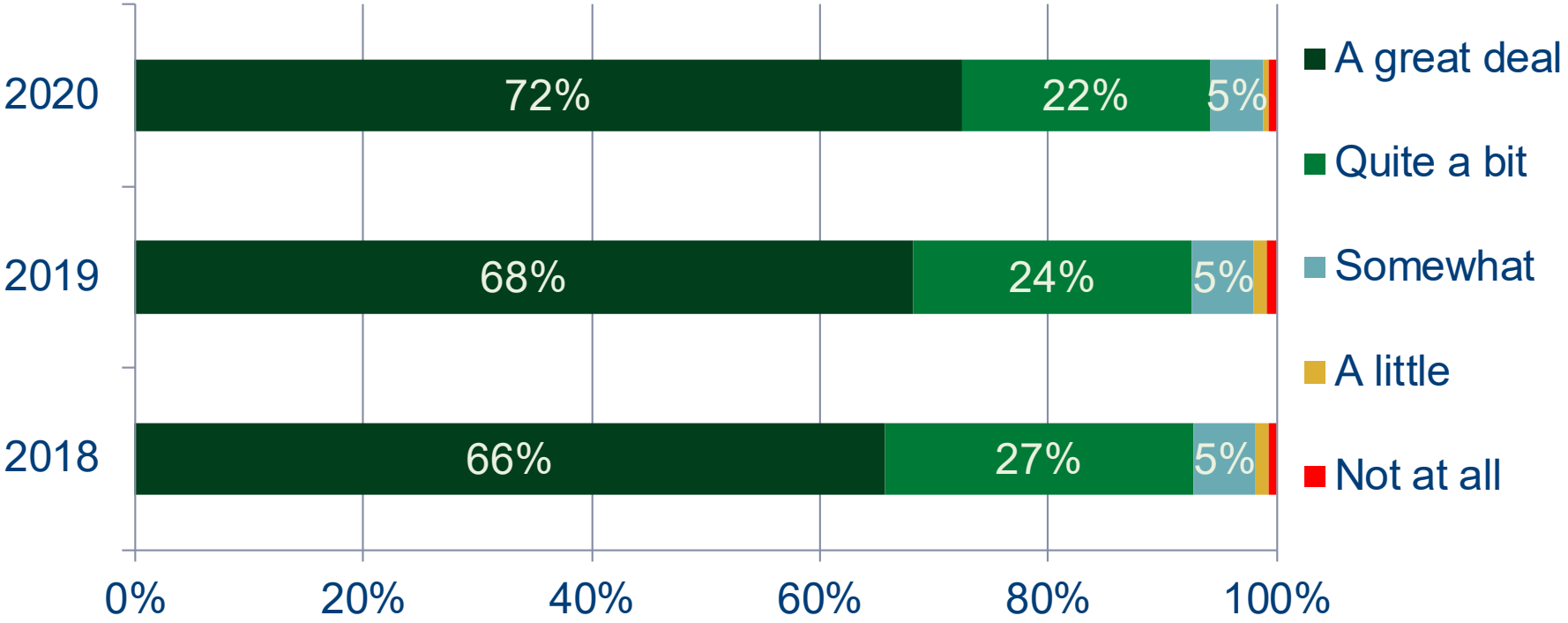
How carefully does your IRIS Consultant listen to you?



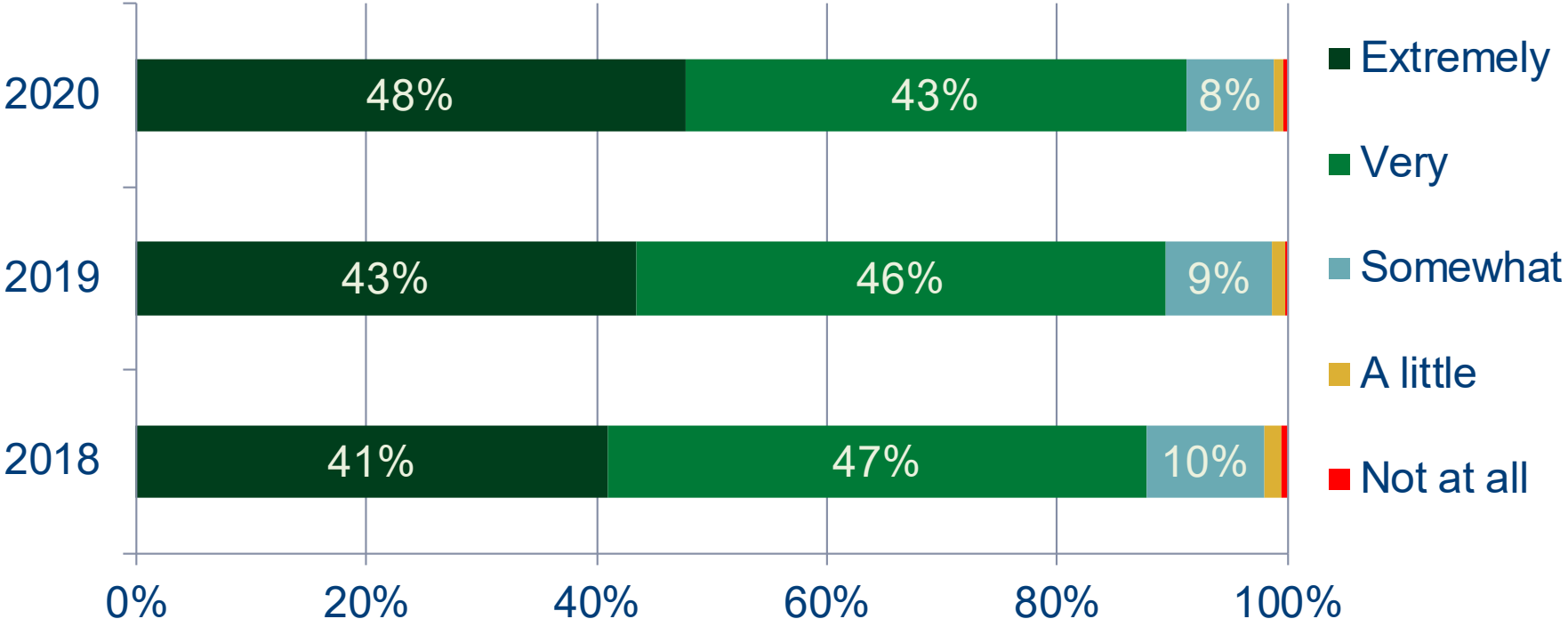
How respectfully does your IRIS Consultant treat you?



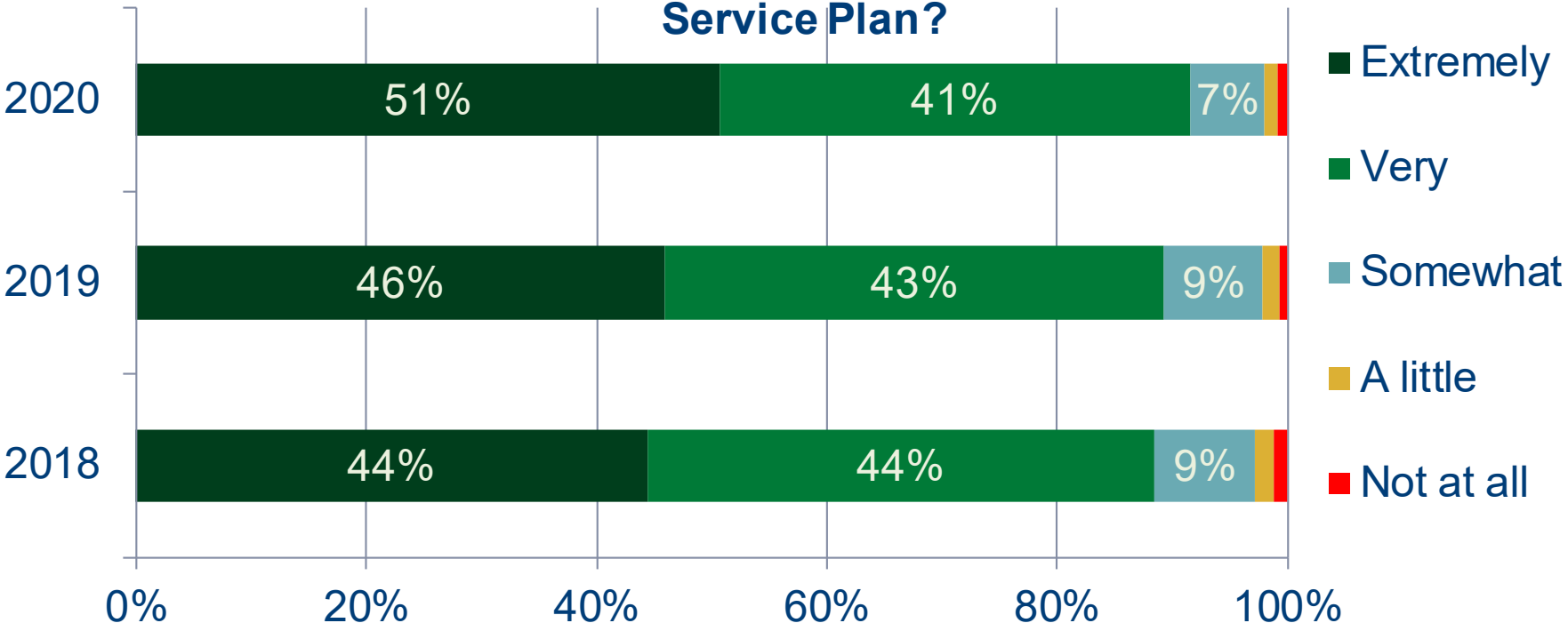
Overall, how much do you like your IRIS Consultant Agency?



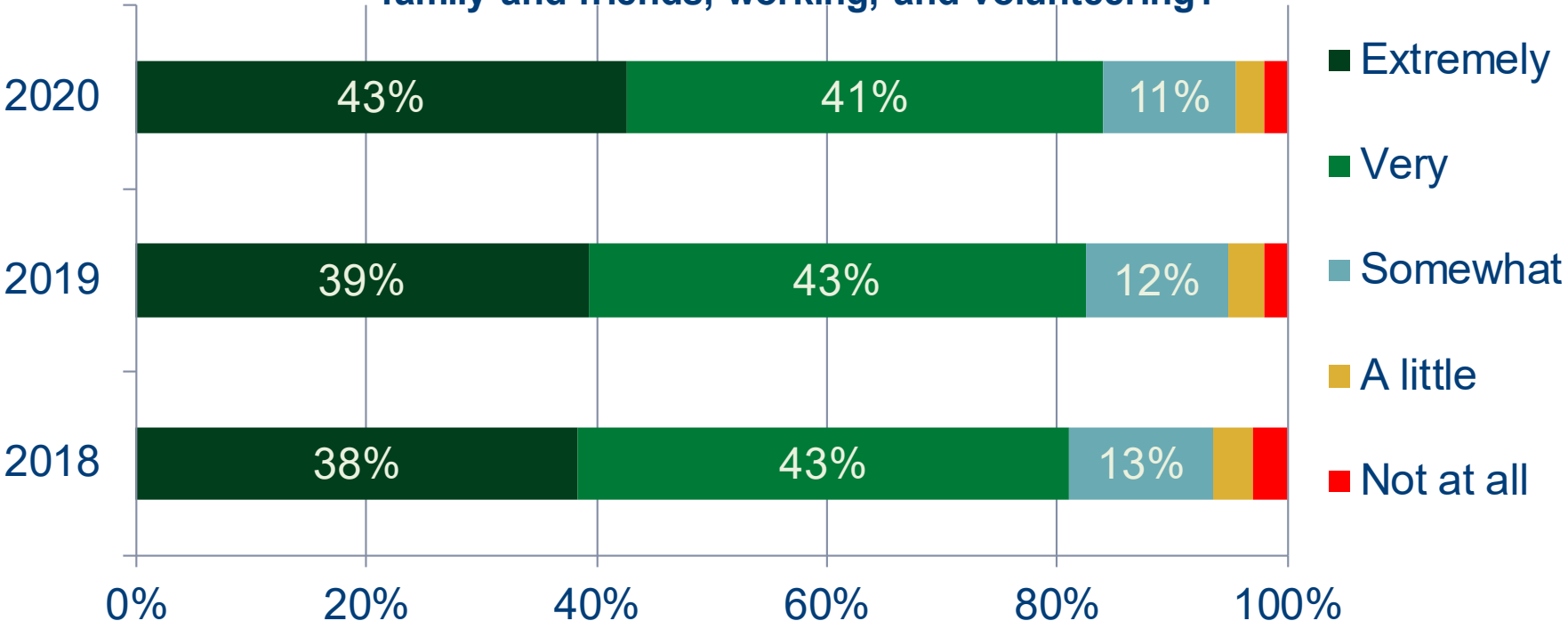
Overall how well do the supports and services you receive in your Individual Support and Service Plan meet your needs?



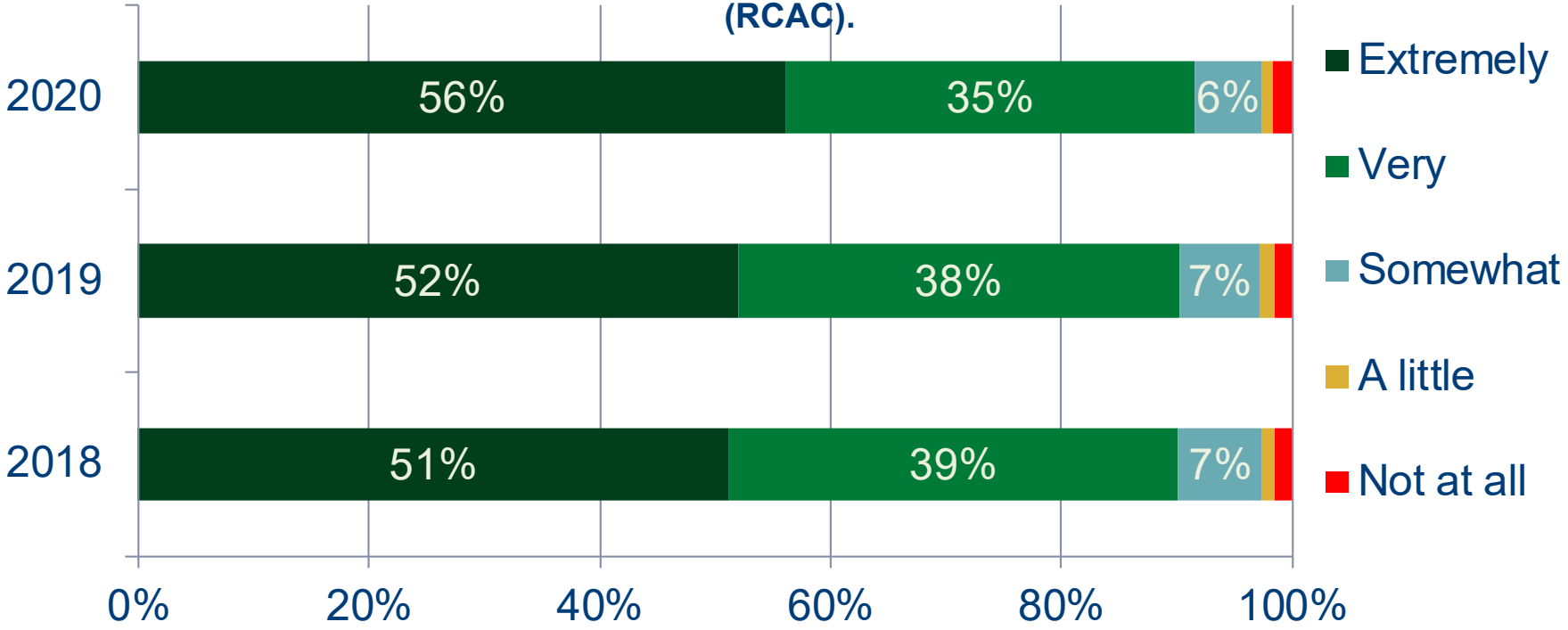
How well does your IRIS Consultant Agency provide you the information you need to develop your Individual Support and Service Plan?



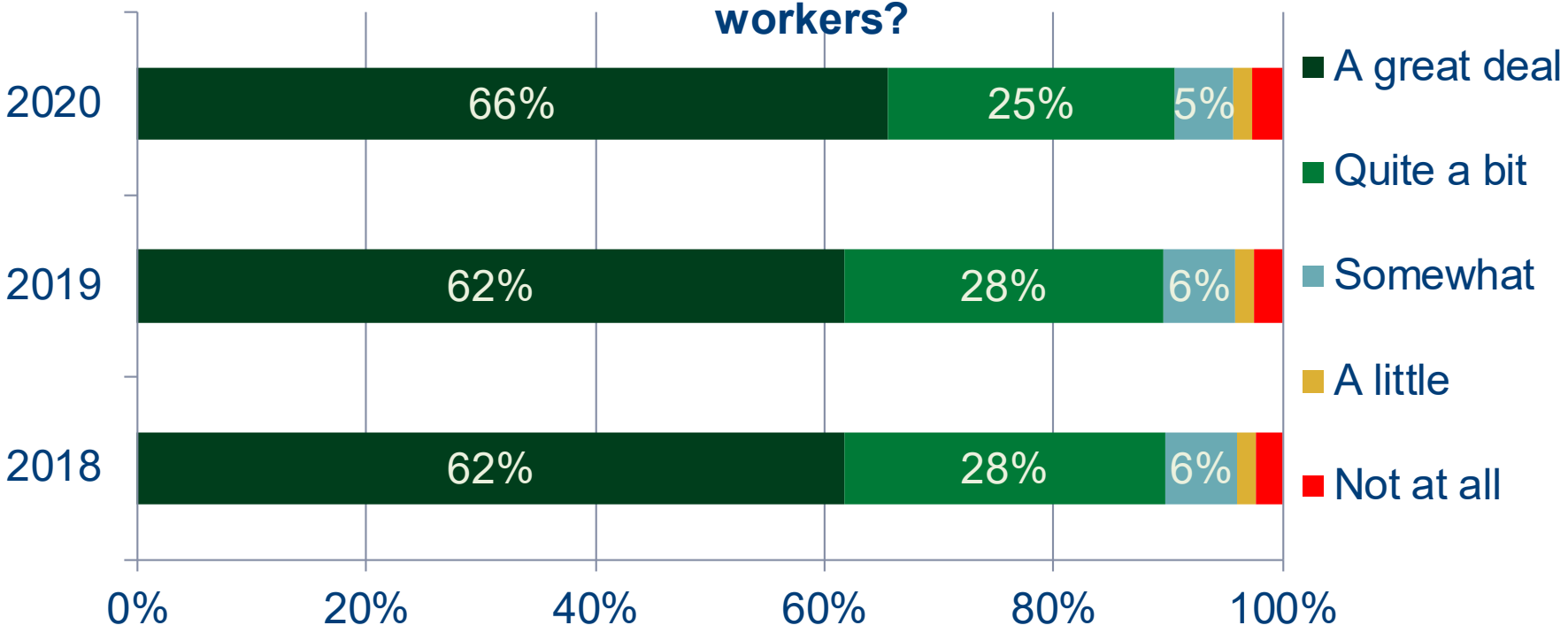
How well does your Individual Support and Service Plan support the activities that you want to do in your community, such as visiting with family and friends, working, and volunteering?



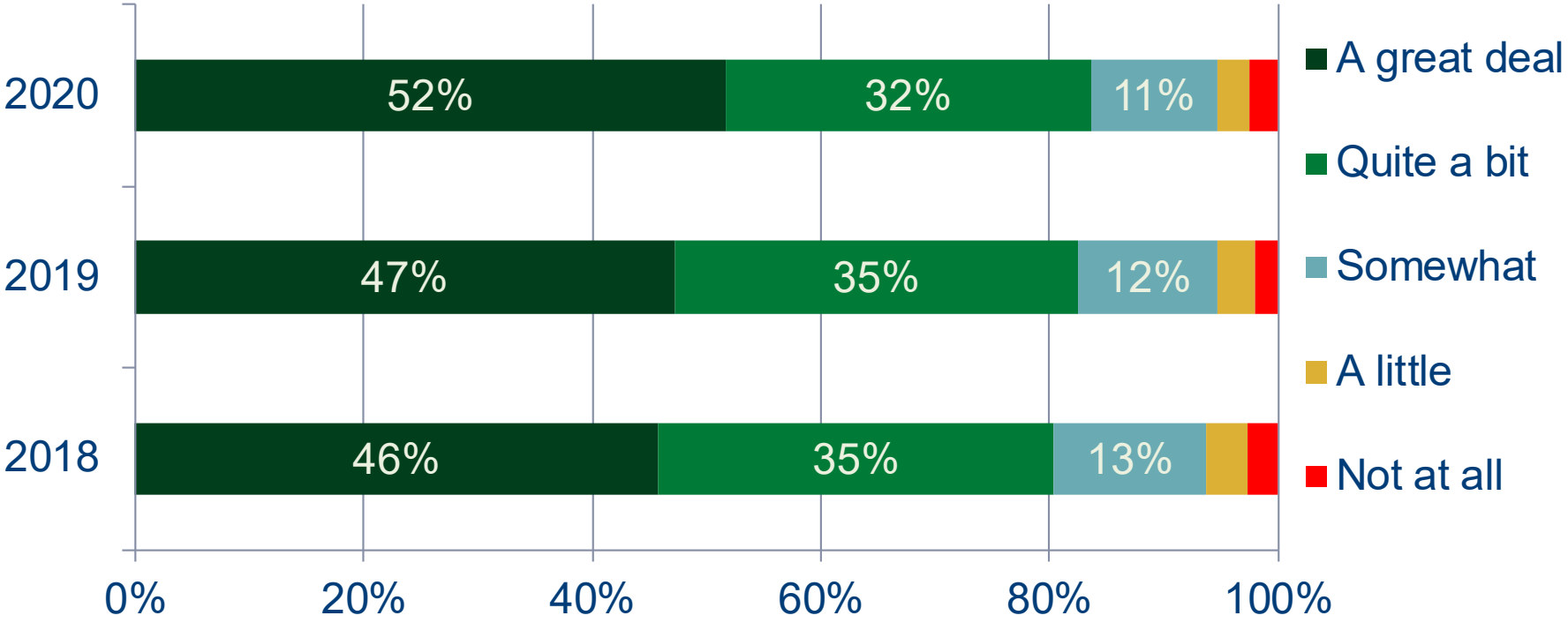
How well does your Individual Support and Service Plan support your needs related to living in a place of your choice? This may include your own apartment or house, Adult Family Home (AFH), or Residential Care Apartment Complex (RCAC).



How much control do you feel you have over recruiting, hiring, training, supervising, disciplining, or terminating your workers?

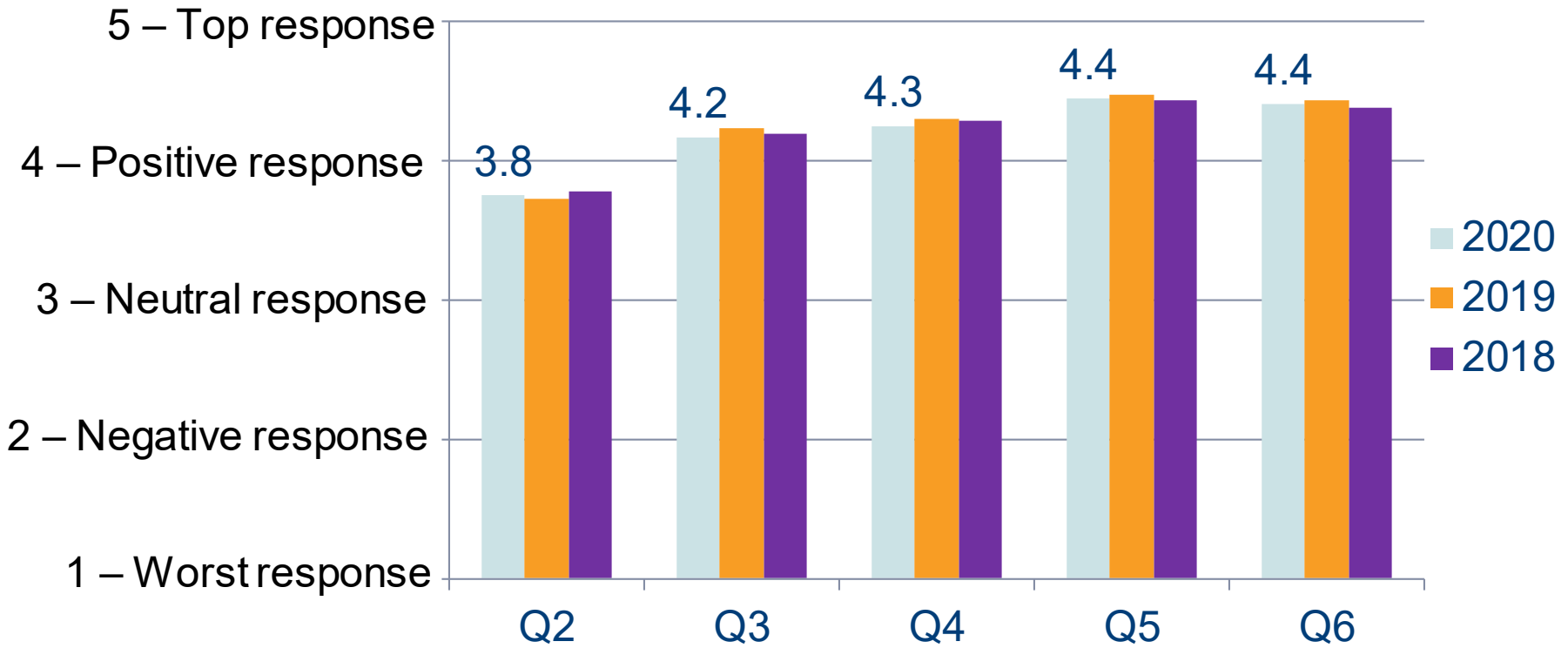


How much control do you feel you have over how your budget is spent to purchase allowable services to meet your needs?

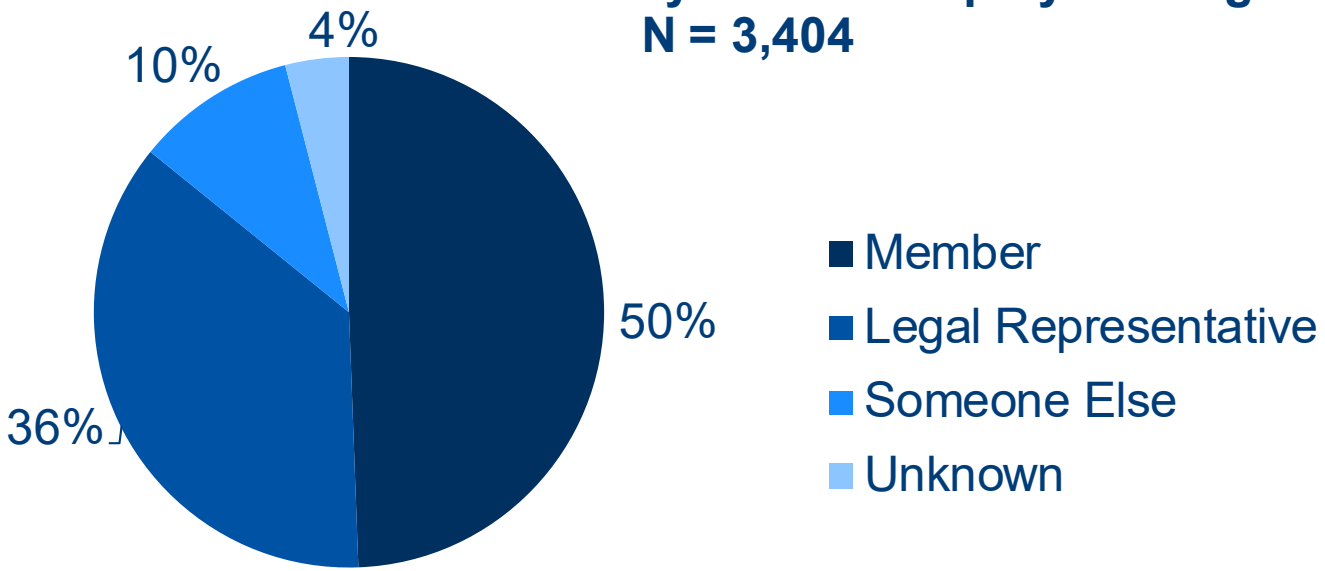


2020 IRIS Fiscal Employment Agent Participant Satisfaction Survey Analysis

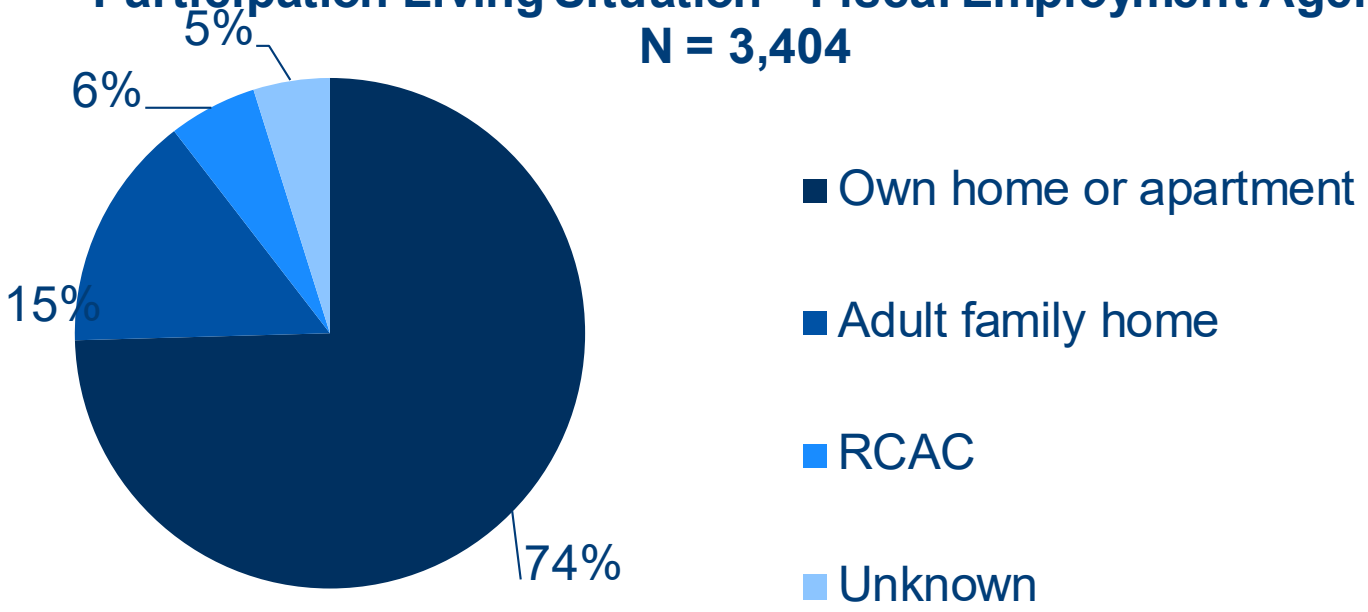
Survey Question Response – Fiscal Employment Agent

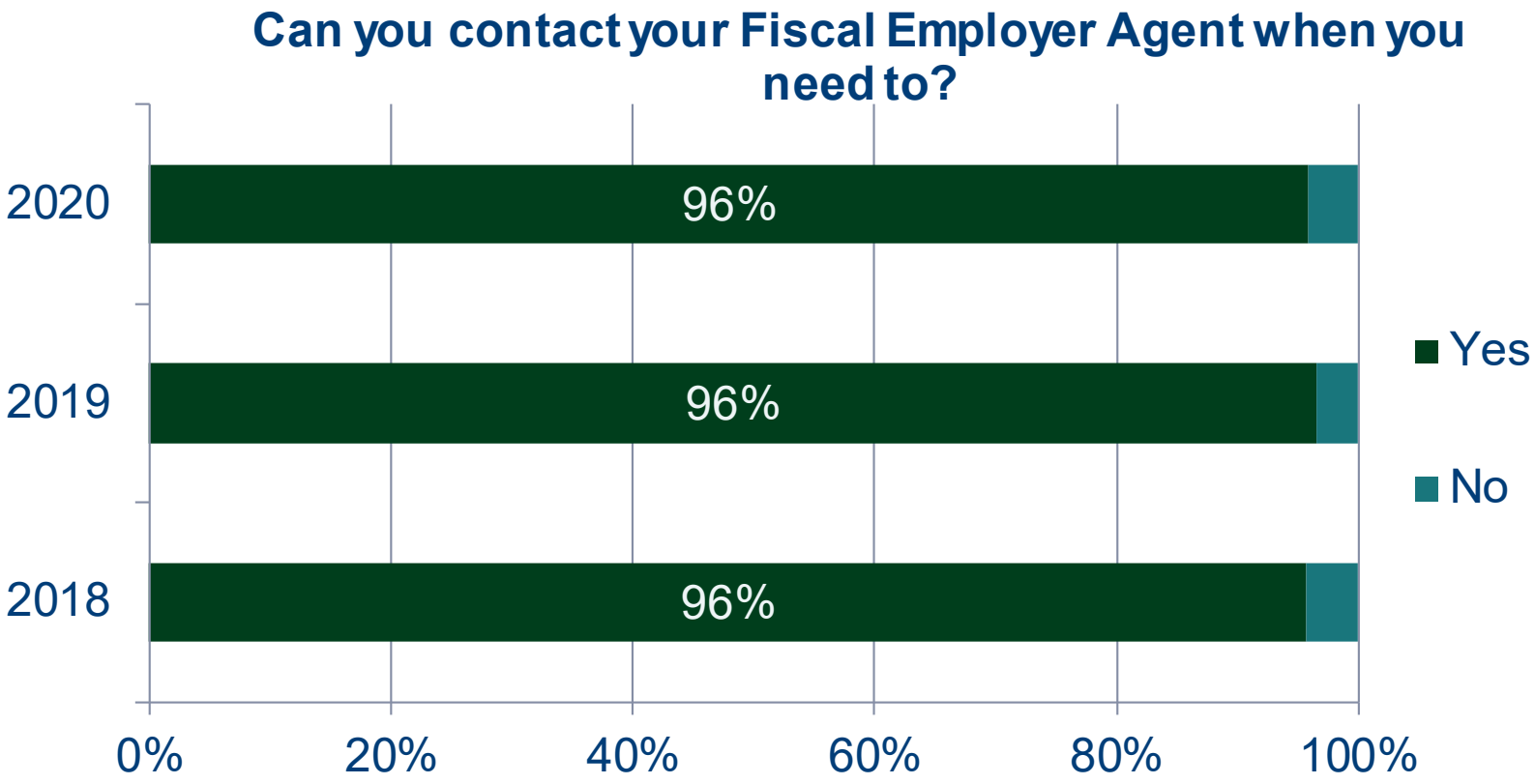


Who Answered Survey – Fiscal Employment Agent
N = 3,404

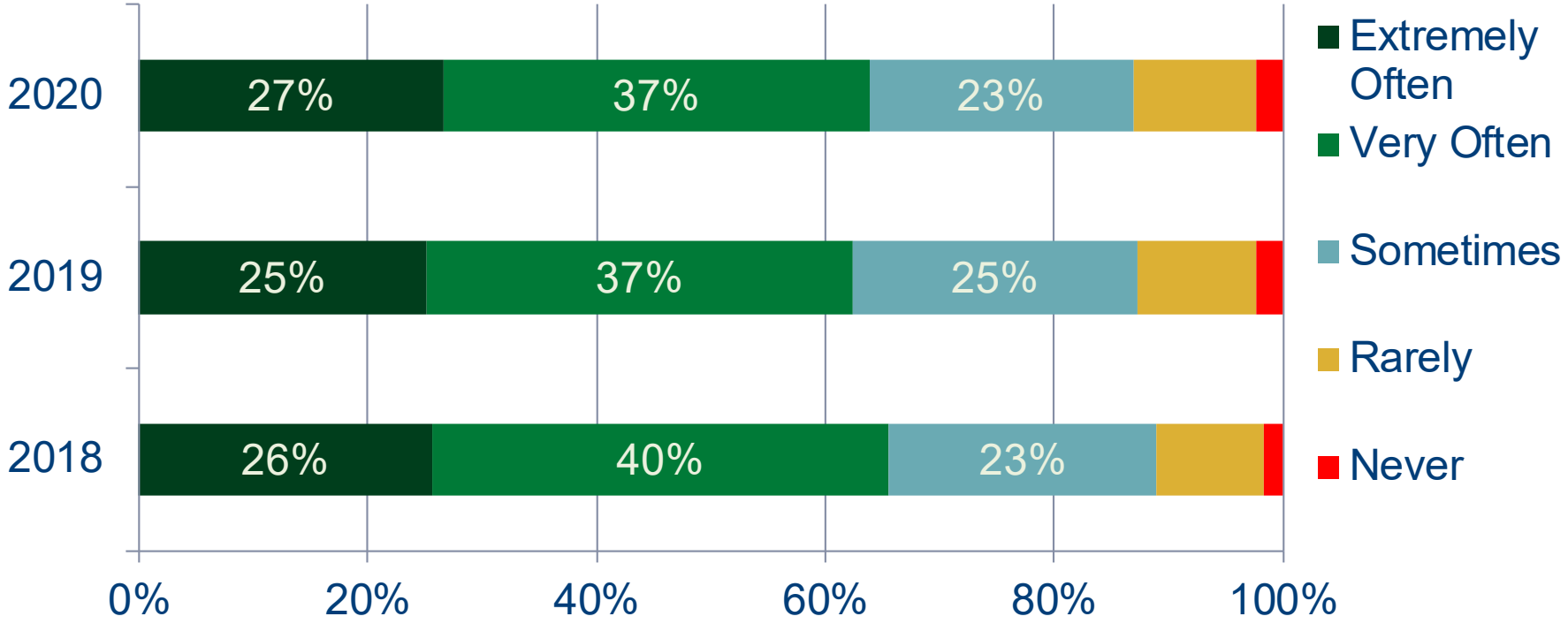


Participation Living Situation – Fiscal Employment Agent
N = 3,404

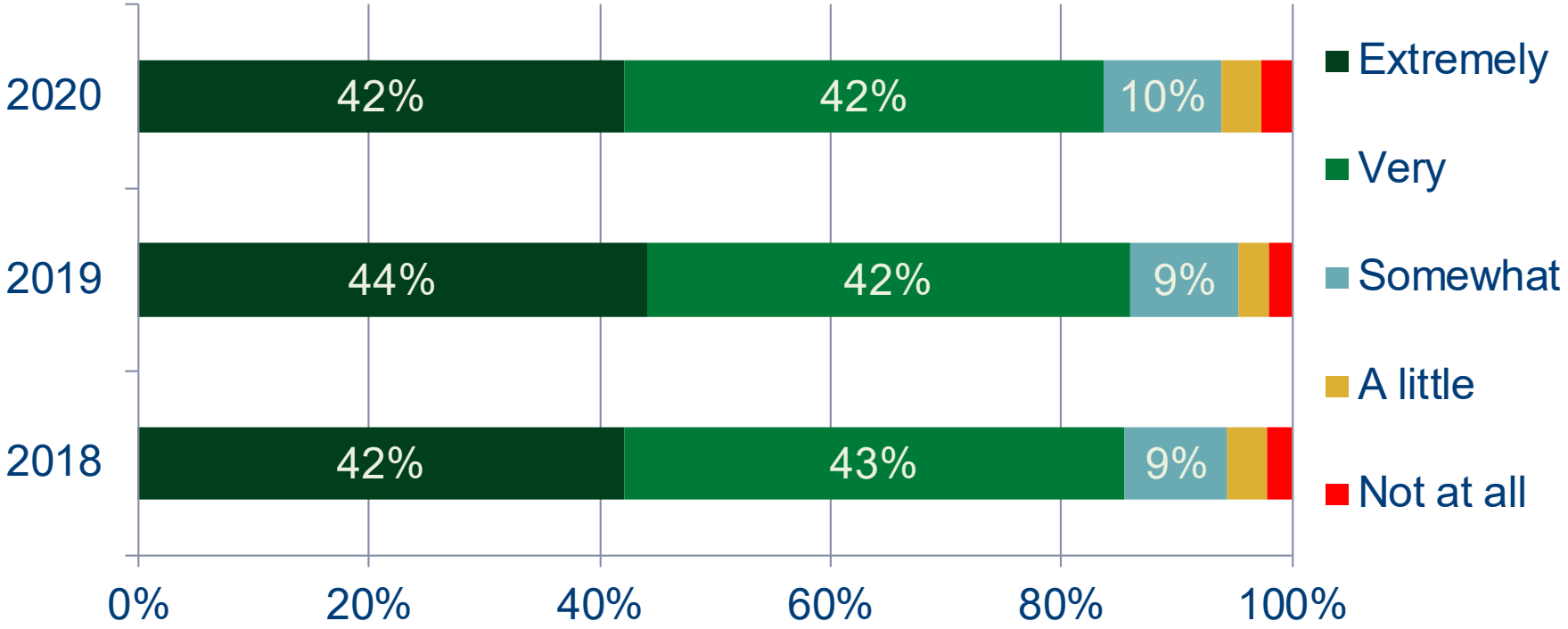



Can you contact your Fiscal Employer Agent when you need to?
2020
2019
2018
96%
96%
96%
Yes
No
0%
20%
40%
60%
80%
100%

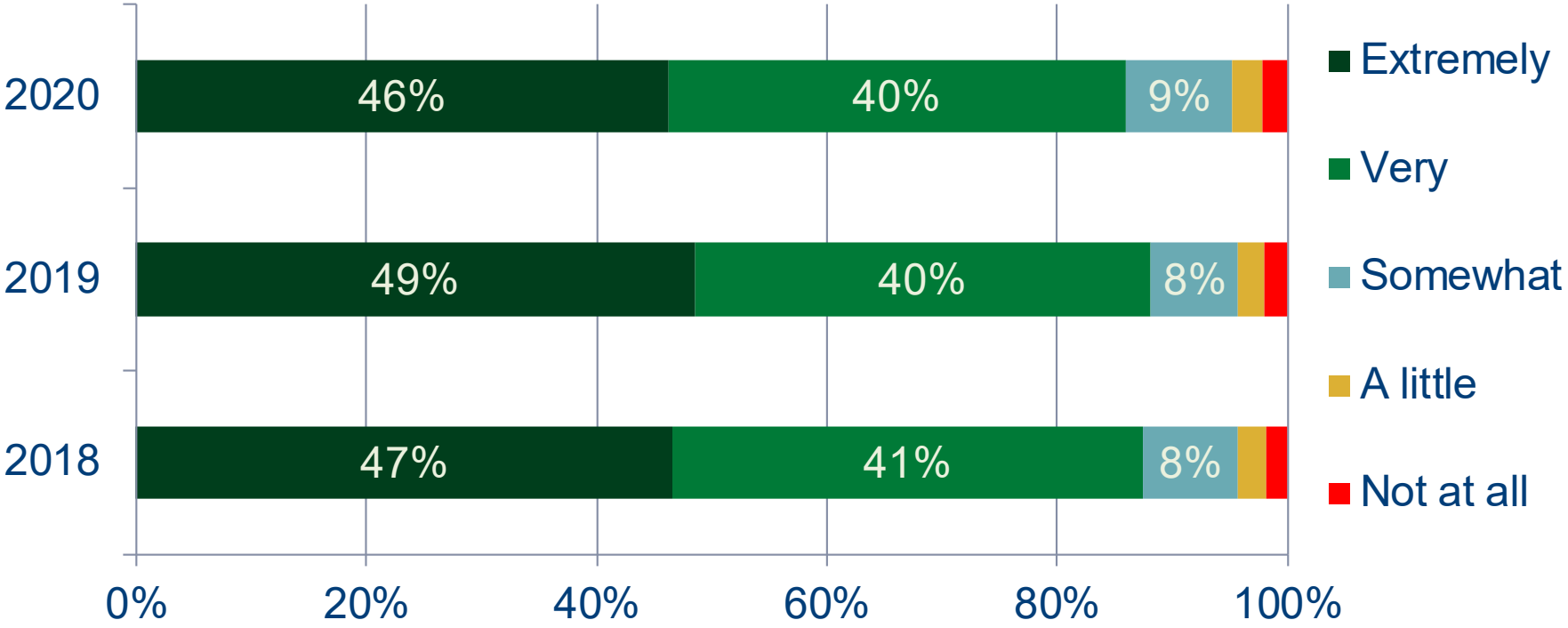
How often do you get the help you need from your Fiscal Employer Agent?



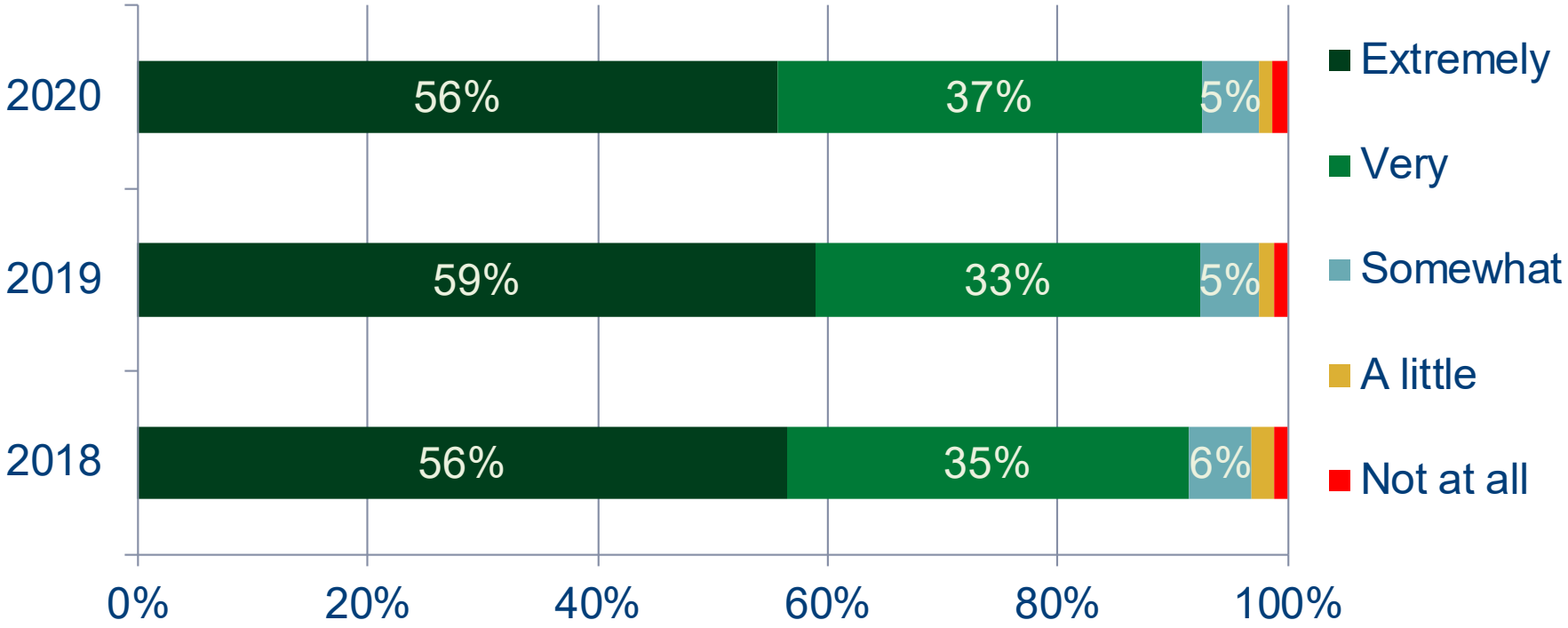
How clearly does your Fiscal Employer Agent explain things to you?



How carefully does your Fiscal Employer Agent listen to you?



How respectfully does your Fiscal Employer Agent treat you?



Overall, how much do you like your Fiscal Employer Agent?