WISCONSIN DEPARTMENT of HEALTH SERVICES

Unwinding

Ann Lamberg, Deputy Bureau Director Bureau of Quality and Oversight
Diana Adamski, ADRC Regional Quality Specialist, Office for Resource Center Development

CMS requirements during the PHE

- CMS ordered states to keep all individuals enrolled in Medicaid during the PHE.
- When unwinding began in May 2023 CMS required all individuals to remain enrolled until they have an opportunity to complete a Medicaid renewal.
- Once the Medicaid renewal was complete an individual may be disenrolled for multiple reasons.

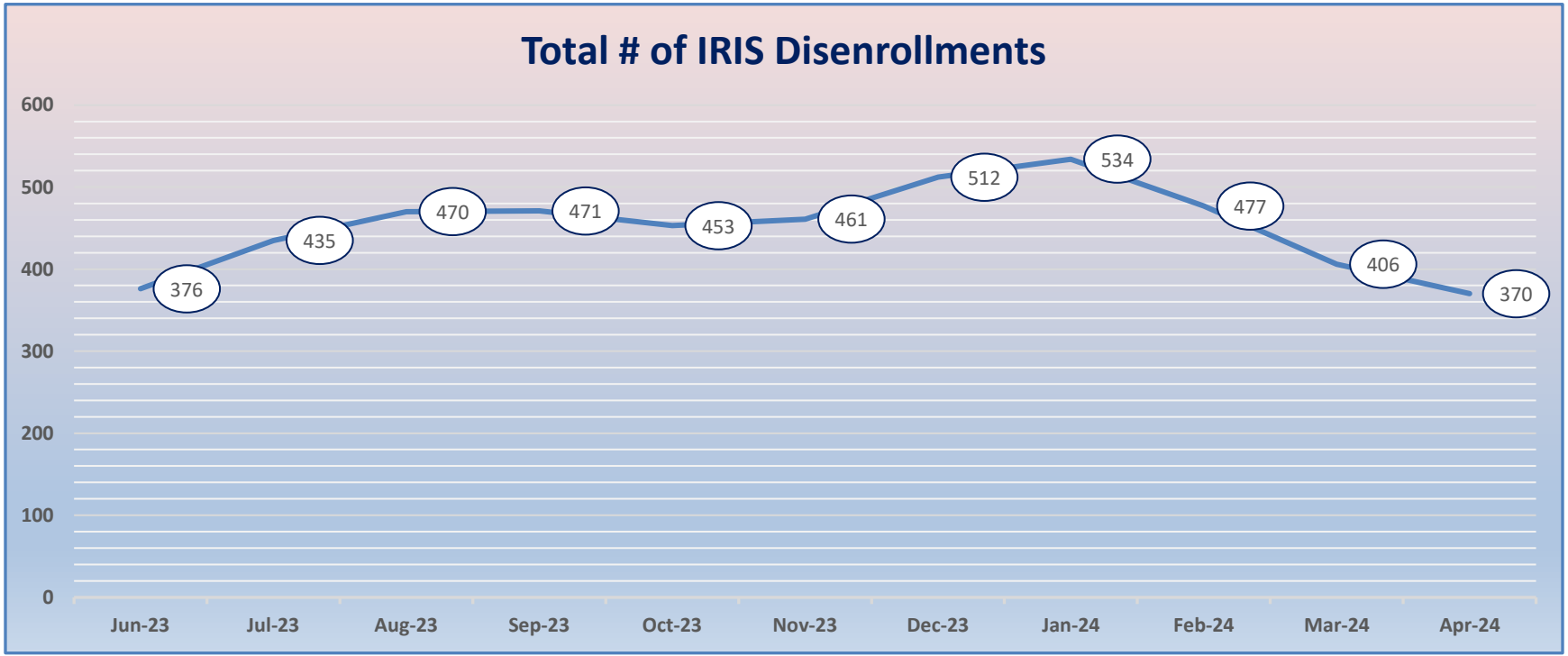
Multiple Reasons for Disenrollment

- Non-payment of cost share
- Loss of functional eligibility
- No Contact
- Health and Safety
- No longer accepting services
- Fraud and abuse
- Loss of Medicaid Eligibility

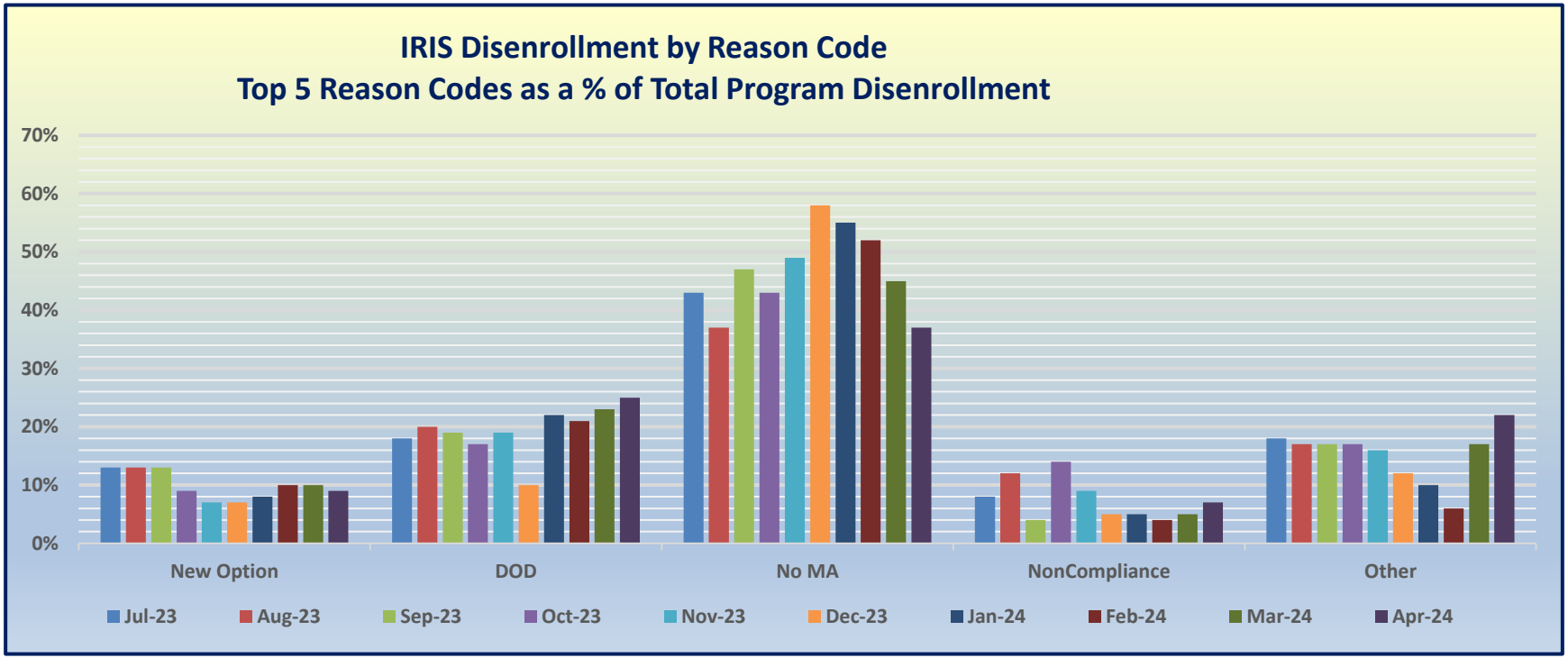
DHS Guidance to Contractors

- Contractors were required to monitor reports from DHS which tracked Medicaid reviews and due dates.
- Contractors were required to notify Participants of their Medicaid due dates and assist with renewal if asked.
- Contractors were monitoring status of individuals renewal in cares
- Contractors were required to report to DHS prior to unwinding how many members and participants would lose eligibility.
- Contractors were required to notify all members and participants who would lose eligibility.

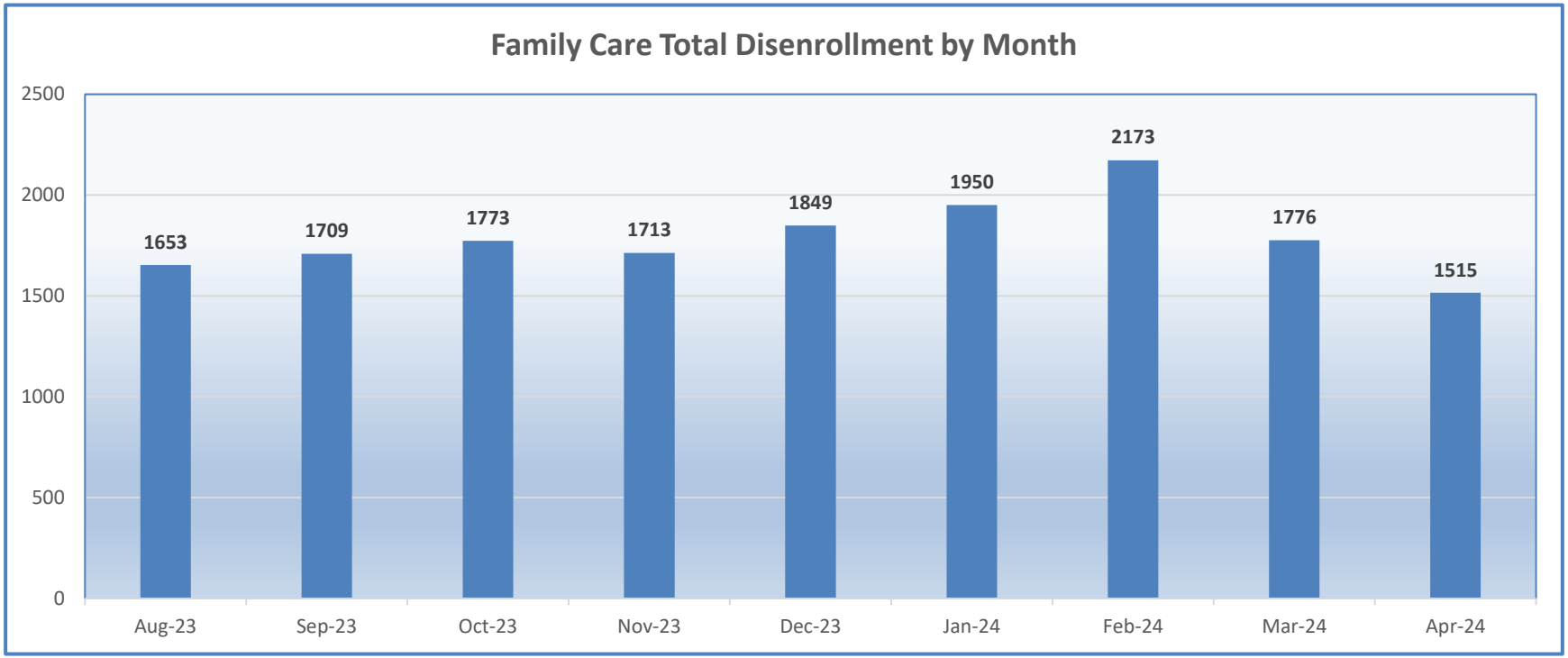
IRIS Total # of Disenrolled Participants



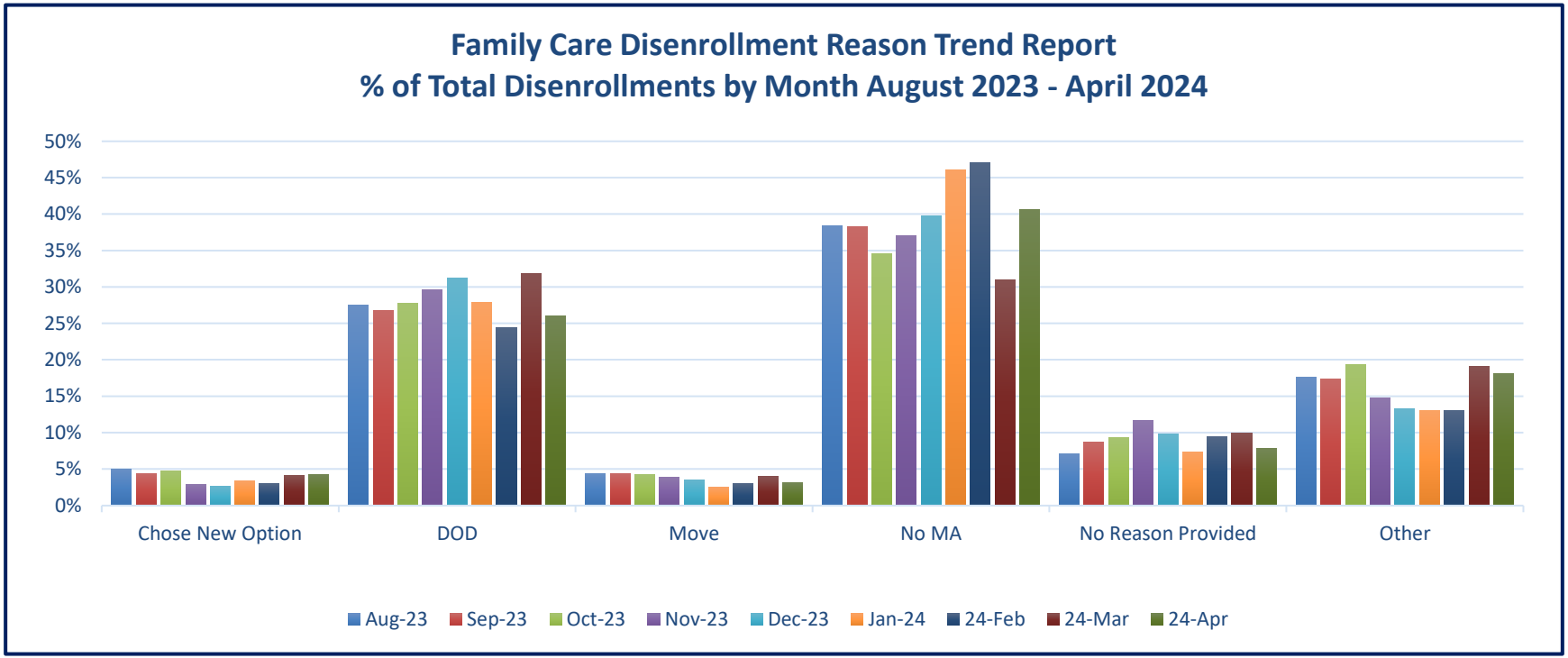
IRIS Top 5 Disenrollment Reason Codes, as a % of the total number of disenrolled participants, by month



Family Care Total Disenrollment Numbers (August 2023 – April 2024)



Family Care Top 6 Disenrollment Reason Codes during COVID Unwinding (August 2023 – April 2024)



Why don’t these numbers provided in this document match the DHS Public Unwinding Dashboard?

- LTC individuals are included in all 3 benefit categories on the dashboard.
- The dashboard does not track individuals who have been re-enrolled. Individuals who lost enrollment may have been reenrolled later in the month.

Post - Unwinding Eligibility Updates shared at Taskforce

- Adverse action will be the due date given for completing renewals.
- Members who submit renewals by adverse action and have not been processed by that date will get a one-month extension of eligibility.
- DHS will continue to use the National Change of Address (NCOA) database to update addresses prior to sending correspondence to members.
- Individuals will get a one-month extension of eligibility at adverse action if their renewal packet is returned due to a bad address.

Post Unwinding Updates for IRIS / Family Care

- IRIS only: Expedited Re-enrollment and Involuntary Disenrollment retractions will no longer continue beyond July 31, 2024. As of August 1, 2024, all MA discrepancies will be processed according to IRIS policy, Program Enrollment, Section D.3 Eligibility-related Disenrollments. The policy allows for Participants to be reenrolled immediately through the ADRC and resume their plan.
- Unwinding Technical FAQs for ICAs/MCOs will become obsolete.
- ICAs and MCOs will continue receiving renewal reports developed for Unwinding. These reports support their eligibility outreach and assistance efforts.
- Monthly ICA/MCO Unwinding meetings will end July 2024.

Role of the ADRC or Tribal ADRS

- Loss or change in eligibility
- Referral to ADRC or Tribal ADRS
- Provide options counseling
- Assist with next steps

IRIS ADVISORY COMMITTEE
Membership

7/23/2024

IAC Composition

The IRIS Advisory Committee will consist of 18 members appointed by the Medicaid Director. Committee members will include IRIS participants, family members of IRIS participants, and representatives from a wide variety of providers and advocacy groups representing the needs and interests of all three target groups served by the IRIS program.*

*IRIS Charter, Section IX. Membership

IAC Composition

Representation	Seats
Self-Advocates	7
Advocates	4
Providers	4
Contractors	3
Total	**18**

Self Advocates (7 seats)

Member	Representation	Term End Date
Rosie Bartel	IRIS Participant	12/31/2026
Martha Chambers	IRIS Participant	12/31/2025
Ramsey Lee	IRIS Participant	12/31/2025
Thomas Gierke	IRIS Participant	12/31/2025
Danielle Dicentio	IRIS Participant	12/31/2025
Andy Thain	IRIS Participant	12/31/2025
Vacant*		

*Previously held by Elizabeth Schlosser, a parent/guardian of an IRIS participant, who resigned from the IAC in March 2024.

Advocates (4 seats)

Member	Representation	Term End Date
Fil Clissa	BPDD	12/31/2024
Melanie Cairns	DRW	12/31/2025
Jason Glozier	WCILC	12/31/2024
Kathi Miller	BOALTC	12/31/2026

Providers (4 seats)

Member	Representation	Term End Date
James Valona	Ability Group LLC	12/31/2024
Kathy Meisner	DSPN	12/31/2025
Julie Strenn	Opportunity Development Centers	12/31/2026
Lynnea White	Barron County Developmental Services	12/31/2026

Contractors (3 seats)

Member	Representation	Rotation Ends
Alexa Butzbaugh (PCS)	IRIS Consultant Agencies*	September 2024
Jonathan Claflin (Premier)	Fiscal Employer Agencies*	September 2024
Sue Urban	Self-Directed Personal Care Agency**	

*IRIS contractors appoint one liaison and backup to attend the IAC meetings. Contracted agencies are represented by one agency on a rotating six-month schedule.
**TMG is contracted to self as Wisconsin's self-directed personal care agency.

HCBS Settings Rule Update: Corrective Action Plan

DHS-IRIS Policy & Implementation Meeting
April 17, 2024

WISCONSIN DEPARTMENT of HEALTH SERVICES

Objectives:

- Overview of HCBS Settings Rule in Wisconsin
- Overview of our Corrective Action Plan
- Next Steps

Overview of the HCBS Settings Rule in Wisconsin

Overview of Federal Regulation

- In 2014, the Centers for Medicare & Medicaid Services (CMS) released new federal requirements regarding the *qualities* of settings that are eligible for reimbursement for Medicaid home and community-based services (HCBS).
- HCBS waivers provide opportunities for Medicaid beneficiaries to receive services in their community rather than in institutions or other isolated settings.
- Each state was required to develop and implement a Statewide Transition Plan to ensure members receive services in HCBS Settings Rule Compliant Settings.
- The HCBS Settings Rule went into effect on 03/17/2023.

DHS Medicaid Waiver Settings

Wisconsin Long-Term Support Programs

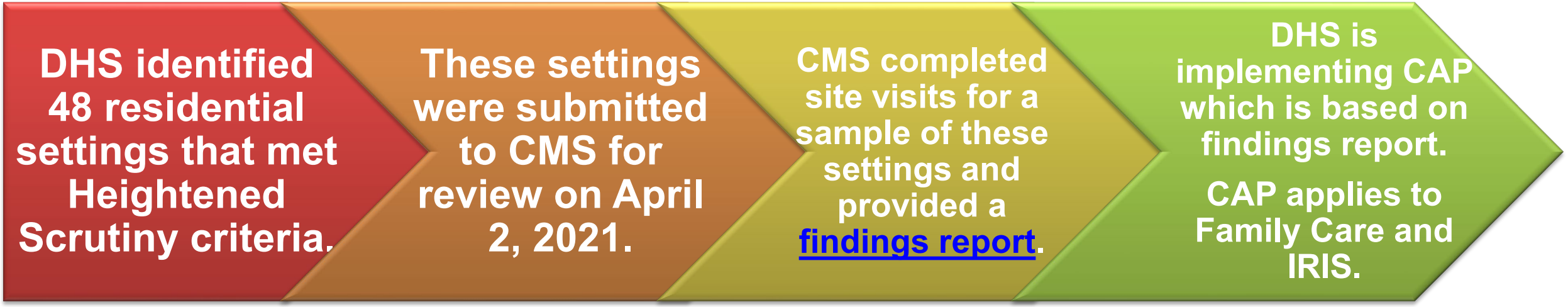
- Family Care (FC)
- IRIS (Include, Respect, I Self-Direct)
- Family Care Partnership (FCP)
- Children's Long-Term Support Waiver

IRIS Waiver Settings

- Adult day care centers (ADCC)
- Prevocational services
- Group supported employment
- Day habilitation services
- Adult Family Homes (AFH) (1-2 & 3-4 beds)
- Residential Care Apartment Complexes (RCAC)

Overview of our Corrective Action Plan

Why does DHS have a CAP?



Summary of CAP

Category Name	Category Milestone(s) Summary	Final Completion Date
1. Forthcoming Heightened Scrutiny Activities	Multiple milestones related to completing heightened scrutiny reviews of the 20 settings not yet submitted to CMS.	Submit settings to CMS by 06/30/2024 Address CMS findings the later of 12/31/2024 or 3 months after CMS issues findings
2. Current Heightened Scrutiny Activities	Responding to the CMS feedback on the settings submitted in 04/2021 once that feedback is received	Address CMS findings the later of 12/31/2024 or 6 months after CMS issues findings
3. Heightened Scrutiny Site Visit	Addressing the findings from the CMS heightened scrutiny site visits	12/31/2024

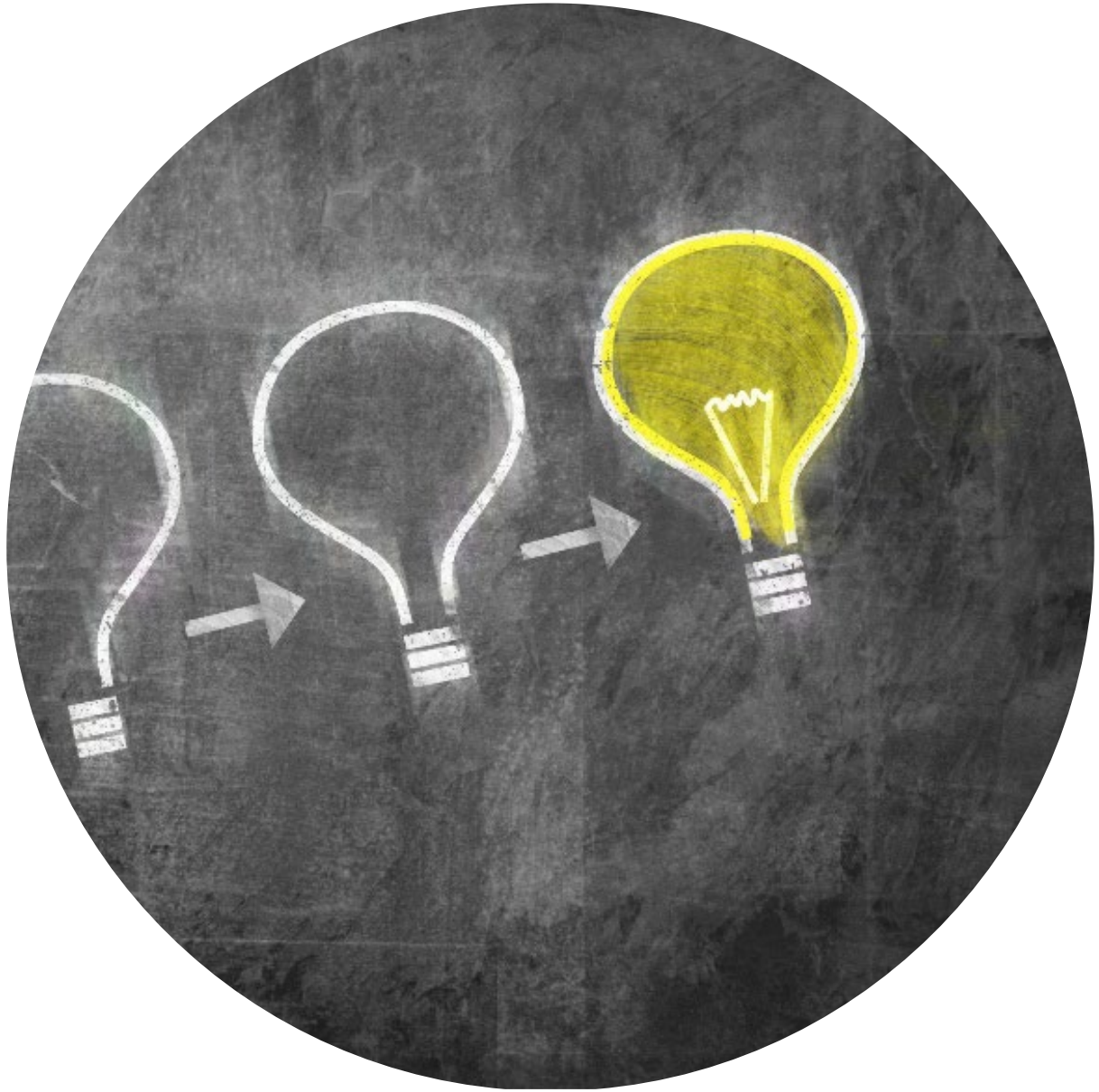
3. ICA-Related Site Visit Findings

- Choice of setting documented in the written plan for participants, including court ordered restrictions
  - Will be applicable to all participants

- For participants in provider owned or controlled residential settings, modifications to the residential HCBS Settings requirements must be documented per the requirements in the Individual Service Plan (ISP). Restrictions cannot be in place that are not documented.

Application to All IRIS Participants

- In both the Site Visit Report Cover and the CAP Milestones, CMS directs Wisconsin to include complying with person-centered planning requirements as part of our remediation.



HCBS-related Questions or Ideas

If you questions, suggestions, or ideas please let us know

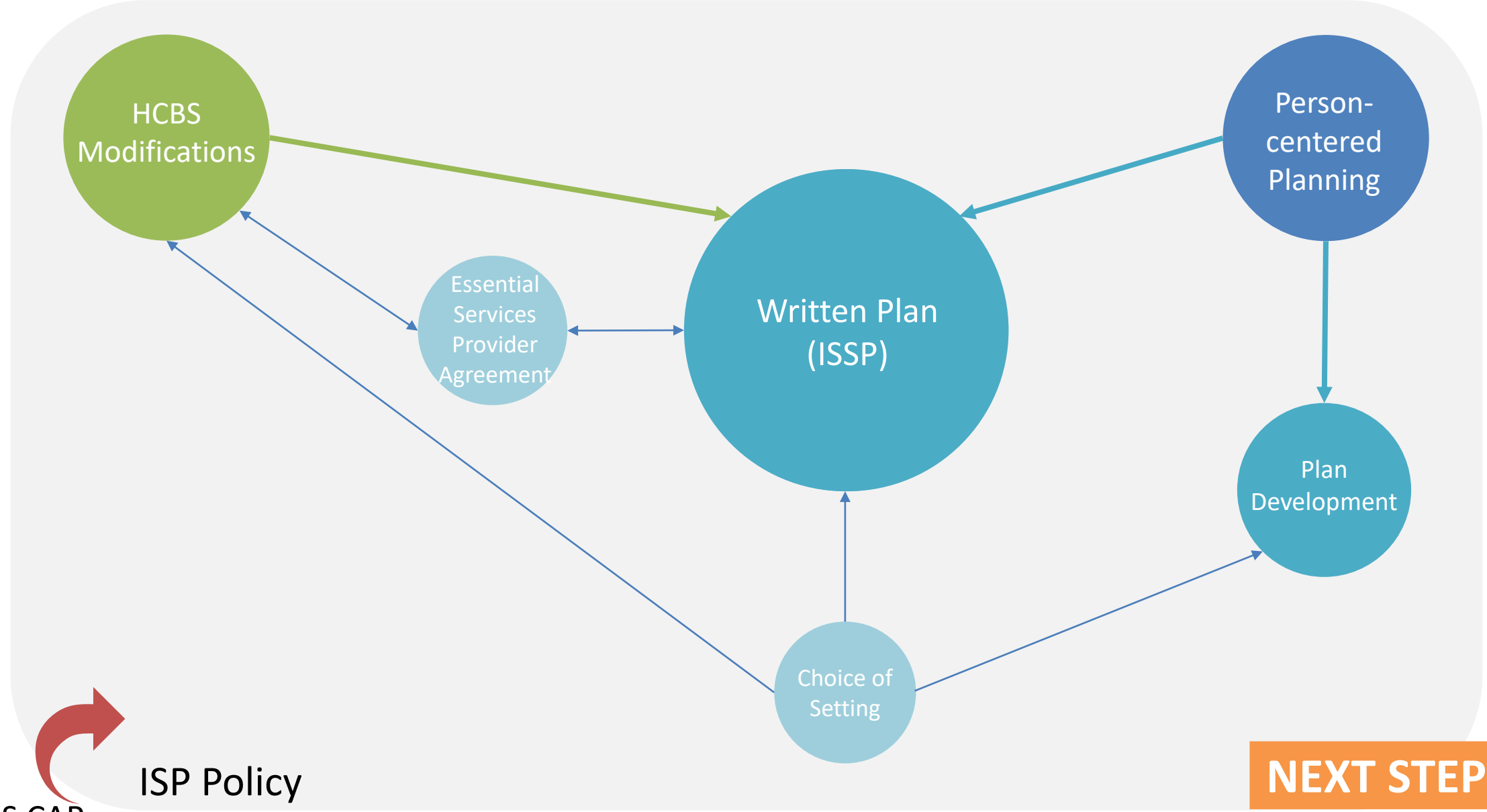
dhshcbssettings@dhs.wisconsin.gov

Work in Progress

Process for Addressing CMS CAP findings

1

Analyze CMS Cover Letter/CAP, CMS Site Visit Findings Report, CFR, IRIS waiver, and current policies to determine program impacts


HCBS Modifications
Person-centered Planning
Essential Services Provider Agreement
Written Plan (ISSP)
Plan Development
Choice of Setting
CMS CAP
ISP Policy
NEXT STEPS

Choice of Setting

42 CFR § 441.301(c)(1)(ix)

(1) Person-centered planning process.

…

(ix) **Records the alternative home and community-based settings** that were considered by the individual.

42 CFR § 441.301(c)(4)(ii)

(4) Home and Community-Based Settings.

…

(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The **setting options are identified and documented in the person-centered service plan** and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Essential Services Provider Agreement

42 CFR § 441.301(c)(2)(ix-x)

(2) Person-Centered Service Plan.

…

(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and **signed by all** individuals and **providers** responsible for its implementation.

(x) Be **distributed** to the individual **and other people** involved in the plan.

Next Steps

- ISP policy is being revised
- HCBS modifications incorporated into the ISP policy
- Develop HCBS Modifications panel in WISITS
- Essential Services Provider Agreement policy under review

- Small workgroup discussions: reviewing feedback and revising drafted policy

Questions?

Include, Respect, I Self-Direct (IRIS) Waiver Renewal Input Session

Wisconsin Department of Health Services
Division of Medicaid Services
Bureau of Programs and Policy

July 2024

Goals for Today

- Describe the IRIS program and waiver renewal
- Hear your ideas for improving the IRIS program
- Share other ways for you to get involved in the waiver renewal

Getting to Know DHS

- The Department of Health Services (DHS) is a state government agency.
- Our mission is to protect and promote the health and safety of the people of Wisconsin.
- DHS oversees the IRIS program and its waiver renewal.

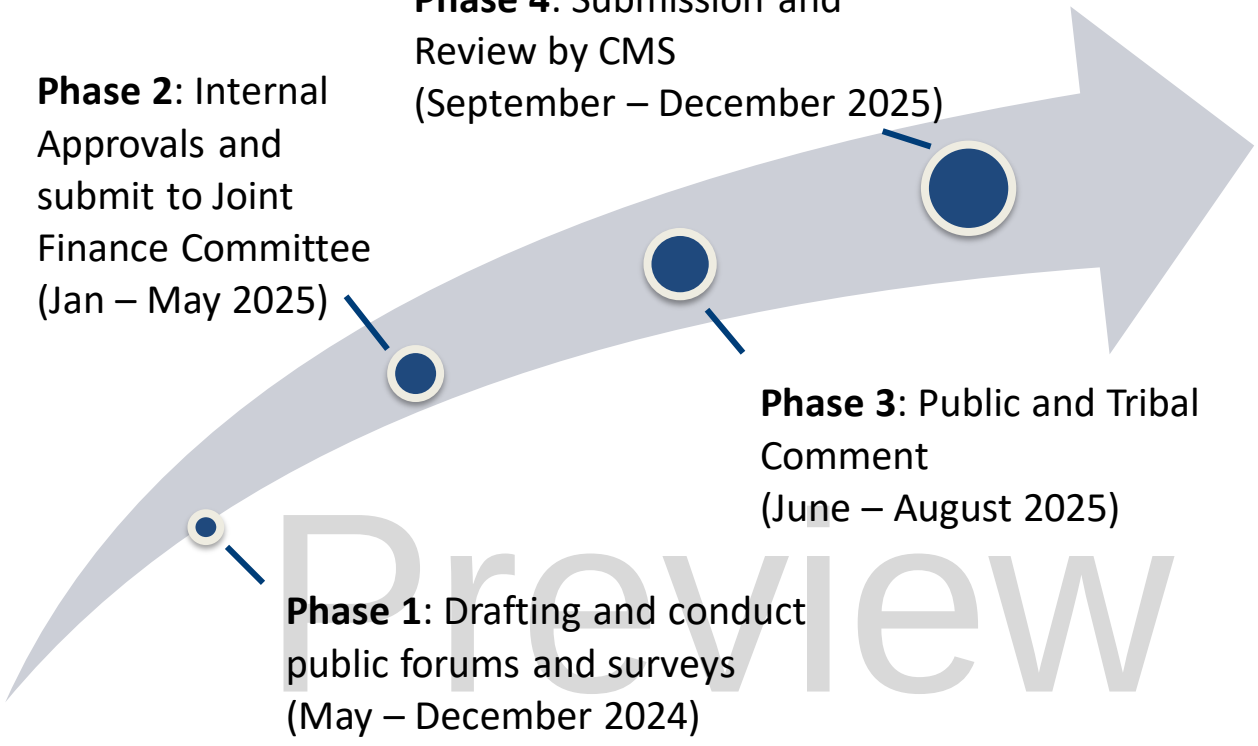
Getting to Know IRIS

- The IRIS program is a self-directed Medicaid long-term care program for adults with disabilities and people over 65.
- Long-term care helps people with daily tasks and activities.
- The goal is to help participants utilize services they need to live in their homes and communities when possible.

What is a Medicaid Waiver?

- A Medicaid waiver is a set of rules that allows DHS to have Medicaid programs like the IRIS program.
- The IRIS Medicaid waiver funds services to help participants successfully live and receive care in their community.

Waiver Renewal Timeline



IRIS Waiver Renewal

- The IRIS program is renewed every five years.
  - Recent renewal: January 2021 - December 2025
  - Next renewal: January 2026 - December 2030
- DHS will spend the next year and a half updating our waiver for 2026.
- This is our chance to improve the IRIS program.

Goals of the Waiver Renewal

To draft a waiver renewal application that:

- Addresses recent program and policy changes.
- Supports participant choice, self-determination, and access to high quality services.
- Uses cost-effective solutions.

Once approved, the waiver will impact the program from 2026 through 2030.

What Can We Change with the Waiver Renewal?

Changes we **can** make	Changes we **can't** make
▪ Which services are covered ▪ What existing services include ▪ Required provider qualifications	▪ Changes that are not allowed by state or federal law

How Your Ideas Will Help

DHS will now be requesting your feedback and ideas. This will help us write a waiver renewal application that meets the needs of IRIS participants.

We Want to Hear from You

DHS wants your feedback and ideas:

- What is working well in the IRIS program?
- How can we improve the IRIS program?
- If added to the IRIS program, what new services would be helpful?
- How could the IRIS program better reflect your culture, background, and values?

Question 1

What is working well in the IRIS program?

For example: Services, remaining active in the community, achieving goals, self-direction, etc.

Question 2

How can we improve the IRIS program?

For example: Services, caregiver or provider access, program assistance, etc.

Question 3

If added to the IRIS program, what new services would be helpful?

For example: Services to help you successfully live, work, and receive care in your home and community.

Question 4

How could the IRIS program better reflect your culture, background, and values?

Want to Learn More?

Visit us online:
dhs.wisconsin.gov/iris/waiver-renewal.htm

Thank You!

WISCONSIN DEPARTMENT of HEALTH SERVICES

START Initiative Phase 2 Wrap-Up

Final Report Briefing

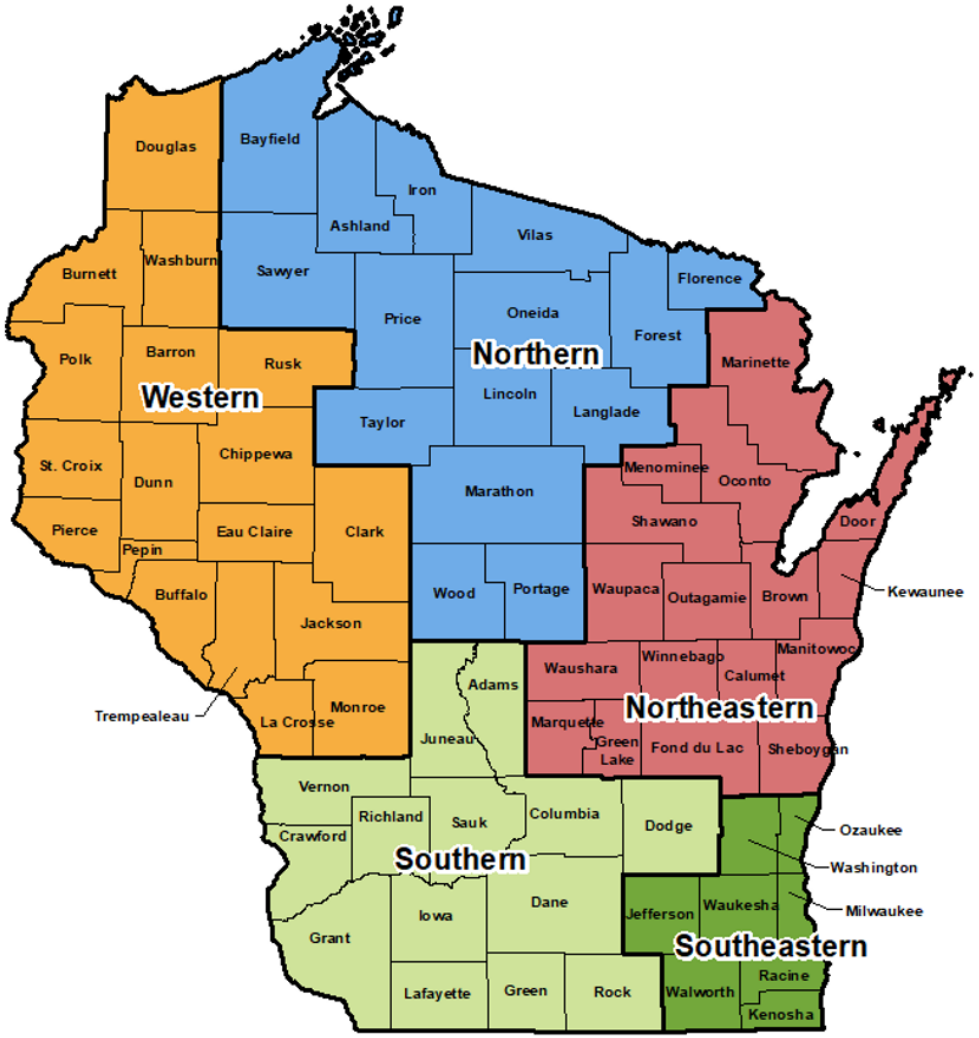
June 17, 2024

Agenda

- Welcome
- Background
- Phase 2 review
- Report focus areas
- Next steps
- Recognitions
- Questions

Welcome work group!

What part of Wisconsin are you from?

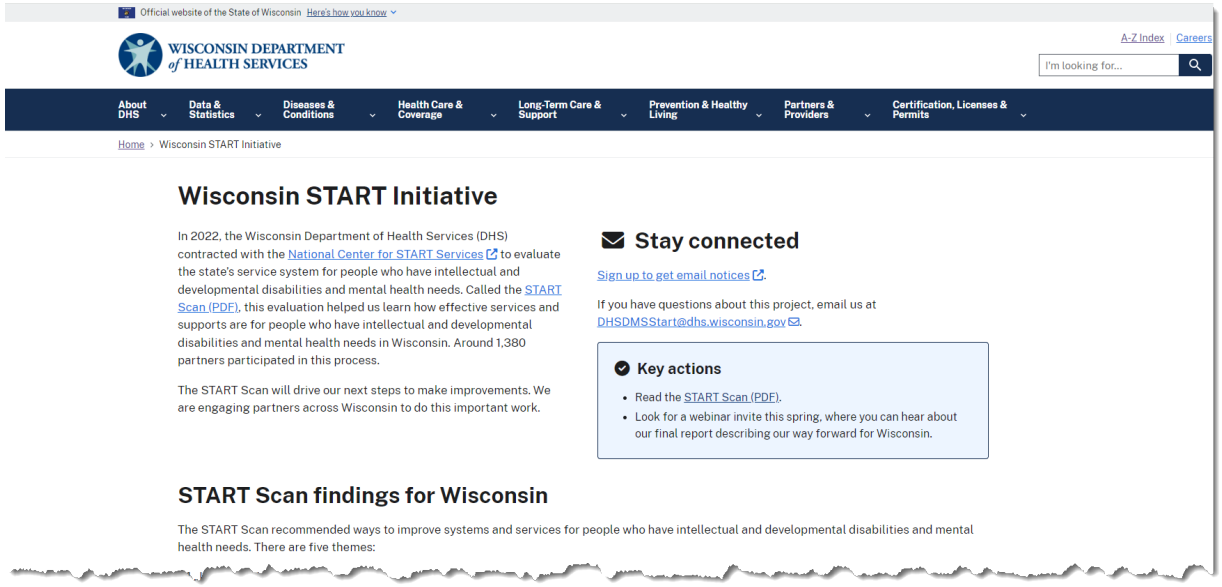


Welcome work group!

Did you attend our kick-off meeting on September 14, 2023?

Welcome work group!

Have you visited our webpage since our last meeting? (dhs.wi.gov/dms/start.htm)



Welcome

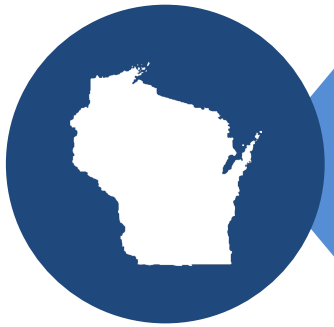
Bill Hanna
Medicaid Director
DMS

Announcing a new name

Wisconsin IDD-MH System Improvement

Why is this work needed?

Affects people every day



Statewide problem

Complex systems and issues

Report and recommendations

Released as early as June 18

Not created or owned by DHS

Solutions must be owned by us all

We can't do it all at once

Welcome

Gynger Steele
Administrator
DCTS

Background

How we got here

Phases

Phase 1

- National Center for START Services evaluation
- Across the lifespan
- Completed in the summer of 2022
- About 1,380 people participated
- Evaluation report is called the START Scan

Phase 2

(current phase)

- Community interest gathered in June 2023
- Formal kick off in August 2023
- Pursued participation of variety of partners
- Current work group is about 1,300 members

START Scan: 5 themes

1. Improve crisis services
2. Expand training and education of providers
3. Increase availability of outpatient and preventative mental health services
4. Improve coordination between service systems
5. Improve supports for those with intellectual and developmental disabilities and mental health (IDD-MH) needs so they have a better quality of life

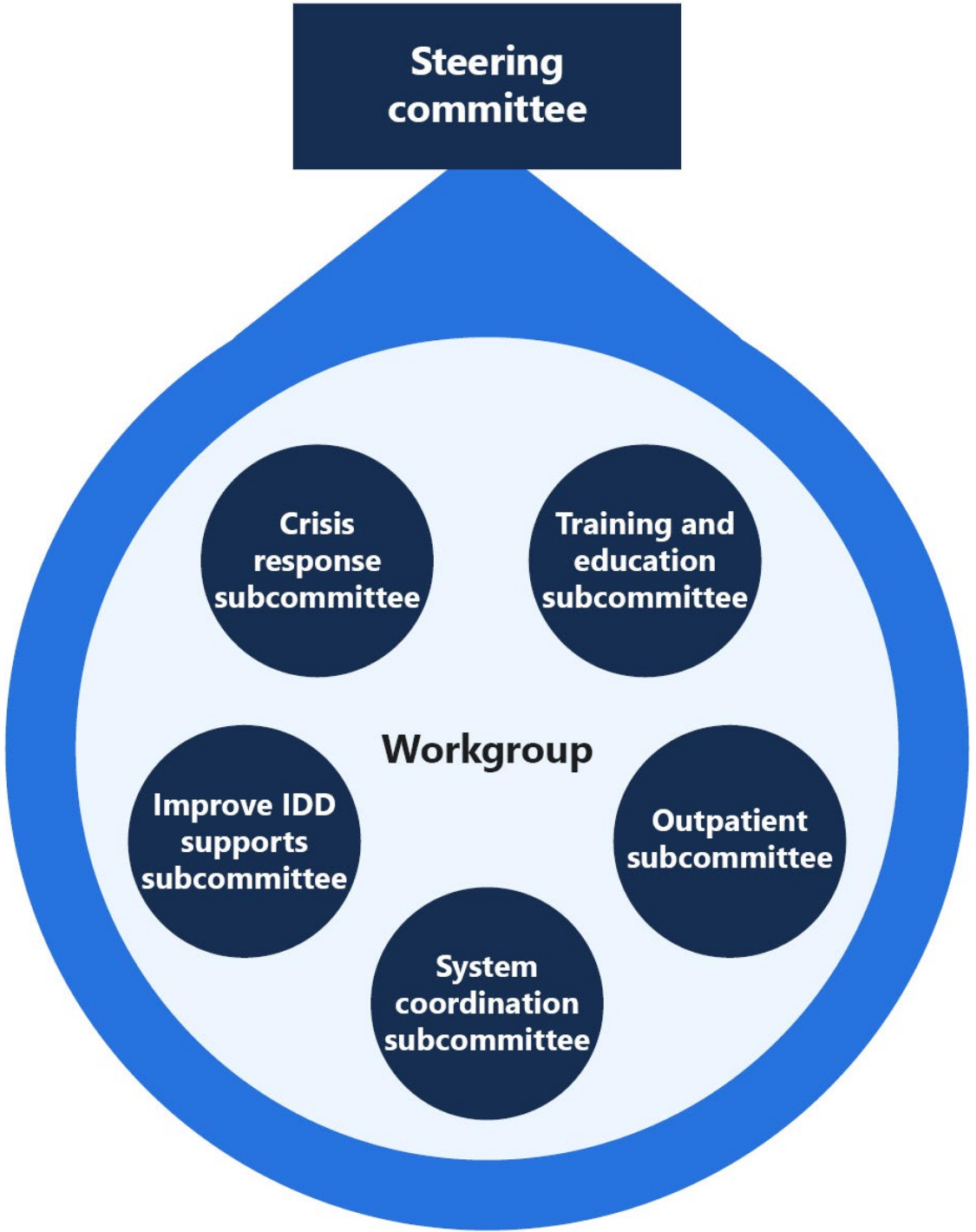
Phase 2

Review

Partner participation

- People with lived experience
- Parents and guardians
- Advocates
- Mental health providers
- State and county workers
- Managed care organizations (MCOs)
- IRIS (Include, Respect, I Self-Direct) workers
- Children's Long-Term Support (CLTS) Program workers
- University employees
- IDD services providers
- Educators
- Law enforcement
- Hospitals
- Others

Team structure



Subcommittee activity

- Five subcommittees were formed, each with 15-20 members representing different professions and/or life experiences. They met weekly or biweekly from September - December 2023.
- Subcommittees developed recommendations around their assigned theme.
- In November and December, each subcommittee developed and launched a survey to get input on their draft recommendations from this work group.

Subcommittee survey poll

How many of you responded to at least one of the five surveys?

Subcommittee activity

- The subcommittee surveys were posted on the webpage and sent to the 1,300 work group at-large members via email.
- Subcommittees used the survey feedback to inform their recommendations.
- Initial recommendations were submitted to the steering committee on Jan. 5, 2024.

900+ responses

Recommendations

- Over 30 recommendations were submitted to the steering committee.
- A smaller group of steering committee members with representation from each subcommittee met to look for ways the recommendations could be organized and combined.
- They found eight focus areas that aligned with the original five START Scan themes.

Eight focus areas

1–Regional Supports

Bringing more resources and supports closer to where people are living to help them avoid crises and help if crises happen.

2–Expand Access to Psychiatric & Behavioral Health Services

Increasing the number and availability of doctors and mental or behavioral health providers who understand how to best serve people who have IDD-MH needs.

3–Rate and Billing Code Improvements

Improving pay so that more providers are interested and able to serve people who have IDD-MH needs.

4–Technology Related

Using or improving technology to make it easier for people to find information and help.

Eight focus areas

5–IDD-MH Specific Training

Providing training to families, providers, leaders, and others so they can learn more about people who have IDD-MH needs and how to support them better.

6–System Review

Making it easier to get the right supports and services.

7–System Navigation

Helping people get the services and supports they need when their needs change or they are moving.

8–Oversight and Process Improvement

Improving services and making sure the best methods are being used.

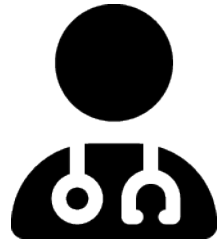
Example recommendations from each focus area

Regional Supports

- Create regional teams that help families, providers, and others.
- Goal: Create regional teams that can respond to requests from families, providers, and others. Teams can offer training and consultation to help avoid crisis situations from occurring.

Top 10

Expand Access to Psychiatric and Behavioral Health Services



- Increase the number of psychiatric nurse practitioners and physician assistants trained to serve people with IDD-MH needs.

- Goal: Increase the education and training for new professionals to include IDD-MH specific training, clinical practice opportunities and mentoring.

Top 10

Rate & Billing Code Improvements

- Provide a tiered rate structure for providers who serve people with IDD-MH needs and pay an enhanced rate to address acuity and care complexity.

- Goal: Increase the number of mental health providers with specific skills to serve people who have IDD-MH needs.

Top 10

Technology Related

- Expand the use of health information exchange systems by counties, crisis workers, first responders, etc.
- Goal: Make important information more easily accessible to responders who need it in crisis situations.

IDD-MH Specific Training

- Expand the DHS Certified Direct Care Professional (CDCP) training program to include modules related to IDD-MH.
- Goal: Create a uniform set of training and educational requirements to increase access to skilled and competent staff.

Top 10

System Review

- Analyze administrative rules and identify rules and regulations that create barriers to supporting people with IDD-MH needs.
- Goal: Review processes and policies to find duplication and unneeded steps. Simplify and streamline.

System Navigation

- Create transition teams that help children move to adult services.
- Goal: Families have the support they need to make decisions during their child's transition from children's to adult services.

Oversight & Process Improvement

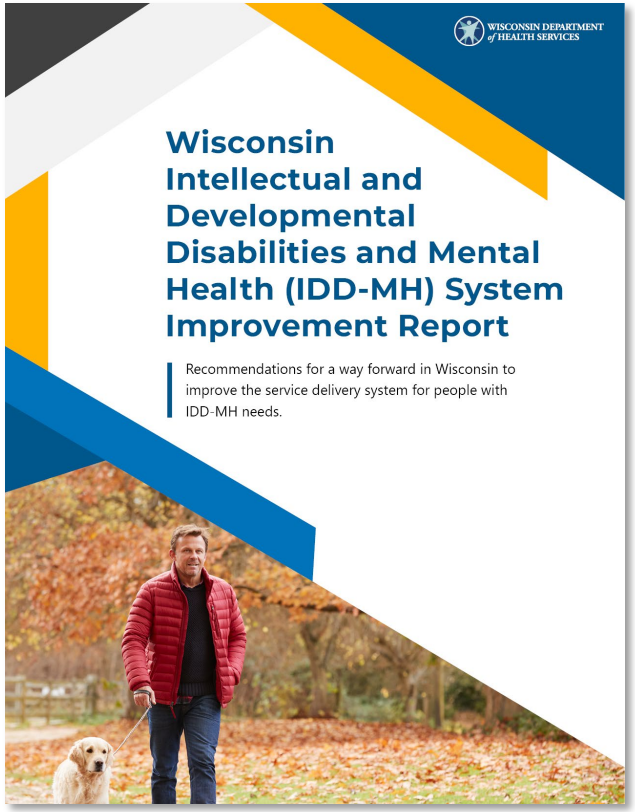
- Establish a community of practice of IDD-MH partners for Phase 3 and beyond.
- Goal: Create an ongoing group of IDD-MH partners to consult on and be connected to Phase 3 of this project and other system improvements beyond Phase 3.

Using momentum

Complete set of recommendations

Check out the report!

- It contains the full set of recommendations!
- It's easy to read and accessible.
- It lists the steering committee's top 10 prioritized recommendations



DHS next steps

- Publish and distribute report
- Organize and kick-off Phase 3 Implementation
- Determine recommendations to implement
- Begin implementation

Recognitions

It takes a village

Thank you to our steering committee members!

- Geri Vanevenhoven
- Joanette Robertson
- Tom Bailey
- Cindy Bentley & Nancy Gapinski
- Colleen Rinken
- Julie Shew
- Lynn Karges
- Jeremy Kral
- Nicole Labinski
- Ann Lamberg

Thank you to our steering committee members!

- Jen Harrison
- Leslie Stewart
- Jeff Kaphengst
- Dan Kramarz
- Alicia Boehme
- Jackie Neurohr

Thank you to our internal work group members!

- Tom Massopust
- Elizabeth Solomon
- Gladys Martens
- Laura Grulke-Rueter
- Dan Kramarz
- Ann Lamberg
- Alicia Boehme
- Nicole Labinski
- Jackie Neurohr

Thank you to our subcommittee members!

Nearly 100 people representing children and adults, all IDD-MH partner groups, across all regions of the state

Thank you work group!

What we need from you:

- Read the report. It will be available June 18 on the website and will be sent to our email list.
- Share the information with others.
- Stay involved. The webpage (dhs.wi.gov/dms/start.htm) will continue to be your source of information about Phase 3 activities.
- Look for ways to start working on the recommendations.

Questions?

DHSDMSStart@dhs.wisconsin.gov

dhs.wi.gov/dms/start.htm

IRIS Service Plan (ISP) Policy

Chris Ma
IRIS Program and Policy Analyst
July 23, 2024

WISCONSIN DEPARTMENT of HEALTH SERVICES

Overview

How does the CMS CAP impact the IRIS program?

ISSP Policy → ISP Policy

Next Steps

How does the CMS Corrective Action Plan (CAP) impact the IRIS program?

Application to All IRIS Participants

In both the Site Visit Report Cover and the CAP Milestones, CMS directs Wisconsin to include complying with person-centered planning requirements as part of our remediation.

Wisconsin Site Visit Cover Letter and Report (medicaid.gov)
https://www.medicaid.gov/sites/default/files/2022-12/wi-site-visit-rpt-cl.pdf

Wisconsin Settings CAP Approval Letter (medicaid.gov)
https://www.medicaid.gov/sites/default/files/2023-09/wi-appvd-cap.pdf

CMS Cover Letter

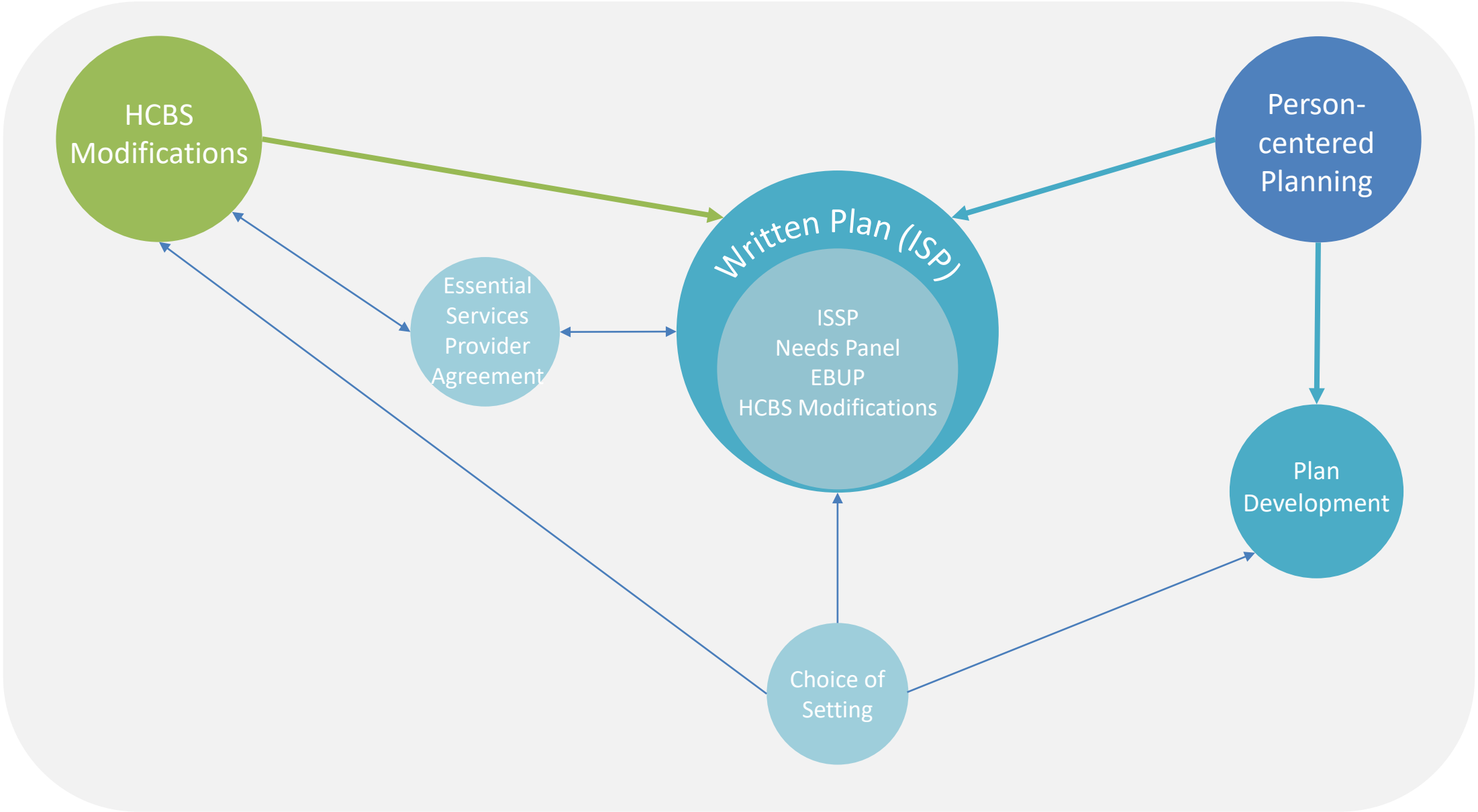
CMS appreciates the efforts of the state to prepare for our visit to Wisconsin. We are asking the state to apply remediation strategies addressing the feedback contained in our report to the specific setting(s) as identified. We note that the HCBS settings criteria identified in the report that are followed by an asterisk require the state to go beyond ensuring that the individual setting has completed the necessary actions identified; specifically, complying with person-centered planning requirements requires further direction to and collaboration with the entities responsible for developing and monitoring the person-centered plans and with the HCBS provider community that is responsible for implementing services and achieving the objectives outlined in the plan. In addition, CMS notes that the state's remediation strategies must be applied to all remaining similarly situated settings you have identified as being presumptively institutional that were not included in CMS' site visit to ensure compliance with the settings criteria at 42 CFR § 441.301(c)(4) by March 17, 2023. Finally, the state should ensure issues identified in this report are addressed in the state's overall assessment process of all providers of HCBS in Wisconsin, to ensure that all providers are being assessed appropriately against the regulatory settings criteria and will implement the necessary remediation to achieve timely compliance.

- Modifications of additional conditions in provider owned and controlled residential settings under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan.*

CMS Approval Letter

Heightened Scrutiny Site Visit	Begin Date	Completion Date
Address findings related to CMS heighted scrutiny site visit including, as applicable, needed remediation required to ensure compliance of the settings visited, remediation of all similarly situated settings that utilize a similar service delivery model, remediation of the process for developing and implementing the person-centered service plan to include justification for modifications of additional conditions with required documentation, and application of site visit feedback to the overall assessment process of all providers of HCBS in the state to ensure that all providers are being assessed appropriately against the regulatory settings criteria.	December 6, 2022	December 31, 2024

ISSP → ISP


HCBS Modifications
Person-centered Planning
Written Plan (ISP)
ISSP
Needs Panel
EBUP
HCBS Modifications
Essential Services Provider Agreement
Plan Development
Choice of Setting

Redefine "Plan"

The Written Plan = IRIS Service Plan (ISP)

- Individual Supports and Services Plan (ISSP)
- LTC Needs Panel
- Emergency Back-Up Plan
- HCBS Settings Rule Modification (if applicable)

ISSP Upcoming Policy Changes

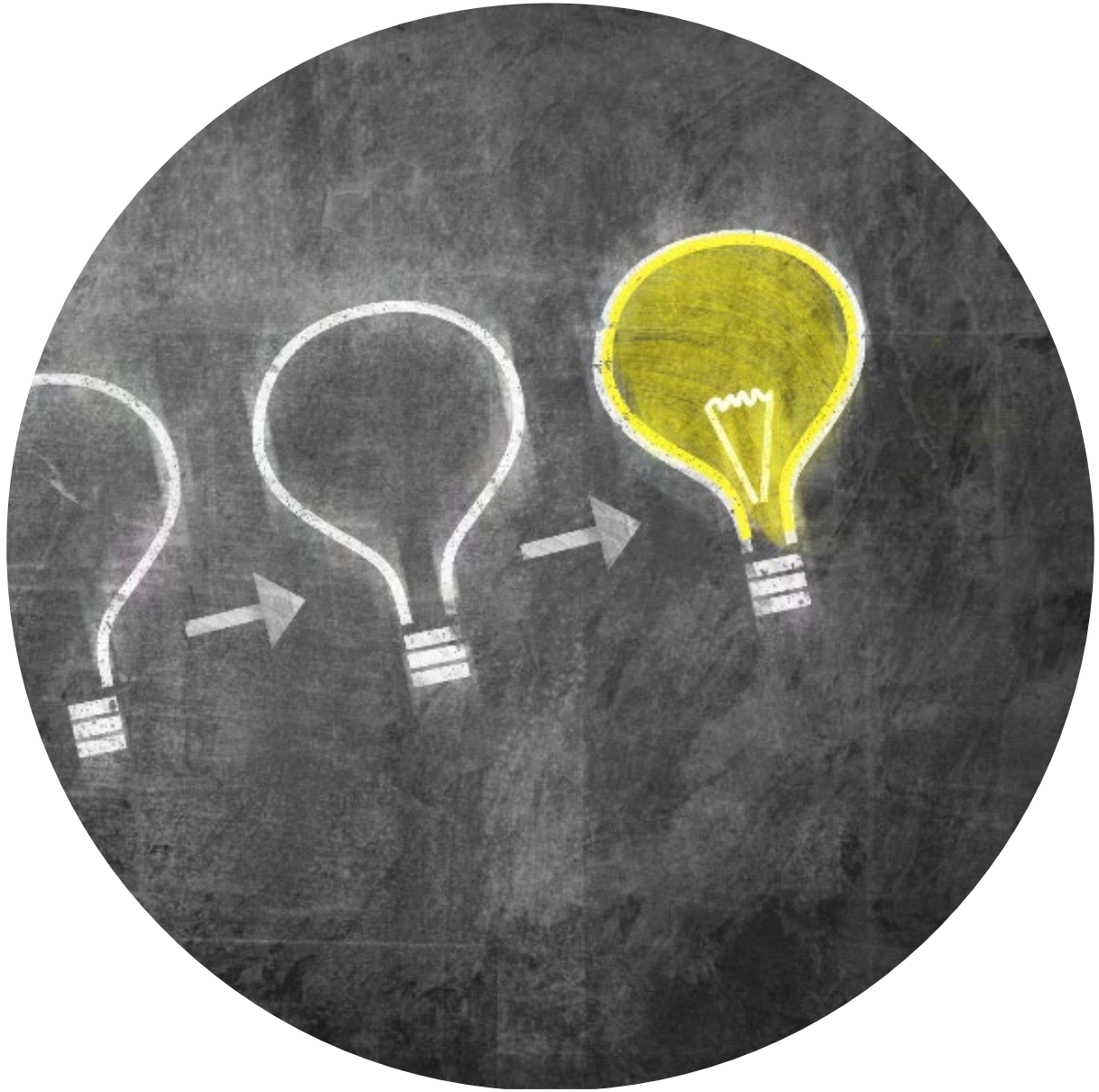
- Addressed gaps identified through the CMS CAP
  - Policy complies with Code of Federal Regulation (CFR) requirements
- Reorganized policy, language and purpose is largely unchanged
- Incorporated business rules into policy
- Clarified and strengthened language around person-centered planning and plan development

Plan Development Highlights

- Added Choice of Setting requirement
- Reorganized the domains of self-direction
  - Primary and Secondary domains
  - Clarified the relationship between primary and secondary domains
- Added LTC Needs Panel as a resource to help identify needs
- Incorporated the procedures into the policy to improve understanding

Work in Progress

- ISP Policy is being revised
- ISP Policy small workgroup with contractors
- HCBS Settings Rule Modification policy being drafted
- Emergency Back-Up Plan being developed in WISITS
- Revising Essential Services Provider Agreement Policy



Questions?

HCBS-related questions:
dhshcbssettings@dhs.wisconsin.gov

Resources

Wisconsin Site Visit Cover Letter and Report (medicaid.gov)

Wisconsin Settings CAP Approval Letter (medicaid.gov)

IRIS Service Plan

A. IRIS Service Plan: Background

Include, Respect, I Self-Direct (IRIS) is a Medicaid Home and Community-Based Services (HCBS) waiver program authorized in §1915(c) of the Social Security Act. IRIS waiver services complement and 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, friends, and communities provide. IRIS program participants make a choice to self-direct all long-term care services and supports, providing the person with a high degree of choice, control, and responsibility over services and supports.

The Centers for Medicare & Medicaid Services (CMS) requires each IRIS participant to develop and maintain a written plan of care that ensures their health and safety and assists with achieving their long-term care outcomes. The IRIS program uses the IRIS Service Plan (ISP) to satisfy this requirement. The IRIS Service Plan includes the participant's Individual Support and Service Plan (ISSP), the Long-Term Care Needs Panel, an individualized back-up plan, any applicable HCBS modifications and HCBS Modification-related risk agreements, as well as the ISP Signature Page. The IRIS consultant (IC) supports the participant through the development of a cost-effective IRIS Service Plan using a person-centered planning process that assesses, identifies, and documents the participant's long-term care needs as well as achievable long-term care outcomes based on the kind of life the participant wants to live, and the supports and services needed to do so.

The IRIS Service Plan reflects the full range of a participant's support and service needs, and achievable long-term care outcomes for the participant to avoid institutionalization and successfully live in the community. The person-centered planning process promotes culturally competent service delivery to individuals of all genders, diverse cultural and ethnic backgrounds, limited English proficiency, and disabilities. When developing the IRIS Service Plan, participants and ICs must consider the following:

- The person-centered planning process is led by the participant, includes people chosen by the participant, and takes place at times and locations convenient to the participant.
- The IC provides necessary information and support to ensure the participant directs the process to the fullest extent possible and is enabled to make informed choices and decisions.
- Participants are empowered to expand their degree of choice and control over decisions made about their long-term services and supports.
- Participants take the lead in identifying their individualized healthcare needs, achievable long-term care outcomes, preferences, strengths, and areas where they may need assistance from informal supports, community resources, ForwardHealth card services, and services funded by the IRIS waiver.
- Waiver services provided to the participant must be safe, cost-effective, and medically or functionally necessary.
- Waiver services provide the participant the opportunity to use and maintain family contacts, friends, and community services.
- Participants collaborate with the IC to establish procedures for ongoing monitoring and implementation of the IRIS Service Plan which includes managing risks, conflicts of interest, determining life satisfaction and measuring quality of service delivery.

- Participants continually exercise decision making for their waiver services and accept the responsibility for directly managing them on an ongoing basis.
- Services must support the participant's efforts to develop as much functional and medical independence as possible in their daily life and in meeting goals. Participants and service providers are provided the education and resources needed to support the participant's efforts to remain in the community.

IRIS participants have access to medically and functionally necessary services available in the Wisconsin Medicaid State Plan through Medicaid ForwardHealth card services as well as HCBS waiver services. IRIS waiver services is the funding source of last resort. Participants must first use and exhaust any community resources and supports; Medicaid ForwardHealth card services; Medicare benefits; and any other services available to the participant before accessing IRIS-funded waiver services and supports. Participants must also consider any available informal supports such as friends and family prior to accessing any IRIS-funded waiver services and supports. The IC assists the participant with identifying informal supports, ForwardHealth card services, and other resources available outside IRIS waiver services that may aid in meeting their needs.

B. IRIS Service Plan Development

1. Budget and Authority

a. Participant Budget

The participant develops a service plan to meet their support and service needs and outcomes within an overall budget. This budget starts with their individual budget allocation (IBA), a monthly estimate of the cost to meet their expected long-term care needs based on their functional screen (see Appendix C of the approved 1915(c) HCBS waiver for details). Participants are informed of their IBA by their ICA during the referral period, as well as each time a new functional screen is completed and their eligibility is redetermined. The Department's enterprise care management system uses the IBA to calculate an overall base budget for the participant over the duration of the service plan. The base budget calculation does not include additional funding requests, such as approved budget amendment requests and approved one-time expense requests. If the IBA changes while a plan is active, the Department's enterprise care management system will recalculate the base budget with the new IBA over the remaining months of the plan.

If the participant believes their base budget is not sufficient to achieve their long-term care outcome, they may submit a request for a budget amendment or one-time expense to DHS for approval. Budget amendments are additional funding requests for specific goods or services that exceed a participant's established base budget. Budget amendments must meet the specific needs identified in the request. One-time expense requests do not increase the participant's budget; they are separate authorizations for the specific goods or services in the approved request.

b. Participant Authority and Responsibility

The IRIS program grants the participant two types of authority to develop and implement their service plan: budget authority and employer authority. Each type comes with important responsibilities.

- Budget authority allows the participant to decide within their budget which goods and services will meet the needs and outcomes described in their service plan. The participant is responsible for prioritizing needs and outcomes, obtaining necessary and

appropriate goods and services from allowed providers, negotiating the most cost-effective rates, and remaining within their budget over the duration of their plan. For supports, services, and goods prioritization methodology, refer to *How to Develop Long-Term Care Outcomes*.

- Employer authority allows the participant to hire their own workers to provide cares and other services specifically identified in the IRIS program. The participant is responsible for recruiting and training their workers, evaluating their job performance, and implementing discipline or termination for unsatisfactory performance. Additionally, the participant is responsible for reviewing and approving their workers' timesheets in a timely manner to ensure they are paid promptly, as required by law (Wis. Stat. §109.03(1)). Timesheet requirements are subject to the IRIS Provider Agreement.

The IC assists the participant in exercising their budget and employer authority by ensuring they are equipped with the tools, resources, and information to fulfill their responsibilities. Further, the IC is responsible for creating service authorizations to implement the service plan, ensuring that those authorizations do not exceed the participant's base budget.

The Fiscal Employer Agent (FEA) assists the participant in exercising their budget and employer authority by paying agency providers and participant-hired workers, withholding income taxes and garnishments, providing tax documents, and processing onboarding documentation. FEAs also provide monthly notices as a tool to assist the participant in monitoring their budget and spending.

c. Self-Directed Personal Care

Self-Directed Personal Care (SDPC) is a Medicaid card service that allows the participant to exercise limited budget and employer authority for receiving medically prescribed personal care. SDPC is authorized for a specific number of hours per week. IRIS uses the enterprise care management system to create SDPC service authorizations, and the participant's worker is paid for SDPC by their FEA. SDPC is included in the participant's service plan, but it is totally separate from their budget for waiver services.

The participant's budget and employer authority for SDPC are limited in the following ways:

- The participant may not hire a worker to provide SDPC at a wage higher than the maximum allowed by DHS, which is set based on state Medicaid funding for personal care.
- The participant may not exchange budget authority between SDPC and other waiver services.
- The participant may not direct their worker(s) to provide more hours of SDPC than are authorized for a week, nor will their worker(s) be paid by the FEA for hours of SDPC that exceed the authorization.

2. Home and Community-Based Settings (HCBS) Settings Rule

TBD

3. Individual Support and Service Plan (ISSP) Planning and Development

a. General Provisions

The participant's individual support and service plan (ISSP) is a part of the IRIS Service Plan (ISP). The ISSP identifies the participant's outcomes, strategies used to meet their goals, as

well as service provider information. To create a participant's ISSP, the ICA meets in-person with the participant and with the optional support of any individual of the participant's choosing. Participant means either the participant or their legal decision maker, if applicable. Meetings must occur at a time and location that is convenient for the participant. For new IRIS program enrollments, the ISSP must be completed during the 60-day IRIS program referral period.

During these face-to-face meetings, the ICA and the participant explore any areas of skill, personal relationships with family and friends, community life, memberships, associations, faith communities, work, and school or other daily activities which may be helpful in creating a thorough picture of the participant and their long-term care needs.

The ICA utilizes various sources of information including discussions and interactions with the participant, the most recent Long-Term Care Functional Screen (LTCFS), LTC Needs Panel, Personal Care Screening Tool (PCST) if applicable, and a behavioral support plan (BSP) if conducted. Additional needs may be identified through a needs-based discovery tool or needs-based assessment developed by the ICA. The ICA comprehensively assesses the various sources of information and identifies the participant's:

1. health status,
2. risk factors,
3. long-term care outcomes,
4. strengths and weaknesses,
5. preferences,
6. informal supports,
7. ongoing participant conditions that require a course of treatment or regular care monitoring,
8. service and support needs, and
9. other factors that may impact their health and welfare.

The participant chooses to self-direct their long-term care services and supports identified in the ISSP. The participant, in collaboration with the ICA, are responsible for planning and developing their ISSP within their base budget. The ISSP contains the type, scope, amount, duration, and frequency of authorized waiver supports and services. The ICA ensures that the total cost of waiver services included on the ISSP does not exceed the participant's base budget without an approved budget amendment or one-time expense request. The supports and services authorized on the participant's ISSP must correlate with a support need identified on the most recent functional screen or LTC Needs Panel. ICAs support the participant with identifying supports, services, and goods that address identified outcomes specific to the participant's disability or qualifying condition, to ensure community-based services prevent the need for institutional-based services.

b. Choice of Setting

During exploratory discussions with the participant, ICAs must discuss and document whether the participant is satisfied with their current living arrangement and what other living arrangements were considered. Satisfaction with their living arrangement must be assessed on an ongoing basis, at minimum monthly during regular monthly contacts with the participant. More frequent contacts may be required based on the participant's response. Annually, the ICA must discuss and document other living arrangements considered by the participant.

For new IRIS program enrollments, ICAs must discuss and document the individual's living arrangement preferences as well as the living arrangement of their choice. After the initial discussion, this must be assessed on an ongoing basis, at minimum monthly during regular monthly contacts with the participant. More frequent assessments may be required based on the participant's response.

The participant may express dissatisfaction with their living arrangement at any time. The ICA must document if the participant is unsatisfied with their current living arrangement.

c. Nursing or Skilled Care

ICAs are required to consult with the IRIS Nurse Consultant Team prior to listing any Private Duty Nursing or nursing services on the ISSP. This ensures that all skilled cares for a participant with complex medical concerns are covered, that the plan is determined to be safe and that nursing services are prior authorized appropriately.

d. Mitigating Risks

ICAs are required to collaborate with the participant to identify potential risks in order to develop and implement strategies to mitigate those identified risks. ICAs can define their own practices for assessing risks and corresponding mitigation strategies. The ICA must document all conflicts of interest identified throughout enrollment and supports the participant in mitigating the conflict by reviewing the Participant Education Manual and completing a Conflict-of-Interest form.

e. How to Identify Long-Term Care Outcomes

Identifying achievable long-term care outcomes is a critical step of the person-centered planning process. As a guide, the participant and ICA review the identified long-term care needs from the recent functional screen and recent LTC Needs Panel. Additional needs may be identified through a needs-based discovery tool or needs-based assessment developed by the ICA. Achievable long-term care outcomes fall under a primary domain with considerations for each secondary domain. All domains are interrelated and must be addressed collectively to ensure the participant's ability to remain in their community.

1. Primary Domains of Self-Direction

   The primary domains of self-direction are described below and ordered based on priority. Each primary domain includes example questions as well as instructions to assist the participant and ICA with determining achievable long-term care outcomes.

   a. **Living Arrangement Personal to the Participant.** A living arrangement person to the participant plays a critical role in the participant's life. A living arrangement personal to the participant is a high priority as it directly impacts the participant's daily life, autonomy, sense of security, and ability to remain their community. This domain greatly supports the participant's ability to maintain employment or participate in their community.

      i. GUIDANCE QUESTIONS AND INSTRUCTIONS: Does the participant control their front door? Does the participant make decisions about when and what to eat? Does the participant want to live somewhere other than where they are currently living? Does the participant decide who else lives in the home? Document the strengths, challenges, and strategies discussed with the participant regarding

this domain. Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they'd like to consider in the future, etc.

b. **Employment.** Employment is essential to the participant's financial independence, self-worth, and income stability. Maintaining employment may provide the participant with the financial means to secure better housing and maintain their access to the community.
   i. GUIDANCE QUESTIONS AND INSTRUCTIONS: Document if and where the participant is currently working for pay or volunteering in the community (i.e. not for pay). Where would the participant like to work? Have they worked or volunteered in the past? Document their experiences and their likes and dislikes with those experiences. Document their general knowledge about integrated employment. Integrated employment means working a job for competitive wages (i.e. at least minimum wage) and is in the community (i.e. worker interacts with typically-abled people). Does the participant have work supports, including benefits counseling? Is the participant interested in benefits counseling to learn how working may affect their benefits? Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they'd like to consider in the future, etc.

c. **Community Integration.** Community integration is crucial in ensuring the participant's social inclusion and participation within the community.
   i. GUIDANCE QUESTIONS AND INSTRUCTIONS: What kind of connections does the participant currently have to the community? Would the participant like more connections? In what ways does the participant contribute to the community? What associations and connections do they have with community groups, interest groups, volunteer groups, religious organizations, sports teams, political groups, special interest groups, etc.? Document the strengths, challenges, and strategies discussed with the participant regarding this domain. Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they'd like to consider in the future, etc.

2. Secondary Domains of Self-Direction
Secondary domains play a supportive role by enhancing the ability to achieve or maintain the primary domains. Secondary domains must be evaluated and incorporated as a strategy used, as applicable, to achieve an outcome related to the primary domains of self-direction. Each secondary domain includes example questions as well as instructions to assist the participant and ICA with determining achievable long-term care outcomes.

d. **Health and Safety.** Health and safety are critical aspects for all primary domains and must be assessed for every outcome. Participants require a healthy and safe environment to achieve stability in their living arrangement,

maintain employment, and integrate into their community. This domain is critical for achieving and maintaining stability in all primary domains.

i. GUIDANCE QUESTIONS AND INSTRUCTIONS: Does the participant have a primary care provider or need assistance to obtain one? Does the participant need assistance getting to the physician on a regular basis or need assistance with medication? Does the participant have concerns for their safety? Is there a concern or need specific to the participant's disability? Document the strengths, challenges, and strategies discussed with the participant regarding this domain. Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they would like to consider in the future, etc.

e. **Transportation.** Transportation is an essential support that allows for the access to employment, the community, and services. Transportation helps reduce potential barriers to maintain employment and community integration.

i. GUIDANCE QUESTIONS AND INSTRUCTIONS: What are the participant's available options for transportation? Does the participant have a vehicle? Does the participant have access to a vehicle? Does the participant have a valid driver's license? Can the participant drive their vehicle without any modifications to their vehicle? Does the participant have auto insurance? Can the participant spontaneously go out for evenings/weekends/overnight trips? Are there any transportation difficulties? Document the strengths, challenges, and strategies discussed with the participant regarding this domain. Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they'd like to consider in the future, etc.

f. **Relationships.** Building and maintaining relationships is vital to the participant's ability to achieve and maintain progress in the primary domains.

i. GUIDANCE QUESTIONS AND INSTRUCTIONS: Who are the important people in the participant's life outside of their immediate family? What are the participant's outcomes in interacting with others in the community, at their job, or with current relationships? What obstacles are stopping the participant from having fulfilling relationships? Add new contacts into the Department's enterprise care management system for any relationships identified. Document the strengths, challenges, and strategies discussed with the person regarding this domain. Indicate if the participant has an outcome they would like to consider and document in their words what the outcome is. Document if the outcome is immediate, long term, something they'd like to consider in the future, etc.

f. How to Develop Long-Term Care Outcomes

The development of achievable long-term care outcomes is a critical step of the person-centered planning process. As a guide, the participant and ICA review the identified long-term care needs from the recent functional screen and recent LTC Needs Panel. Additional needs may be identified through a needs-based discovery tool or needs-based assessment developed by the ICA.

Each achievable long-term care outcome is unique to the participant, goal-oriented, and describes what is important to the participant. Each service or support identified and included on the participant's ISSP must support an achievable long-term care outcome and must correlate with an identified need on the participant's functional screen and LTC Needs Panel.

Every achievable long-term care outcome must consider the health and safety of the participant, support the development of positive relationships, and provide control and access to transportation. The ICA assists the participant in identifying and establishing the participant's needs, goals, and achievable long-term care outcomes. Achievable long-term care outcomes must have a direct correlation to the findings of the most recent functional screen, LTC Needs Panel, and be related to the domains of self-direction.

The services and service providers identified on the plan must support the participant's outcomes and preferences. The participant, with support from their ICA, is responsible for obtaining necessary and appropriate goods and services from verified IRIS program providers at cost-effective rates.

Each step must be completed before moving onto the next step.

1. Step One: The participant and ICA determine which achievable long-term care outcomes are related to ensuring the participant's health, safety, and independence related to achieving, maintaining, or establishing a living arrangement personal to the participant. If any achievable long-term care outcomes are identified, refer to 3.g.1-6, *How to Develop Strategies to Address Identified Long-Term Care Outcomes*, prior to completing 3.f.2.
2. Complete Step One prior to this step (Step Two). Step Two: The participant and ICA determine which achievable long-term care outcomes are related to ensuring the participant's health, safety, and independence related to achieving, maintaining, or obtaining community-integrated employment. If any achievable long-term care outcomes are identified, refer to 3.g.1-6, *How to Develop Strategies to Address Identified Long-Term Care Outcomes*, prior to completing 3.f.3.
3. Complete Step Two prior to this step (Step Three). Step Three: The participant and ICA determine which achievable long-term care outcomes are related to ensuring the participant's health, safety, and independence related to achieving, maintaining, or establishing community inclusion. If any achievable long-term care outcomes are identified, refer to 3.g.1-6, *How to Develop Strategies to Address Identified Long-Term Care Outcomes*.

g. How to Develop Strategies to Address Identified Long-Term Care Outcomes

1. The participant, with support from their ICA, determines which support or funding source is the most appropriate for achieving, maintaining, or obtaining the identified long-term care outcome. ICAs must ensure the exhaustion of the primary payers before the participant makes a request for waiver-funded services. Support and funding sources must be identified and utilized in the order prescribed:
    a. **Medicare, Medicaid, or other government-funded services.** Examples of services Medicare may cover are durable medical equipment such as wheelchairs, walkers, and hospital beds. Medicaid services are Wisconsin State Plan services associated with the participant's ForwardHealth card

services such as mental health services and dental services. The availability of ForwardHealth card services is based on the participant's Medicaid group.

i. Supports and services from other funding sources, such as Medicare, Medicaid, or other government-funded services must be exhausted prior to exploring and utilizing waiver services. If the participant receives a Medicare or Medicaid denial for a service or support, the denial must be provided prior to authorizing a service or support on the ISSP.

b. **Community supports and services.** Community supports and services are not authorized or paid for by the participant's budget and are readily available to the general population. Examples of community supports and services may be the participant's county resources, place of worship, community center, etc.

c. **Informal supports.** Informal supports are supports provided by individuals who are available to provide unpaid, voluntary assistance to the participant in lieu of paid supports and/or State Plan or home and community-based services (HCBS). They are typically individuals from the participant's social network such as family, friends, neighbors, etc.

d. **HCBS Waiver Services.** Waiver services are services provided through Medicaid waiver programs.

2. The participant, in collaboration with the ICA, develops different strategies and identifies various funding sources and supports to achieve, maintain, or obtain the participant's achievable long-term care outcomes. Funding sources and support describe what the participant will use to achieve, maintain, or obtain their achievable long-term care outcome. Strategies must be unique to the participant and describes how the participant is going to use their identified funding source or support to achieve, maintain, or obtain the identified long-term care outcome. Examples of strategies include:
    a. Utilizing an individual to assist with supportive home care tasks.
    b. Utilizing a church's van or bus to provide transportation to and from church services.
    c. Utilizing an agency provider to provide respite services.
    d. Utilizing an agency provider to provide supported employment.

3. After the participant identifies and develops their achievable long-term care outcomes, strategies, and funding sources for establishing, obtaining, and maintaining their achievable long-term care outcomes, and it's determined a waiver service is required to meet the long-term care outcome, the ICA assists with prioritization of services, supports, and goods while ensuring the participant remains within their base budget. Reference 3.f.1-3, *How to Develop Long-Term Care Outcomes*, for prioritization methodology. All waiver-funded services and supports must meet all the listed elements below:
    a. appropriateness for meeting an identified need,
    b. correlates to an achievable long-term care outcome,
    c. cost-effective,
    d. functional necessity or medical necessity (DHS 101.03(96m)),
    e. an allowable IRIS service, and
    f. verified provider in the Department's enterprise care management system.

If the requested waiver service or support does not meet all elements listed above, the ICA must issue a Notice of Action (NOA).

4. After the ICA and participant determine that all elements are met, an ICA must consider the following criteria when assessing identified services and supports, prior to authorizing any services and supports and the participant's ISSP:
    a. Are all services and supports identified on the ISSP needs-based (i.e., identified on the screen) and outcome-driven (i.e., an allowable long-term care outcome)?
    b. Are all the services and supports identified on the ISSP allowable and cost-effective for this Medicaid waiver program?
    c. Are all the services and supports identified on the ISSP addressing an unmet need, rather than duplicating an existing service on the plan?

    If the participant's request for additional services or supports does not meet the program criteria or cannot be justified per this policy, the ICA must not authorize the support or service and issues the participant a Notice of Action (NOA) and appeal rights.

5. After the services and supports are determined to meet all the criteria above, the participant, with support from their ICA, determine the following:
    a. Identify the **type** of support/service/good needed.
    b. Identify the **amount** of support/service/good needed.
    c. Identify the **provider** of the support/service/good.
    d. Identify the **total cost** of the support/service/good needed.

6. The participant, with support from their ICA, is responsible for obtaining necessary and appropriate goods and services from allowed providers at cost-effective rates. The total cost of each waiver service must be deducted from the participant's base budget. Before providers can be authorized or paid to provide waiver services on any IRIS Service Plan, the provider must meet all qualifications. Qualification requirements vary based on the type of service provider. The FEA must verify the provider met the provider qualifications, set up the provider in the Department's enterprise care management system, and provide a start date.

7. After the FEA verifies the provider, the ICA is responsible for selecting the appropriate service code that corresponds to the allowable IRIS service. Refer to the Service Definition Manual.

h. Choice of Provider

The IRIS program does not maintain a provider or worker directory or network that participants can reference when seeking participant-hired workers or agency providers. It is the responsibility of the participant, with the support of the ICA, to identify potential providers. Before agency providers and participant-hired workers can be selected for the ISSP, they must first be approved by FEAs to provide services and supports in the IRIS program. This requires the successful completion of the FEA review of required program-specific, Medicaid-specific, and Internal Revenue Service-specific documents.

Participant-hired workers must also successfully complete the criminal and caregiver background check processes to be considered for employment by an IRIS participant.

DHS will be requiring IRIS agency providers to register through ForwardHealth as Medicaid providers. This is tentatively scheduled for fall 2024. Participants will be able to utilize ForwardHealth as a resource to help identify providers. However, ForwardHealth cannot assist in locating participant-hired workers, only agency providers. More information will be provided at that time, including any necessary updates to this policy.

4. Long-Term Care (LTC) Needs Panel

TBD

5. Individualized Back-Up Plan

TBD

6. IRIS Service Plan Signature Page

TBD

C. IRIS Service Plan Guidance

D. Service Authorization (Placeholder)

E. Essential Service Provider Agreements (Placeholder)

F. Participant Provider Service Agreements (Placeholder)