IRIS Service Plan

A. Background

IRIS (Include, Respect, I Self-Direct) 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 self-direct all long-term care services and supports, providing the person with a high degree of choice, control, and responsibility over their services and supports. Because participants have increased choice about selecting their waiver services and assume a direct role in managing their person-centered IRIS Service Plan (service plan), they also accept the risk and increased responsibility for their spending choices. Agreement to comply with all IRIS programmatic policies is a requirement for participants.

The Centers for Medicare & Medicaid Services (CMS) requires each IRIS participant to lead the person-centered planning process. The participant, with assistance from the IRIS consultant agency (ICA), develops and maintains a written plan of care that ensures their health and safety and assists with achieving their long-term care outcomes (goals). The IRIS program uses the IRIS Service Plan to satisfy this requirement. The service plan includes the participant's Individual Support and Service Plan (ISSP), the Long-Term Care Needs Panel, an individualized back-up plan (i.e., emergency back-up plan), as well as HCBS Settings Rule Modification documentation for participants receiving residential services in provider-owned or provider-controlled residential settings. The ICA supports the participant through the development of a cost-effective 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 service plan reflects the full range of a participant’s support and service needs, and achievable long-term care outcomes for the participant to successfully live in the community and avoid institutionalization. The person-centered planning process encourages culturally competent service delivery to individuals of all genders, diverse cultural and ethnic backgrounds, limited English proficiency, and disabilities. When developing the service plan, the participant and ICA 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 participant takes 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.

- The participant collaborates with the ICA 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.
- The participant continually exercises decision making for their waiver services and accepts the responsibility for directly managing them on an ongoing basis.
- Services must support the participant's efforts to develop as much functional independence as possible in their daily life and in meeting the participant's needs and outcomes (goals). The participant 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-funded services are the funding source of last resort. Participants must first use and exhaust any community resources and supports; Medicaid ForwardHealth card services; Medicare benefits; any other services; and consider informal supports available, such as friends and family, prior to accessing any IRIS-funded waiver services and supports. The ICA assists the participant with identifying ForwardHealth card services, informal supports, and other resources available outside IRIS waiver services that may aid in meeting their needs.

Participant means either the participant or their legal decision maker, if applicable. If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant. The legal decision maker, on behalf of the participant, is required to comply with all IRIS programmatic policies.

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 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, or their eligibility is redetermined. The DHS enterprise care management system uses the IBA to calculate an overall base budget for the participant over the duration of the service plan. The initial 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 DHS 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 meet their needs, they may submit a request for additional funding, such as a budget amendment or one-time expense request, to the Wisconsin Department of Health Services (DHS) for approval to evaluate need and cost-effectiveness. A budget amendment is additional funding requested when a participant has identified a need and associated long-term care outcome that cannot be met by the participant's established base budget or other Medicaid benefit. A budget

amendment 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. For additional information see the Additional Funding Requests Policy, P-03656.

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.

- The participant must assume the required role of "budget authority", which means that the participant exercises decision-making authority and assumes management responsibility for their spending choices. Budget authority allows the participant to determine, within their budget, which goods and services will meet the needs and outcomes described in their service plan. The participant is responsible for identifying needs and outcomes, obtaining necessary and appropriate goods and services from verified 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 Section B.3.e, How to Develop Strategies to Address Identified Long-Term Care Outcomes.
- The participant must assume the required role of "employer authority", which includes multiple employer-related responsibilities such as recruiting, hiring, training, supervising, discharging their providers, and agency provider responsibilities, as applicable. If the participant chooses to employ Participant-Hired Workers (PHWs), it is the participant's responsibility to establish their PHWs' work schedules to ensure that their PHWs do not work more hours than the participant's service plan will allow. It is the participant's responsibility to review, verify, and approve their PHWs' submitted timesheets to ensure they are paid promptly, as required by law (Wis. Stat. §109.03(1)). In order to approve their PHWs' timesheets, the participant must verify and ensure that their PHWs have recorded the amount of time that they worked accurately. Timesheet requirements are subject to the IRIS Provider Agreement. The IRIS Provider Agreement is the written agreement that outlines terms and conditions between contractors and DHS. To remain enrolled in the IRIS program, the participant must fulfill the responsibilities included in the required "employer-authority" role.

The ICA 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 ICA is responsible for creating service authorizations to implement the service plan, ensuring the service 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 PHWs, 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 as well as any approved budget amendments and one-time expenses.

c. Self-Directed Personal Care

Self-Directed Personal Care (SDPC) is a Medicaid ForwardHealth 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. The IRIS program uses the DHS enterprise care management system for 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 is separate from their budget for waiver-funded services.

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

- The participant may not seek reimbursement from a Medicaid waiver program for a worker to provide SDPC at a wage higher than the maximum reimbursement rate 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-funded services.
- The participant may not direct their worker(s) to provide more hours of SDPC than are prescribed for a week, nor will their worker(s) be paid by the FEA for hours of SDPC that exceed the authorization.
- SDPC must be utilized and exhausted prior to accessing waiver-funded services.

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

a. Background

In 2014, the Centers for Medicare & Medicaid Services (CMS) published the HCBS Settings rule. The federal requirements define the qualities of settings eligible for reimbursement for Medicaid home and community-based services. Under the requirements, DHS must ensure that settings in which home and community-based services are provided meet and remain in compliance with the settings rule requirements. The IRIS program and all IRIS participants are subject to the HCBS Settings rule. For more information, see the DHS Home and Community-Based Services Settings Rule webpage.

b. HCBS Settings Rule Requirements

All HCBS Settings must have all the qualities below, as well as any additional qualities determined by DHS, based on the needs of the participant indicated on their IRIS Service Plan.

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
2. 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.
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5. Facilitates individual choice regarding services and supports, and who provides them.

These requirements are monitored by the licensing or certifying agency for services rendered in a licensed or certified setting. It is the responsibility of the participant to report to DHS any settings that may infringe on their HCBS rights. If an ICA is made aware of a setting that does not meet the general qualities above, it is the ICA's responsibility to report the setting to Division of Quality Assurance (DQA) via email at DHSWebmailDQA@dhs.wisconsin.gov.

c. Provider-Owned or Provider-Controlled Residential Settings

An adult residential setting subject to the HCBS Settings rule is a provider-owned or provider-controlled residential setting. Applicable settings are licensed 3-4 bed adult family homes (AFHs), certified 1-2 bed AFHs, and certified residential care apartment complexes. The following additional conditions must also be met for all provider-owned or controlled settings providing residential services:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, such as group homes, residential facilities, or other housing situations, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant. The State ensures the written agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
2. Each individual has privacy in their sleeping or living unit:
    a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
    b. Individuals sharing units have a choice of roommates in that setting.
    c. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
3. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
4. Individuals are able to have visitors of their choosing at any time.
5. The setting is physically accessible to the individual.

These requirements are monitored by the licensing or certifying agency for services rendered in a licensed or certified setting. It is the responsibility of the participant to report to DHS any settings that may infringe on their HCBS rights. If an ICA is made aware of a setting that does not meet the general qualities above, it is the ICA's responsibility to report the setting to Division of Quality Assurance (DQA) via email at DHSWebmailDQA@dhs.wisconsin.gov.

d. Individualized HCBS Settings Rule Modification for Participants in a Provider-Owned or Provider-Controlled Residential Setting

For participants receiving residential services in a provider-owned or provider-controlled residential setting, the HCBS Settings rule modification process must be followed to determine if a participant may need an HCBS Settings rule modification, which is a

restriction or limitation to a participant's HCBS rights defined in Section 2.c.2-4. An HCBS Settings rule modification is:

1. Identified and discussed between the participant and residential setting provider,
2. Implemented by the residential services provider,
3. Supported by a specific assessed need to ensure the health, safety, and well-being of the individual or the community, and
4. Documented on the HCBS Settings rule modification form and approved by the participant.

e. HCBS Settings Rule Modification Form Process

CMS requires all HCBS Settings rule modifications to be clearly documented in the participant's service plan. To satisfy this requirement, the IRIS program uses the HCBS Settings rule modification form. The HCBS Settings rule modification form documents the discussion, review, implementation, and monitoring of an HCBS Settings rule modification. This form is completed with all participants receiving residential services in a provider-owned or provider-controlled setting. HCBS Settings rule modification discussions take place during the initial person-centered planning process and at any time throughout their program enrollment.

The participant, with the guidance and support of the ICA, discusses what the HCBS Settings rule is, the impacts of the HCBS Settings rule modification form, and how it may apply to the participant. During the discussion, the participant with the assistance of their ICA, determines whether an HCBS Settings rule modification may be needed.

Each time the HCBS Settings rule modification form is completed, the ICA must provide a copy to the participant to distribute to their residential provider and document this in a case note. See Section E, Essential Service Provider Agreements for details. The ICA must include the distribution of the HCBS settings rule modification form, if the HCBS Settings rule modification form is provided to the participant during a monthly or quarterly in-person meeting.

1. HCBS Settings Rule Modification Not Needed

After review and discussion, if the participant determines an HCBS Settings rule modification is not needed, complete the relevant participant and ICA section of the HCBS Settings rule modification form. A signature is not required from the participant. The form is considered complete and is uploaded to the DHS enterprise care management system with a corresponding, detailed case note. The ICA must provide a copy to the participant to distribute to their residential provider and document this in a case note. See Section B.2.g, Risk Agreement (HCBS Settings Rule Modification) if there are identified health and safety concerns.

2. HCBS Settings Rule Modification Needed

If the participant determines an HCBS Settings rule modification may be required, the ICA must provide a copy to the participant to complete with the residential provider. Responses on the form must be accurate and thorough. Participants must provide the ICA with the completed and signed form within 30 days of receiving the form. The ICA ensures the form is completed and signed prior to uploading it to the DHS enterprise care management system. If the form is not complete, the ICA discusses and completes any missing information with the participant, and then

uploads to the DHS enterprise care management system. The ICA must provide a copy to the participant to distribute to their residential provider and document this in a case note.

f. Participant Understanding and Informed Consent Requirements

Any HCBS Settings rule modification must have the participant's informed consent to be implemented. Informed consent is the participant's signature captured on the HCBS Settings rule modification form which includes the date consent is given. The participant's informed consent is an acknowledgement of understanding from the participant. The participant may choose to either provide informed consent or not provide informed consent. If the participant provides informed consent, the HCBS Settings rule modification is considered approved by the participant and can then be implemented by the residential provider. See Section B.2.g, Risk Agreement (HCBS Settings Rule Modification) if the participant does not provide informed consent.

g. Risk Agreement (HCBS Settings Rule Modification)

If the participant does not agree and does not provide informed consent to the HCBS Settings rule modification, the ICA must discuss any potential risk(s) with the participant. The ICA must complete a Risk Agreement Form, F-01558, specific to the requested HCBS Settings rule modification with the participant. Once complete, the HCBS Settings rule modification form and Risk Agreement are uploaded to the DHS enterprise care management system with a corresponding, detailed case note documenting the conversation and decision.

h. HCBS Settings Rule Modification Review

This form is required for all participants receiving residential services in a provider-owned or provider-controlled residential setting. The HCBS Settings rule modification form must be reviewed and completed with the participant on an annual basis at plan renewal, or more frequently, as needed. At minimum, the ICA must discuss and review the existing HCBS Settings rule modification form and completes a new HCBS Settings rule modification form with the participant annually at plan renewal.

At each review, the ICA, participant, and residential setting provider, as applicable, discuss the effectiveness of any implemented HCBS Settings rule modifications by reviewing the data collected by the residential setting provider. If the participant determines that the HCBS Settings rule modification is no longer effective or needed, the participant must complete a new form with their ICA indicating an HCBS Settings rule modification is not needed.

When the HCBS Settings rule modification form is updated, whether a modification is needed or not needed, the ICA must provide a copy to the participant to distribute to their residential provider. If the HCBS Settings rule modification form is provided to the participant during a monthly or quarterly in-person meeting, the ICA must include the distribution of the HCBS Settings rule modification form in the case note.

Additionally, the HCBS Settings rule modification process must be reviewed with the participant in the following circumstances:

1. New HCBS Residential Setting Provider

This is applicable to a participant who does not have an existing HCBS Settings rule modification form on file and has a new residential provider. If the participant has recently moved or plans to move to a new residential setting provider, the ICA must review and discuss the HCBS Settings rule modification form. If the participant determines an HCBS Settings rule modification is needed, the participant must complete the form within 30 days of moving to their new residential provider. The participant returns the form to their ICA to be uploaded to the DHS enterprise care management system.

2. Move to a New HCBS Residential Setting Provider

   If the participant has an existing HCBS Settings rule modification form and recently moved to a new residential setting provider, the ICA must review and discuss the HCBS Settings rule modification form. If there is no form on file, a new form must be completed. If the participant determines an HCBS Settings rule modification is needed, the participant must complete and sign the form within 30 days of moving to their new residential provider.

3. Transferring from a Long-Term Care Program

   If the participant transfers from a long-term care program and has an existing modification in place, the ICA will review the modification form for completeness. If the form is complete and the participant indicated informed consent with their signature, the ICA must upload the form into the DHS enterprise care management system within 30 days of the participant's transfer.

   If the modification form is not complete and does not have the participant's informed consent, the ICA must review and discuss the HCBS Settings rule modification form and process with the participant. If the participant determines an HCBS Settings rule modification is needed, the participant must complete the form within 30 days of the participant's transfer. The participant returns the form to their ICA to be uploaded to the DHS enterprise care management system.

4. Review Request

   If the participant or residential provider requests a review of the existing HCBS Settings rule modification form for changes, the participant reviews the existing form with the ICA within 30 days. Refer to Section 2.e, HCBS Settings Rule Modification Form Process for process information.

5. Participant Withdrawing Consent

   Through conversation, if the participant withdraws consent to an existing HCBS Settings rule modification, the participant must complete Section B.2.e.1 of the HCBS Settings rule modification process with the ICA. See Section B.2.g, Risk Agreement (HCBS Settings Rule Modification) if the participant does not provide informed consent and there is an identified health and safety risk.

i. Residential Setting Provider Compliance

If the residential setting provider is implementing a modification without the participant's informed consent, the ICA must follow the program policy Reporting and Follow-up for Immediate Reportable and Critical Incidents, P-03131.

If the residential setting provider is not following requirements outlined in the HCBS Settings Rule Modification Form, specifically regularly collecting and reviewing data, the HCBS Settings rule modification cannot be implemented. The ICA must discuss this with the participant and inform the participant the modification cannot be implemented. The conversation must be documented in a case note.

j. Participant Compliance

The unwillingness or inability to comply with HCBS Settings rule responsibilities may result in a program requested disenrollment from the IRIS program due to health and safety concerns or due to a general unwillingness to comply with programmatic requirements. For additional information, refer to the Program Enrollment Policy, P-03547.

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

a. General provisions

The participant's ISSP is a part of the service plan. The ISSP identifies the participant's outcomes, strategies used to meet their goals, as well as service provider information. To create a participant's initial ISSP, the ICA meets in-person with the participant and with the optional support of any individual of the participant's choosing. 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 in-person 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, LTC Needs Panel, Personal Care Screening Tool, if applicable, and a Behavioral Support Plan, if conducted. Additional needs may be identified through a needs-based discovery tool or needs-based assessment developed by the ICA. The ICA comprehensively reviews the various sources of information and identifies the participant's:

- Health status
- Risk factors
- Long-term care outcomes
- Strengths and weaknesses
- Preferences
- Informal supports
- Ongoing participant conditions that require a course of treatment or regular care monitoring
- Service and support needs
- Other factors that may impact their health and welfare

The participant chooses to self-direct their long-term care supports identified in their service plan. 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-funded supports and services. The ICA

ensures 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 and LTC Needs Panel. The ICA supports 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. Nursing or skilled care

The ICA is required to consult with the IRIS nurse consultant team prior to listing any Private Duty Nursing or skilled care on the ISSP. This is to ensure that all skilled cares for a participant with complex medical concerns are covered, the plan is determined to be safe and that nursing services are prior authorized appropriately.

c. Mitigating risks

The ICA is required to collaborate with the participant to identify potential risks in order to develop and implement strategies to mitigate those identified risks. The ICA can define their own practices for assessing risks and corresponding mitigation strategies. The ICA must document all conflicts of interest identified throughout enrollment and support the participant in mitigating the conflict by reviewing the Participant Education Manual, P-01704 and completing the form, Conflict of Interest Disclosure–Participant, F-01310A.

d. 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 personal 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 in 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). Does the participant currently have community integrated employment? If so, does the participant have any community integrated employment goals? If the participant does not have employment, would the participant like to work? Where would they 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 would it look like for the participant to feel more connected to the community. It would be helpful to ask about any connections the participant currently has to their community, any contributions to their community, and any associations and connections 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.

a. **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.
b. **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.
c. **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 DHS 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.

e. 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 achievable long-term care 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.

Per program policy, if the participant has any funds approved through the budget amendment process, the participant must use those funds for the requested service and the funds cannot be transferred to a different service or service type. Refer to the Additional Funding Requests Policy, P-03656 for additional guidance and requirements.

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 Section 3.f.1-6, How to Develop Strategies to Address Identified Long-Term Care Outcomes, prior to completing Section 3.e.2.
    a. For this step, the participant and ICA must consider strategies that will ensure a healthy and safe living arrangement. In order for the participant to successfully live in the community, the participant and their ICA must focus on maintaining their living arrangement to remain in the community. Strategies may include prioritizing services and supports related to Support services or Living Situation services such as supportive home care or adult family home, respectively. Dependent upon the participant's circumstances, these services may also include the prioritization of other services such as respite, day services, or adult day care, if necessary to maintain their living arrangement.
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 Section 3.f.1-6, How to Develop Strategies to Address Identified Long-Term Care Outcomes, prior to completing Section 3.e.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 Section 3.f.1-6, How to Develop Strategies to Address Identified Long-Term Care Outcomes.

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

1. The participant, with support from the ICA, determines which support or funding source is the most appropriate for achieving, maintaining, or obtaining the identified long-term care outcome. The participant with the support of their ICA, identifies the types, quantities, and usual costs of the waiver services that are required to meet their long-term care needs and associated long-term care outcomes subject to the requirements of medical and functional necessity for home and community-based waiver services. The ICA must ensure the exhaustion of community resources and primary payers; as well as consider informal supports available to the participant before making a request for waiver-funded services. Support and funding sources must be identified and utilized in the order prescribed:
    a. **Medicare, Medicaid card services, or other government-funded services.** Examples of services Medicare may cover are durable medical equipment such as wheelchairs, walkers, and hospital beds. Medicaid card 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 card services, 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 card 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, Medicaid card services, or home and community-based services (HCBS). Informal supports are typically individuals from the participant's social network such as family, friends, neighbors, etc.
    d. **HCBS waiver services.** Waiver-funded services are services provided through Medicaid waiver programs.

2. The participant, in collaboration with the ICA, develops strategies and identifies various funding sources and supports to achieve, maintain, or obtain the participant's achievable long-term care outcomes. Funding sources and identified supports 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 describe 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:
    - Utilizing an individual to assist with supportive home care tasks.
    - Utilizing a church's van or bus to provide transportation to and from church services.
    - Utilizing an agency provider to provide respite services.
    - 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 Section 3.e.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 (Wis. Admin. Code DHS § 101.03(96m))
    e. An allowable IRIS service
    f. Verified provider in the DHS enterprise care management system.

    If the requested waiver-funded service or support does not meet elements 3.a-e listed above, the ICA must issue a Notice of Action (NOA).

    A NOA is not required if the waiver-funded service or support does not meet 3.f above since the waiver-funded service or support is not being denied. However, to access the service or support, the participant must select a verified provider.

4. After the ICA and participant determine that all elements are met, an ICA must consider the following criteria prior to authorizing any services and supports on 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 an 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, or good needed.
    b. Identify the **amount** of support, service, or good needed.
    c. Identify the **provider** of the support, service, or good.
    d. Identify the **total cost** of the support, service, or 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 provider must enroll with Wisconsin Medicaid through the ForwardHealth Portal. The FEA verifies Medicaid provider enrollment, set up the provider in the DHS 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.

g. Choice of Provider

DHS requires all providers and vendors of home and community-based services under an adult long-term care waiver program, such as the IRIS program, to enroll with Wisconsin Medicaid through the ForwardHealth Portal. Participants may utilize ForwardHealth as a resource to help identify providers and vendors online using the ForwardHealth Provider Directory. However, PHWs are not affected by this change.

The IRIS program does not maintain a provider or worker directory or network that participants can reference when seeking PHWs or individual providers. The participant selects their own qualified service providers. Throughout enrollment, the ICA is the main resource and support for service providers and vendor information. The ICA has localized knowledge and provides the participant with the tools, resources, and information consistent with the participant's needs.

Before PHWs can be selected for the service plan, PHWs 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. PHWs must also successfully complete the criminal and caregiver background check processes to be considered eligible for reimbursement by the Medicaid waiver program for services provided to an IRIS participant.

4. Long-Term Care (LTC) Needs Panel

a. Overview

The Long-Term Care (LTC) Needs Panel is an assessment tool used to assist in identifying and documenting a participant's unique needs. Additionally, the LTC Needs Panel provides information on how the needs are being met which includes information on the support or funding source. Results from the functional screen inform the needs documented in the LTC Needs Panel. The LTC Needs Panel is accessible to ICAs within the DHS enterprise care management system. In tandem with the ISSP development process, after long-term care outcomes and their corresponding support or service is identified, the ICA completes the participant's LTC Needs Panel. The LTC Needs Panel is organized by categories based on the functional screen.

The categories are:

1. Activities of daily living (ADLS) which identifies personal care needs
2. Instrumental activities of daily living (IADLS) which identifies supportive home care, transportation, money management, or medication management needs
3. Additional supports which identify any overnight care, employment services, the participant's current living situation, and any additional information the IRIS consultant (IC) believes is pertinent
4. Health related services
5. Behavioral and mental health which identifies any mental health, substance abuse, and behavior supports needs
6. Any medical providers, medical equipment needs, fall risk prevention, emergency response services, school services, day programs, respite services, environmental hazards, and egress-related needs

b. Choice of Setting

Choice of Setting is documented in the participant's service plan. Choice of Setting discussions must take place during the initial service plan development, as well as annually thereafter. Additional discussions may be required based on the participant's needs. During this discussion, the ICA must document if the current living arrangement was the participant's choice among other living arrangements and the choice of setting was based off the participant's needs and preferences. The participant's satisfaction with their living arrangement must be assessed annually at minimum, unless previous conversations indicated a desire for a new living arrangement.

The participant may express dissatisfaction with their living arrangement at any time. In a case note, the ICA must document any concerns the participant may have regarding their current living arrangement as well as any agreed upon steps the ICA and participant discussed to resolve the dissatisfaction. The agreed upon steps must include ongoing communication with the participant, at least monthly, and a timeframe to find a solution. The ICA may also refer the participant to local housing resources and when appropriate, provide information to help the participant identify available adult family homes or residential care apartment complexes. The ICA must determine if the dissatisfaction is related to a health and safety concern. If there are any health and safety risks identified and related to the living arrangement, the ICA must address potential risks with the participant through a Risk Agreement.

1. **Continued dissatisfaction**
   If the participant continues to report dissatisfaction **and** the living arrangement poses a continued health and safety risk, the ICA must report the concerns to the appropriate entity, such as Adult Protective Services or refer the participant to the

aging and disability resource center (ADRC) or Tribal aging and disability resource specialist (ADRS), as applicable.

c. When to Complete or Update

The Long-term Care Needs Panel (LTC Needs Panel) is completed, reviewed, or updated at the following times:

1. Prior to program enrollment.
2. Annually during the IRIS Service Plan renewal.
3. Within 30 days of a change in condition that requires an ISSP update.
4. When there is a documented positive or negative change in condition that results in a new functional screen, and
5. After the annual rescreen (functional screen) is completed.

d. Administrative Procedures

The participant is responsible for identifying how each need is being met. The participant, in collaboration with the ICA, determine if the need is being met through informal supports, another funding source such as private pay, Medicaid card services, etc., or through waiver funding such as IRIS waiver-funded services. The participant may refuse support for the identified need. If the participant indicates that a need is currently being assessed, the ICA must document follow-up timeframes in the notes section.

Once all the sections and their accompanying questions have been completed, the ICA completes an overall review of the LTC Needs Panel responses and ensures responses align with the most recent functional screen.

The ICA reviews each section of the LTC Needs Panel after completing or updating the functional screen and meeting with the participant. Any undocumented needs must be included as a note in the Support or Service section of the LTC Needs Panel.

Once all the sections and their accompanying questions have been completed, the ICA changes the panel's assessment status to "Completed" and saves the completed assessment to the participant's document console in the DHS enterprise care management system.

When the LTC Needs Panel is updated or reviewed annually, the ICA saves the changes and adds the assessment to the participant's document console.

5. Individualized Back-Up Plan

a. Back-Up Plan Requirements and Responsibilities

CMS requires every IRIS Service Plan to incorporate strategies to mitigate risk. An individualized back-up plan (back-up plan) is a comprehensive document that addresses contingencies such as emergencies, including instances when the participant's primary caregiver or other service or support provider, excluding an agency provider, are not available for a short period of time. The back-up plan is a participant-focused document developed with the participant's unique needs and circumstances.

An effective back-up plan is comprehensive and accessible to the participant and their back-up individuals. The back-up plan is a resource for those who are unfamiliar with the

participant and their needs, depending on the type of emergency. A back-up plan must address the following components:

1. Contact information for the participant's legal representative, if applicable, and IRIS consultant.
2. Contact information for people who are willing to provide care if a PHW is unavailable or does not report to work as scheduled.
3. Information and contact information to address medical needs, as applicable.
4. Information and contact information to address behavior needs, as applicable.
5. Information and contact information to address medication needs, as applicable.
6. Contact information for suppliers and repairers of medical supplies, as applicable.
7. Information related to the participant's daily schedule.
8. Information to use in the event of an emergency medical situation.
9. Information to use in the event of a home emergency or natural disaster.
10. Additional participant-specific information not captured above.
11. Dates and signature of the participant.

The ICA ensures the participant understands their role in accessing or obtaining any needed funding in the event of individualized back-up plan activation, if the individuals or agencies, excluding provider agencies, will not be providing informal supports. Before providers can be authorized to provide waiver services on any IRIS Service Plan, the provider must enroll with Wisconsin Medicaid through the ForwardHealth Portal. The FEA must verify Medicaid provider enrollment, set up the provider in the DHS enterprise care management system, and provide a start date.

The ICA is responsible for educating the participant and legal decision maker, if applicable, regarding the requirements of maintaining an accurate, functional, and effective individualized back-up plan. This information is in the Participant Education Manual, P-01704 and discussed with the participant during orientation and annually thereafter.

b. Back-up plans and Self-Directed Personal Care (SDPC)

Participants who receive IRIS Self-Directed Personal Care (SDPC) services will be required to maintain a back-up plan that also satisfies the requirements of the IRIS SDPC program. The IRIS SDPC nurse reviews the back-up plan to validate the plan's compliance with the IRIS SDPC program.

c. Participant Responsibilities

Participant health and safety is a top priority. Participants have a responsibility in maintaining their individualized back-up plans are accurate, functional, and effective.

The unwillingness or inability to maintain an accurate and reliable back-up plan may result in the participant's involuntary disenrollment from the IRIS program due to health and safety concerns or due to a general unwillingness to comply with IRIS program policies.

The participant ensures that individuals and agencies identified on the individualized back-up plan are agreeable to their role. The individuals listed on a participant's individualized back-up plan, must provide contact information. There could be denial of enrollment or disenrollment if a participant does not adhere to this requirement. PHWs who are already providing full-time or primary care on the participant's current ISSP cannot be designated as a back-up plan provider.

The participant is responsible for accessing or obtaining any needed funding in the event of individualized back-up plan activation, if the individuals or agencies, excluding provider agencies, will not be providing supports.

d. Initial Back-Up Plan

For initial plans, the back-up plan must be completed, reviewed, and uploaded within the 60-day IRIS program referral period. The ICA uploads the reviewed back-up plan to the participant's document console in the DHS enterprise care management system.

e. Back-Up Plan Annual Review

The back-up plan is comprehensively reviewed by the participant and ICA on an annual basis, prior to the expiration of their existing service plan. This is to ensure continuity of care and maintain the health and safety of the participant. The ICA and participant review and update each section of the individualized back-up plan with new and accurate information, if necessary.

The participant ensures that individuals and agencies identified on the individualized back-up plan are agreeable to their role and provide contact information. This means that providers must first be approved by the FEA and are established in the DHS enterprise care management system as allowable providers.

The ICA ensures the participant understands their role in obtaining any needed funding in the event of individualized back-up plan activation, if the individuals or agencies will not be providing informal supports. Before providers can be authorized to provide IRIS waiver services on any IRIS Service Plan, an FEA must have verified they meet the provider qualifications.

f. Back-Up Plan Updates

The participant maintains the responsibility to inform the ICA of any changes needed to the back-up plan. At minimum, the participant and the ICA review the accuracy and effectiveness of the back-up plan once per quarter and as needed when there is a change in the participant's circumstance. If a change is needed, the participant and IC update each section of the individualized back-up plan with new and accurate information. Any changes made to the back-up plan must be reviewed for accuracy and signed by the participant. Then the IC must upload the signed and updated back-up plan to the participant's document console in the DHS enterprise care management system.

PHWs and agencies identified on the back-up plan that will provide paid services and supports must be established in the DHS enterprise care management system as a provider prior to the implementation of the back-up plan.

g. Individualized Back-Up Plan Data Collection, Reporting, and Monitoring

DHS verifies the completion of Chapter 3.0 of the Participant Education Manual, P-01704 using the form IRIS Participant Education Manual: Acknowledgement, F-01947 and development of an accurate individualized back-up plan through the record review process.

C. IRIS Service Plan guidance

1. IRIS Service Plan Timeframes

a. Implementation

The service plan must be completed, reviewed, or updated:

1. During the 60-day referral period, prior to program enrollment,
2. Annually at IRIS Service Plan renewal,
3. When there is a documented change in condition within the participant's most recent functional screen, and
4. After the annual rescreen (functional screen) is completed.

2. IRIS Service Plan Updates

a. Participant Requesting Updates

The participant may request updates to their service plan, as needed. If a participant would like to make changes to their service plan, such as adding a new waiver service or increasing the amount of a waiver service, the changes must be based upon the participant's identified long-term care needs and associated long-term care outcomes. To determine whether the service plan changes are allowable, the participant must consult the ICA to ensure the participant-requested change to their service plan is needs-based, allowable, cost-effective, and supports the participant with achieving, maintaining, or obtaining their identified long-term care outcomes. Prior to initiating or receiving any changes to their waiver services, the participant is required to update their service plan with their ICA.

The participant must accept and sign any updates made to their service plan that impact their waiver-funded services or supports. The ICA must verify any updates made to the participant's service plan. Signatures must be captured on the service plan and uploaded to the DHS enterprise care management system.

b. Change in Condition

During an IRIS Service Plan update, if there are changes in the participant's condition, a new functional screen may be required. A change in condition may require consultations with the IRIS SDPC nurse or nurse consultants. Within 30 days of a change in condition, the ICA must update the participant's service plan accordingly.

c. Increase to the Participant's IBA

When the participant's functional screen is completed and there is an increase in the IBA, the ICA must enter the new IBA into the DHS enterprise care management system within five business days.

If the new recalculated IBA is higher, the ICA must assist the participant in reviewing and updating the participant's ISSP. The increased funding must first be applied towards any existing budget amendment requests. Prior to assessing and authorizing other service and support needs, the ICA must assist the participant with support, service, and goods prioritization using the same methodology described in Section B.3.e, How to Develop Long-Term Care Outcomes. Increased funding must be applied to address the following domains of self-direction in the order prescribed:

1. Establishing or maintaining a living arrangement personal to the participant.
2. Obtaining or maintaining community-integrated employment.
3. Establishing or maintaining community inclusion.

When evaluating the current ISSP, an ICA must consider the following criteria when reassessing services and supports for a new, recalculated, higher IBA:

- 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)?
- Are all the services and supports identified on the ISSP allowable and cost-effective for this Medicaid waiver program?
- 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 an NOA and appeal rights.

d. Decrease to the Participant's IBA

When a participant's functional screen is completed and there is a decrease in the recalculated IBA, the ICA must assist the participant in updating their IRIS Service Plan within 90 days to ensure the participant has the necessary waiver funds to cover their waiver services. The ICA and participant must review the existing ISSP and assist the participant with support, service, and goods prioritization. The recalculated IBA must address the following domains of self-direction in the order prescribed:

1. Establishing or maintaining a living arrangement personal to the participant.
2. Obtaining or maintaining community-integrated employment.
3. Establishing or maintaining community inclusion.

When evaluating the current ISSP, an ICA must consider the following criteria when reassessing services and supports for a decrease to the participant's IBA:

- 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)?
- Are all the services and supports identified on the ISSP allowable and cost-effective for this Medicaid waiver program?
- Are all the services and supports identified on the ISSP addressing an unmet need, rather than duplicating an existing service on the plan?

The 90 days allows the IC to meet with the participant and discuss the current identified needs and services and supports identified on the ISSP. During this discussion, the IC must:

- Make adjustments to current waiver services in their ISSP to align with the new IBA, with the participant's approval.
- Determine if a reduction of a service or support is required, then the ICA issues an NOA.
- A NOA must be issued to terminate waiver services no longer needed.
- Submit a budget amendment request to DHS, if needed.

The ICA must update the IBA when the ISSP is updated. The DHS enterprise care management system automatically denies service authorizations submitted overbudget. A decrease to the participant's IBA is an update to their service plan which requires the

participant's approval and signature. The approval and signature must be captured on the service plan with an effective date.

3. IRIS Service Plan Annual Renewal Requirements

Annual plan renewals are the development of new IRIS Service Plans. Annual plan renewals may occur no earlier than 90 days from the expiration of the current plan. Annual service plan renewal requirements mirror the prescribed processes identified and described in the IRIS Service Plan Policy.

a. Service Plan Renewal Requirements

When completing or updating the IRIS Service Plan, the participant receives support from their ICA in completing update requirements. Service plan update requirements mirror the prescribed processes identified and described in Section B.3.a-g, Individual Support and Service Plan (ISSP) Planning and Development.

1. The participant, with support from their ICA, reviews and updates their assessed needs and preferences.
2. The participant, with support from their ICA, identifies, reviews, and updates the participant's achievable long-term care outcomes.
3. The participant's strategies and funding sources for establishing, obtaining, and maintaining the participant's long-term care outcomes are identified and documented.
4. The ICA assists the participant with support, service, and goods prioritization using the same prioritization methodology described in Section B.3.f, How to Develop Strategies to Address Identified Long-Term Care Outcomes.
5. The ICA reviews and updates the participant's LTC Needs Panel to ensure the following are complete and accurate:
    a. The participant's identified long-term care needs are being met which includes both waiver and non-waiver services and supports that are used to meet the needs of the participant in the community and in their home; and
    b. The participant's Choice of Setting information reflects what is important to the participant and their living arrangement needs and preferences.
6. Review, update, and confirm the participant's Emergency back-up plan for completeness and accuracy.
7. If the participant receives residential services in a provider-owned or provider-controlled residential setting, the ICA and participant must complete a new HCBS Settings rule modification form for completeness and accuracy, at least 30 days prior to the start of the new service plan year. See Section B.2, Home and Community-Based Services (HCBS) Settings Rule for information about the process.
8. The ICA, in collaboration with the participant, reviews, updates, and confirms the participant's Essential Service Provider Agreement and Participant Provider Service Agreement, as applicable.
9. When the participant's IRIS Service Plan is agreed to and completed, the participant and their legal representative, as applicable, sign the service plan to acknowledge and accept any updates made to their service plan.
10. The ICA must verify the service plan for completeness and accuracy.

D. Service Authorization

You can find the IRIS Service Plan: Service Authorizations, P-03501 on the DHS website.

E. Essential Service Provider Agreements

1. Background

The Centers for Medicare & Medicaid Services (CMS) requires information sharing as integral to ensuring the health and safety as well as continuity of care for people receiving Medicaid long-term care waiver services, including all IRIS waiver participants. The Essential Service Provider Agreement form fulfills this CMS requirement.

The Essential Services Provider Agreement Form facilitates the sharing of the IRIS participant's pertinent information as it relates to their health and safety. The form is shared with the participant's essential service providers who are involved in the care of the participant. Sharing information with the participant's essential service providers promotes the provider's sense of belonging to the larger team supporting the participant. The shared information can be helpful in expanding a provider's perspective from the narrower focus of delivering a specific service to seeing their contribution to the participant's overall health, safety, and life.

2. What is an Essential Service Provider?

a. Definition

An 'essential service provider' is a provider who delivers specific waiver-funded services and supports and has regular, direct contact with the participant.

1. "Regular" means contact that is scheduled, planned, expected, or otherwise periodic.
2. "Direct" means visual interaction with a participant, whether in person or over video conference.

b. Applicable Providers

The following service providers are considered essential service providers:

1. Adult day care
2. Daily living skills training
3. Day services
4. Prevocational services
5. Respite
6. Supported employment—individual and group
7. Nursing services
8. Residential services (1-2 bed AFH)
9. Residential services (other, includes 3-4 bed AFH and RCACs)
10. Support broker services
11. Supportive home care (excluding chore services)

c. What Information Is Shared With Essential Service Providers?

An essential service provider must receive pertinent service plan information to effectively ensure continuity in the participant's care. At minimum, the following information is required to be shared with all essential service providers:

1. Demographic information:
    a. Name of participant
    b. Plan start and end date

c. Name of provider or agency
d. IRIS consultant agency
e. IRIS consultant
f. Fiscal employer agency

2. Achievable long-term care outcomes
3. Strategies for achieving or maintaining achievable long-term care outcomes
4. IRIS waiver-funded services and supports

For participants receiving residential services in a provider-owned or provider-controlled residential setting, the current HCBS Settings rule modification form must also be distributed.

The participant may choose to provide additional information or details to their essential service providers; however, it is not a program policy requirement.

3. Essential Service Provider Agreement Form

a. ICA Requirements

The ICA discusses the CMS requirement with the participant which includes reviewing and explaining the requirement for sharing the participant's information with essential service providers. The ICA must implement the requirement to be compliant with the federal regulations.

During the discussion, the ICA must ensure the participant understands their responsibilities and how to answer questions from essential service providers. The ICA ensures the participant understands they will be provided with a list of their achievable long-term care outcomes, strategies, and services and supports to distribute to their essential service providers.

The ICA must enter a case note when they meet with the participant to ensure they understand the form, their responsibilities and how to answer questions from essential services providers. The case note must document the date the essential service provider forms were provided and a detailed note about the discussion with the participant.

The participant, with support from the ICA, must distribute the forms and gather signatures from all essential service providers. For participants completing their initial service plan, signatures must be gathered within 90 days of enrollment. If the form is provided during a monthly or quarterly in-person meeting, the ICA must include this information in the case note.

Unless the participant requests electronic copies, the ICA must provide hard copies of the form to the participant for distribution to their essential service providers. Providers may send signed forms to the ICA or participant. If the ICA receives a signed form, the ICA must upload the document into the DHS enterprise care management system.

b. Participant Requirements

The participant is responsible for returning all signed forms to the ICA via mail, electronically, or in-person.

1. **Initial and Annual Renewal of the Service Plan**
   The participant is responsible for distributing and gathering signed forms from their essential service providers. If the participant is completing their initial service plan, the form must have returned signatures within 90 days of enrollment.

   For the annual service plan renewal, all essential service providers must submit signed forms within 90 days of the new plan start date.

2. **Ad-hoc Service Plan**
   For any newly added essential service provider identified and added to the service plan after the plan year begins, the participant must redistribute the form to all current essential service providers. For existing essential service providers, the redistributed form is for informational purposes. The participant must obtain and distribute a signed form from the newly identified essential service provider within 90 days of the change.

c. Essential Service Provider Refusal to Sign

1. **ICA Responsibility**
   If an essential service provider notifies the ICA to acknowledge receipt of the form and indicates their refusal to return a signed form, the ICA must document the refusal in the DHS enterprise care management system.

2. **Participant Responsibility**
   If an essential service provider notifies the participant to acknowledge receipt of the form and indicates their refusal to return a signed form, the participant must notify their ICA. The ICA must document the details of the refusal in the DHS enterprise care management system.

d. Participant Compliance

The unwillingness or inability to comply with Essential Service Provider Agreement responsibilities may result in a program requested disenrollment from the IRIS program due to health and safety concerns or due to a general unwillingness to comply with programmatic requirements. For additional information, refer to the Program Enrollment Policy, P-03547.