

**IRIS – Self-Directed Supports**  
Policy and Procedure Related to  
Aging and Disability Resource Center Functions  
Version 1

**Structure of IRIS Self-Directed Supports Waiver**

The programmatic structure for IRIS is provided by two statewide contracted agencies. These agencies were selected through competitive Department procurement procedures. The Independent Consulting Agency (ICA) is managed through a contract with The Management Group (TMG). The Financial Service Agency is managed through a contract with Milwaukee Center for Independence.

The **ICA** is responsible for initial intake of an individual who has chosen IRIS. This includes assisting the person in selecting a consultant who will work in partnership with the person to plan for needed supports, both informal as well as publicly funded supports and services. The support plan developed must remain within the person's individual budget and must assure that the person will be healthy and safe. The Consultant must also assure that the consumer is oriented to IRIS policy and procedure, including the steps the consumer may take if he or she has unexpected needs or has complaints about his/her services or supports.

The **ICA** is responsible for developing a network of Consultants who will work in partnership with the consumer. This will include assurance that the person has the necessary experience to fulfill this role and meets background check requirements. The ICA must assure that the Consultants have the capacity to meet all programmatic requirements while assuring the highest level of self-direction for the consumer. The ICA is also responsible for consumer training and support so that the people who select IRIS have the information needed for successfully managing all supports and services to meet their needs.

Finally, the **ICA** maintains a 24-7 Call Center. The Call Center assures that the IRIS consumer always has immediate access to a knowledgeable person to problem-solve crisis needs. Consumers are oriented to this resource during the plan development process. Also each individual will develop back-up plans for typical situations such as a provider who doesn't show up as scheduled, equipment failure or other intermittent needs that can be anticipated based on individual support needs. This advance planning should reduce the number of occasions that the person will need the assistance of the Call Center. The Call Center also meets basic business needs of the program including data tracking, collecting federally required information, and assuring that all waiver participation requirements are met.

The **Financial Service Agency** assures that all services are paid according to an individual's plan. The FSA provides training to the consumer about his/her obligations for financial accountability. The FSA will also work with the providers selected by the consumer to orient the provider to programmatic requirements. The FSA processes all payments to service providers and other vendors. This will include completing encounter data and employer functions such as payroll and payroll taxes. If providers have questions about payment for services rendered, or want to assure that the service they are delivering will be reimbursable, they will work with the FSA to address these issues. The FSA is also responsible for completing the background check process for any service type that requires this safeguard.

### **Functional and Financial Eligibility**

Individuals who wish to participate in IRIS must meet the following criteria in order to qualify:

- Reside in a Family Care county;
- Have a nursing home level of care as determined by the LTC Functional Screen (an updated LTC FS will display SDS Waiver eligibility status); and
- Meet Medicaid Home- and Community-Based waiver financial and non-financial eligibility criteria.

IRIS will follow the existing financial and non-financial eligibility policies now in place for the Home- and Community-Based waiver programs. As Family Care and IRIS are implemented in a county, people already eligible for the waivers will be eligible for IRIS, if they choose to participate in IRIS. There would be no need for IM to re-determine eligibility for an HCBW participant solely because s/he chooses IRIS over Family Care. People coming off the waiver wait list who choose IRIS will have their eligibility determined exactly as it would be done for any of the existing Home- and Community-Based Waivers.

#### **Functional Eligibility – change in condition, change in IRIS budget, consumer request**

The ADRC completes an updated LTC FS at the request of a consumer. An updated LTC FS is also needed anytime the consumer has experienced a substantial change in condition that is expected to endure on a long-term basis.

If a consumer has experienced a short-term change in condition, for example increased assistance with Activities of Daily Living immediately following surgery, but the change is expected to be short-term, the consumer would work with the ICA to access exceptional expense funds to meet this short-term increase in needs. Short-term changes in condition will not require an updated LTC FS.

If a consumer has a substantial, long-term change in function, then a change in condition LTC FS will be requested from the ADRC by either the consumer or the ICA. This would require a review of updated records and potentially a home visit to assess the change in condition directly.

If a consumer or ICA has concerns that a LTC FS is inaccurate, when compared to his or her functioning, then the ADRC would review the LTC FS and revise if determined necessary.

The ADRC will also need to complete an annual recertification of functional eligibility using the LTC FS. The ICA and FSA will establish procedures for tracking the person's annual recertification timeline and will refer the consumer to the ADRC with adequate time for the process to be completed within the required timeline.

The ADRC will follow current procedures related to consumer notification as a result of loss of eligibility due to changes in a person's functioning. The consumer also retains the right to appeal any LTC FS that he/she believes to be inaccurate.

Consumers will have access to two budget adjustment procedures that will not require a change in the LTC FS: (1) the Budget Adjustment Request process and (2) the Exceptional or Unexpected Needs Fund process. The consumers access these processes through the ICA. The Department will handle notification of appeal rights to individuals, as appropriate, related to any budget change requests that are reduced or denied.

### **Functional Screen Access**

The Department will assure that ADRCs have access to screens for all consumers within their catchment area. The ADRC will have access to the LTC FS without the need for transfer requests or release of information forms. However, the ADRC staff are bound by strict confidentiality requirements, as well as requirements related to Protected Health Information. This means that ADRCs will only access an individual's LTC FS when a specific business function required by the ADRC is being performed. ADRCs are to access the LTC FS only for consumers residing in the county(ies) they serve.

The ICA will be given Read Only Access to the LTC FS for individuals who chose IRIS and enroll. Prior to enrollment in IRIS, the ADRC will release the LTC FS to the ICA with the consent of the consumer. The vehicle for documenting consumer consent is the signed IRIS Enrollment form. The ICA will need to receive an electronic or faxed version of the LTC FS for planning purposes.

### **Financial Eligibility - Cost Share Obligation**

If a person has a cost share obligation in order to meet financial eligibility requirements, he or she will need to pay this on a monthly basis. If the person is transitioning between long-term care programs, for example Family Care to IRIS or IRIS to Family Care, then the person only pays one cost share per month. This means that the program the person is exiting will collect the cost share from the person for the transitional month. The new program will begin to collect the cost share the following month. The FSA collects the cost share from the person enrolled in IRIS. The MCO collects the cost share from a person enrolled in Family Care or Partnership.

### **Estate Recovery**

All Medicaid estate recovery policies apply equally to Wisconsin's Long-Term Support Programs. Thus, a consumer's choice of IRIS will not exempt the person's assets from estate recovery upon the person's death.

### **Offering Choice to Current Managed Care Enrollees**

The Department is aware that the requirement to notify all current Managed Care enrollees of this new option for services could create a burden on ARDCs. Thus, the Department has established a time-limited process for initial conversations with potential consumers who respond to the notification of choice letter. The Department is contracting for the establishment of a toll-free IRIS Information Line. The role, scripted response and call flow chart for this function are provided for your information in the attached *IRIS Notification and Enrollment Process for Current Enrollees in Family Care or Partnership* document. Sections Two and Three relate to the IRIS Information Line processes.

The ADRC will follow up with Managed Care members who express interest in changing to IRIS after a discussion with the IRIS information line. Please refer to the ***IRIS Notification and Enrollment Process for Current Enrollees in Family Care or Partnership*** document for the complete outline of this process. Section Four of this document outlines the steps the ADRC will complete with the consumer. If the consumer opts for IRIS, then with the consumer's consent, the MCO is notified of the consumer's intent to enroll in IRIS and disenroll from Managed Care. The appropriate enrollment/disenrollment forms are completed by the ADRC. Please see additional directions below.

### **Updated Enrollment Counseling Materials**

Effective July 1, 2008 all ADRCs will have access to updated Enrollment Counseling materials. This will include the addition of comparable information for IRIS and will assure that the ADRC has tools needed to provide clear and unbiased information to the consumer. Specifically, these are the new items available:

- Update of the 1/18/08 *Resource Centered Technical Assistance* document (by 8/1/08).
- Flow chart describing the SDS Option within MC and IRIS- SDS Waiver.
- IRIS Brochure – broad description of the program for consumers.
- Independent Consulting Agency - description of this Agency's role – Brochure.
- Independent Consultant – roles and responsibilities.
- Financial Service Agency– roles and responsibilities.
- Consumer roles and responsibilities in IRIS.
- Allowable Services.
- General Cost of community supports document.
- IRIS Consumer Handbook (by July 1, 2008).
- IRIS Website information for consumers and others (by July 1, 2008).

### **Enrollment and Disenrollment**

Once an individual's IRIS service plan is developed and approved, the ICA will provide the final enrollment information to the ADRC. This will include communication of a **Start Date** to the ADRC. The ADRC will enter the **Start Date** in the **PPS Self-Directed Supports Module**.

The ADRC will then complete the **IRIS Enrollment and Family Care Disenrollment forms** to communicate a change in status to the Economic Support Unit (ESU).

The details related to the completion of the **Enrollment/Disenrollment form** is dependent upon the person's programmatic status at the time of IRIS enrollment.

### **Family Care or Partnership to IRIS**

If the consumer is currently enrolled in Family Care or Partnership, then the person will be disenrolled from the managed care option effective the day prior to the IRIS **Start Date**. The form will indicate that the consumer has enrolled in IRIS and will include the **Start Date**. The ADRC forwards this form to the ESU staff per usual protocols between the ADRC and the ESU. The ADRC will work with the consumer/ICA to notify the MCO of the disenrollment date so that the MCO can terminate all services on the end-date. The ADRC enters the IRIS start date in PPS.

### **County-Managed Waiver to IRIS**

If the consumer is a participant in the CIP, COP or Brain Injury Waivers, as operated by county agencies in the process of rollover to Managed Care, then the person will have an end-date entered in HSRS by the county waiver agency for the “historic” waiver effective the day prior to the IRIS **Start Date**. The form will indicate that the consumer has enrolled in IRIS and will include the **Start Date**. The ADRC forwards this form to the ESU staff per usual protocols between the ADRC and the ESU. The ADRC will work with the consumer/ICA to notify the County Waiver Agency regarding the waiver end-date so that the county and providers are notified to terminate all services on the end-date. The county waiver agency will enter an end date in HSRS and the ADRC will enter the IRIS start date in PPS.

### **Person from the Wait List or New Applicant Chooses IRIS**

If the consumer has been on a wait list for long-term supports, then the ADRC completes the IRIS enrollment form and sends it to the ESU per usual protocols between the ADRC and the ESU. The ADRC will enter the IRIS start date in PPS.

### **IRIS to Family Care or Partnership (in the future)**

If the consumer is currently enrolled in IRIS, then the person will be disenrolled from IRIS effective the date the person chooses to enroll in a Managed Care option. The form will indicate that the consumer has enrolled in Managed Care and will include the **Enrollment Date**. This form is forwarded to the ESU staff per usual protocols between the ADRC and the ESU. The ADRC will work with the consumer to notify the ICA of the disenrollment date so that the ICA can terminate all services on the end-date. The ADRC will enter the IRIS end-date in the PPS.

### **Guidance to Economic Support Units**

The Department has issued guidance through an Operations Memo to Economic Support Units (ESUs) to process IRIS enrollments consistent with policy and procedure for Medicaid Home and Community-Based Services Waivers. This includes entry of the IRIS start date into the CARES system and a code that identifies the person as an IRIS consumer. The entry of this date will prompt an automated notification to the MMIS system. This assures the IRIS consumer access to all Medicaid Fee-for-Service benefits through Medicaid.

### **Urgent Services Agreement**

An urgent services agreement, when people are served while financial eligibility is pending, is only available within the Managed Care system.

### **Immediate Need for Service**

When a person interested in IRIS has an immediate need for service, the ICA will work with consumers to develop a temporary plan to deliver services quickly. The ICA would then continue to work with the consumer to develop an ongoing service plan within 90-days.

If the person did not have Medicaid eligibility prior to their IRIS start date, then retroactivity criteria for Medicaid eligibility apply and are determined by the ESU.

**Person’s Right to Choose and Change Programmatic Options**

A consumer has the right to change the option selected for the delivery of his/her long-term supports at any time. The consumer who wants to exercise this right will contact the ADRC and the ADRC will provide disenrollment counseling. The ADRC would also provide enrollment counseling related to Managed Care and other options such as Medicaid Card services that are options for the consumer. Once the person has made his/her choice the appropriate **Enrollment/Disenrollment forms** are completed as noted above.

There are no limits on the frequency with which a person can change programs, although if a person changes programs multiple times within a one-year timeframe the ADRC may work with the consumer in an attempt to determine the issues the person is facing with the decision-making process.

**Benefit Package**

The IRIS Self-Directed Supports Waiver is a Medicaid Home and Community-Based Services Waiver. The administrative functions of the program are provided through the ICA and the FSA. Ultimate oversight and responsibility for IRIS remains with the Department. Each person who selects the IRIS option will have access to the Independent Consultant and the FSA. These agencies assure that federal waiver requirements are followed, quality of services and safety for each individual is assured and that all funds expended are for waiver allowable services and in accordance with required state and federal regulations. These functions are funded through the Department and do not affect a person’s individual budget for services.

The person is able to use his or her individual budget for a broad array of services. It is important to note that the IRIS program will promote people’s use of informal supports from family, friends and members of their community. The person will also have public funds within the individual budget to purchase supports and services needed within the community. IRIS allowable services are listed below. The IRIS waiver contains a very flexible and unique service called Customized Goods and Services. The definition of this service is also provided below.

**IRIS Self-Directed Supports Waiver - Allowable Services:**

Adaptive Aids
Adult Day Care
Adult Foster Care (1-4 bed)
Communication Aids/ Interpreter Services
Community-based Residential Facility
Consumer Education and Training
Counseling and Therapeutic Resources
Customized Goods and Services (see definition below)
Daily Living Skills Training
Day Services
Home Delivered Meals
Housing Counseling
Housing Start-up
Home Modification

Personal Emergency Response System
Prevocational Services (excludes sheltered work)
Residential Care Apartment Complex
Relocation Related Utility Costs
Respite Care
Skilled Nursing (only services not covered/authorized by MA state plan)
Support Broker
Supportive Home Care
Supported Employment
Transportation
Specialized Medical Equipment & Supplies
Vocational Futures Planning

**Customized Goods and Services** refers to a service, support or good that enhances the consumer's opportunities to achieve outcomes related to living arrangement, relationship, community inclusion, work and functional or medical status. Each service, support or good selected must meet each of the following four criteria and at least one of the criteria as stated in the second list.

Must meet all four of the following criteria:

1. The item or service is designed to meet the participant's functional, vocational, medical or social needs and also advances the desired outcomes in his/her Individual Service Plan;
2. The service, support or good is documented on the Individual Service Plan;
3. The service, support or good is not prohibited by Federal and State statutes and regulations, including the State's Procurement Code;
4. The service, support or good is not available through another source or experimental in nature.

AND

Must meet at least one of the criteria in the following list:

- The service, support or good will maintain or increase the participant's safety in the home or community environment;  
OR
- The service, support or good will decrease or prevent increased dependence on other Medicaid-funded services;  
OR
- The service, support or good will maintain or increase the participant's functioning related to the disability;  
OR
- The service, support or good will maintain or increase the participant's access to or presence in the community.

### **Residential Settings**

People may live in any community setting that they choose and still select IRIS. However, the IRIS Individual Budget is not adjusted to provide funding for residential settings on a long-term basis. Funding may be added to a person's individual budget for short-term needs through the Exceptional Expense Fund in the following limited circumstances:

- For an individual residing in a residential setting upon enrollment in IRIS but with a plan to relocate within three months;
- For an individual with a short-term increase in his or her needs where a residential setting is an effective way to meet those needs;
- For an individual as part of a back up or crisis plan, which could include meeting the person's needs when a typical caregiver is unavailable; or
- For the purpose of respite for the individual and their typical caregivers.

### **Room and Board**

Payment for room and board expenses are specifically prohibited within federal Medicaid regulations. Therefore, individual budgets may not be used to meet these expenses in any setting.

### **Access to Medicaid State Plan Services**

IRIS is not a managed care program. Therefore, the consumer retains access to all Wisconsin Medicaid State Plan Services (Medicaid Fee-for-Service). This means that the person can access medical, dental, prescriptions, in-patient hospitalization and other medically oriented community services through Medicaid certified providers. This includes important services such as Personal Care, Home Health, Private Duty Nursing, Mental Health Services, Durable Medical Equipment and Supplies, and Speech, Occupational and Physical Therapy services. These services are subject to Medicaid policy and procedure, including prior authorization for some services. These services do not affect the person's individual budget amount. In the future, the Department intends to develop and offer the self-directed personal care service to IRIS consumers. However, this is not yet an option.

### **Legally Responsible Individuals and Family-Members as Paid Providers**

IRIS consumers are permitted to develop plans that utilize informal and unpaid supports from family, friends and members of their community. There are circumstances when the most effective solution to meeting an individual consumer's outcomes are met by the ability to hire legally responsible individuals or family members as paid care providers. The following services permit the use of qualified legally responsible people or family members as service providers. These services are: 1-2 bed Adult Family Home; Customized Goods and Services; Daily Living Skills Training; Nursing Services; Respite; Specialized Medical Equipment and Supplies; Specialized Transportation; Supported Employment; Supportive Home Care; and Support Broker – Agency. These individuals must meet all service provision requirements and must agree to background checks as required by the service type.

**Complaints and Grievances**

If the consumer has a complaint or grievance related to a service provider or the FSA then the concern is to be directed to his or her Independent Consultant. Concerns about the Independent Consultant are to be directed to the ICA. Concerns about the ICA are to be directed to the Department.