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

F-01922 (03/2018)

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: IRIS Advisory Committee			Attending: **Committee Members:** Anne Karch, Carrie Bublitz-Cardarella, Fil Clissa, James Valona, Kathi Miller, Kevin Fech, Kimberly Rux, Mitch Hagopian, Rose Bartel **DHS Staff:** Curtis Cunningham, Amy Chartier, Grant Cummings, Ann Lamberg, Christian Moran, Sheldon Kroning, Christine See, Kyle Novak, Kim Jewett, Leon Creary, Shelly Glenn
Date: July 12, 2022	Time Started: 9:30 am	Time Ended: 1:27 pm	
Location: Zoom Webinar			Presiding Officer: Curtis Cunningham, Assistant Administrator

Minutes

Committee Members Absent: Jason Valona, John Donnelly, Martha Chambers

Meeting Call to Order

- Introductions
  - Meeting called to order by Curtis Cunningham
  - All committee members and DHS staff present introduced themselves

Welcome Alicia Boehme, Director BQO.
May minutes reviewed. No discussion. Motion to approve by Kathi Miller. Second by Fil Clissa. Approved unanimously.

Department Updates, presented by Curtis Cunningham

MROS, Fee Schedule and IBA Budget will be addressed later in the meeting. Independent Living Plan will be reviewed later.

25 projects on the ARPA grant, $7M in funds available. Need to be compliant by March 2023.

Utilization of IRIS funding to build intentional communities for persons with specific disabilities will be brought to the IAC for discussion.

Working on developing EVV Hard Launch process. Continued pressure for same. Will bring it back to committee for input prior to launch.

In the process of biennial budget, and input is encouraged.

Committee feedback:
For Anne's specific participant, some things have come up including issues with hiring. She believes some of it is pay. Hard to hire when fast food is hiring at $17-18/hr. Tried to hire with staffing agencies, but agencies were not taking new clients. People are going to nursing homes because PCWs cannot be found. Concerned with only 3 participants on this call and with 3 empty seats on the committee. Curtis agreed that workforce is tough right now. There has been the 5% increase in wages. DHS has a career ladder marketing campaign that they're working on. There's nothing we can do immediately, but there are projects in progress. The caregiver survey is out right now and will

provide some necessary feedback for DHS. Providers are reminded to fill out survey. It is an agency-based survey and not self-directed. DHS is currently working on SDPC survey.

Mitch added that there are problems with care quality that have to do with the inability to staff homes. Have heard Molina is purchasing My Choice Wisconsin. Concerned because they already own TMG and SDPC oversight agency. Does the department have feedback and what is the DHS role in the process? Curtis mentioned that DHS is still evaluating the situation. There are number of ways these things can happen. Merger, acquisition, etc. Office of the Commissioner of Insurance has a large part of the process. DHS's role is having conversations about recertification of contracts or whether it will be assigned to new entity. Depending on the arrangement, this may be a notification to members or letting them know they can change. These conversations are fluid and can be changing. DHS has the authority to reassign and review contracts. There is no prohibition from a company having a FC and IRIS entity. From a CMS standpoint of conflict free management, there is no case manager and provider conflict. Mitch expressed concern that they will be in competition for the same client base. They want to participate in the process and express comments. Next IAC Mtg would be a good time to discuss. My Choice Family Care and Care Wisconsin merger took place rapidly, and there is some concern this may as well. Curtis indicated that DHS does not believe that would be the case in this situation. DHS needs to consider the contract provisions that need to be in place, preserve options counseling at ADRC level, and make sure members know they have the option to change at any time.

Rosie fears we are at the point where agencies are not taking new participants. There are problems with different rates. Usual and customary is different from one place to the next as far as wages. She is aware of someone who should be in her own home yet, but they couldn't find a home care agency. The individual was held in the hospital for 15 days to get an assisted living spot. There are concerns that facilities are closing as well. There are fears that some folks are going to be dying in their home alone. We are dealing with real people's lives. Bellin School of Nursing went back to 3-year program from 4-year program to get more RNs quicker. We are reactive and not proactive right now. Would like to see participants involved in workgroups/discussions. Curtis added that DHS is seeing a backlog with hospitals getting individuals into nursing homes/assisted living. Trying to address the situation as we are hearing across avenues of this issue. We believe that many of the initiatives we are funding are proactive work. There are open forums with direct support care workers and providers. We will also seek opportunities for feedback from participants.

Fil added that if today is not the day to have the conversation, then we need to discuss the inconsistency of pay and information people are receiving next time. Training also needs to be addressed. In a self-directed model, there needs to be training for participants. The process to make changes is cumbersome and participation is burdensome.

James mentioned that this is not specific to IRIS. All agencies are having these issues. We have a caregiving crisis throughout the state.

Anne said they are seeing issues in other businesses as well. Rosie and Anne have a history of working on policies and issues. Would like a workgroup of participants. Curtis added that DHS is working on continuing the conversation regarding rates of usual and customary. We now have some specific information with the survey. We will all have to work through this to preserve self-direction and navigate through this.

Fiscal update presented by Grant Cummings

We have previously provided an overview of fee schedule. Provider workgroup meetings are continuing. Provider survey to be issued in the fall to inform the rate development work. Still trending to have the rates established in July 2023. IBA - targeting the Fall. There is some updated information

they are reviewing. It's almost ready to get uploaded in system, and it will be brought back to the committee before-hand.

MROS update was 4% due to inflationary concerns. Went forward with adjustment for July 1 with that change.

Mitch requested clarification on the reduction from July 1st. Was there a reduction July 1st or was it two 6% reductions? Grant clarified that last July was first step down. Second step down was this July but it was 4% from first indicated rate amount.

ARPA Updates presented by Curtis Cunningham

There will be two rounds of grants in Aug $15M per grant round to support and improve HCBS system. Proposals will be reviewed and evaluated for sustainability and impact on members. Requesters needs to be a non-profit or provider to request funding. We would like to see collaborations with ICAs and grass roots organizations. Also looking at scalability for trainings to be state-wide. Programs will begin as a pilot then potentially added to contracts in the future. It's kept pretty open right now. $2M cap per grant. Looking to have a summit at the end of the grant period. The Independent Living Plan is to address the pre-Medicaid population. It would allow people with disabilities to receive services prior to enrolling in Medicaid so they can ideally divert the need to divest their assets and move into assisted living. There will be $7,500 for each participating individual to receive HCBS benefits. It will be run through ADRCs. Eligibility would require one ADL or specific diagnosis. We will evaluate the impact of this pilot and see what savings might be. Other states have shown cost effectiveness of a program like this. We will seek an 1115 waiver or seek that authority, if successful, to receive the 60% federal match. 5000 individuals will be selected for one year.

Kathi wondered how advocacy will be addressed for those folks. Curtis indicated it will be run thru ADRC. Not in the existing program. They could access advocacy for non-publicly funded services. Mitch asked if it would be statewide. Curtis said that with the limit of 5000, we are thinking 10 ADRCs. We will do a request for applications. DHS will request population projections. It will be interesting to see how long it will take to get 5000 folks to participate. For the elderly population, we are getting people already in assisted living when coming into Family Care. We are looking to get involved earlier to see if they need a wheelchair or 5-10 hours a week of personal cares to keep them from assisted living and stay in their own home. Another concern is that people can't leave the hospital because they don't have the basic limited supports to get home. There is no presumptive eligibility for long-term care. Curtis shared the ARPA Funding Page and reviewed it.

Comments by Rosie before PHE update after Public Comment: She has been having issues with background checks. Has been asked three times, and her worker has submitted three times. Sheldon indicated he would follow up with Rosie outside of the meeting.

Public Health Emergency Unwinding Update presented by Ann Lamberg

There is an Aug 16 deadline to see if the PHE will end Oct 16. Workgroups continue to meet. Ombuds, ADRC, etc. Sharing tools and resources with ICAs. Working on how to monitor the functional screens.

Public Comment

Ramsey Lee: Thank you for the hard work of the members. He agrees with Anne's comments on staff shortages. He is having trouble finding workers. He would like to see a continuing development of partnering with high schools for care workers.

Andy Thain. Wondering why the minimum rates for supportive home care are different that personal care workers - $16/hr vs. $10.50/hr. He did a budget amendment to change the rate of pay for his supportive home care. Thank you for the 5% increase in personal care, now increase the supportive home care rate.

Barbara Katz: Family member is a participant. 1. Hopes rates are considered in all positions. 2. Usual and customary rates need to be more consistent and transparent. Consider the geographic location as well. 3. Better coordination between the FEAs and ICAs. When finding new workers, they have to tell the ICA they have a new hire, and they have to reach out to the FEA to send the DocuSign packet. Can the IC coordinate the process instead of requiring participants to make multiple phone calls?

Mary Swifka: Family member is in the program. Requires cares of 24 hours a week. PCW is paid $14/hr while the agency rate is $28//hr. Rates for personal cares need to be more transparent. Local businesses are paying much more for positions in other areas such as retail and manufacturing. She does the same work as the care workers and does not take payment for that. She would like to see whatever would be paid to her go to the care workers.

Melissa Douglas: Need remote services help for IDD. She would like references for obtaining remote services for IDD individuals. Amy Chartier provided the link in chat: https://www.dhs.wisconsin.gov/publications/p03081.pdf

Lawrence Brown. Concerned with EVV requirements and caregiver rates. Need to keep workers happy. Worried about the shortage in workers. Propose increasing the usual and customary rates.

Julie Burish: Care workers within Waukesha County have different rates. She has coordinated with other program participants to "share" great worker experiences. They often find the ICAs are paying different rates. Need to be consistent and transparent. Increase in rates should be a budget adjustment and not a budget amendment. There should be budget authorization training of ICAs. This training might be a great grant opportunity. Paperwork is taking too long to process. Currently waited 3 weeks for processing.

Statewide Transition Plan presented by Christian Moran

Reviewed presentation. There will be open public comment beginning in September for one month. There are 30 in MCOs not in compliance. Smaller numbers of non-compliance in ICA/FEA - 7 to 10 at most. Looking for feedback on Prong 3 of the Heightened Scrutiny. This can be an agenda item or feedback can be sent to Shelly.

Mitch had a question regarding Slide 12. There are 15 new settings requesting review - are they new places? Kaycee said they are a mix of new and existing that have requested review. Mitch referenced the DQA Provider Search website for licensed facilities and asked how to find out if a non-licensed facility is compliant. Christian indicated there are only 2 non-residential facilities that are NOT in compliance out of 370 total. Curtis said DHS is working on a collection system for 1-2 Bed AFHs as an ARPA project. We have a team in IRIS that does confirmations for 1-2 Bed AFHs which is communicated through provider enrollment. Mitch asked what the criteria was for those as some are quite isolated programs. Curtis indicated that there was a survey done, and they were required to remediate based on survey answers. Most were able to come in compliance. We have the other abilities in the third prong and other advocates to become involved in noncompliance. Mitch doesn’t recall anything that talked about the non-res settings. Were the facilities tagged for remediation made public? If they weren't, can we see what their remediation questions were? Curtis explained that the reason there is a difference are the ones in heightened scrutiny in Prong 1 and 2 will be residential. The non-residential fall under same process as residential.

Ann Lamberg added that there were several non-res providers that had a remediation plan, and they successfully completed the remediation. The team worked closely with the non-res providers to become compliant. Mitch stated that the 3rd prong has been there from the beginning, and it's odd that not one was found to be noncompliant. Especially with the sheltered workshops and other settings. Curtis said that neither State nor CMS have defined authority under Prong 3 outside of the checklist. Mitch said they are aware of some facilities that appear to be obviously isolating. He wondered if there can be a records request made to DHS for documents submitted as a part of HCBS Compliance. Curtis indicated that would likely be an open records request but is also agreeable to discussing at additional meetings. Mitch asked if there is any information regarding the CMS Site visit feedback. Christian stated that the official report has not issued yet. He believes that some of the older settings may have raised a few questions. Fil asked what some of the non-compliance issues were. Curtis answered that they included locks on doors, access to funds, visitors at any time, and the ability to come and go. Fil added that it's good to have policy, but we also need to develop the HCBS culture. Participants need to know what their rights are.

Mitch asked if there is discussion about setting up a reporting system if they see something in violation of the settings rule? Curtis said that these are all conversations that need to be had. DHS is waiting for CMS's expectations on that third prong.

Ombudsman Update presented by Kathi Miller, Board on Aging and Long Term Care

Leslie Stewart is managing attorney for DRW. They handle ombudsman services for 18-59 years old. BOALTC is over 59. They work together and confer before this meeting to present.

- Wages are a big issue. Usual and customary has come up many times. It's insurance lingo but IRIS is not an insurance. Glad others are voicing what they are seeing.
- Leslie had a case Kathi hasn't incurred yet. DQA has a misconduct registry reporting and ways of reaching out to consultant, but there is no equivalency in the IRIS program for them to access. Most people would like access to this. There are some resources with incident reporting with ICAs, police, and incident reporting. We could possibly pursue as a committee how to help them.

Most calls are regarding navigating the program and wages.

Amy added that the registry is part of the IRIS onboarding. Background check takes information from the DQA database into consideration. In a non-licensed setting the caregiver cannot be added to the registry. DQA does investigate their own settings. Kathi wondered if there is a form on the website to file a complaint on the website. Amy mentioned that CMS requires DHS to file any report on abuse, neglect, or misappropriation and who it was referred to. There were 7 substantiated claims of abuse/neglect, and approximately 30 investigated by DQA. The balance (95%) were investigated by APS.

Policy and Topic Tracker presented by Amy Chartier

Tracker update was given for the current six months (July – December 2022). There is a different look to modify what we were collecting with policy revision. We are working closely with contractors. We are still working on ISSP development. The internal review will be in August with the provided feedback. We are reviewing draft language for eligibility and enrollment. Language will be provided during off-months. Sept placeholder for EVV. With hard launch there will be edits. Sept - internal review completed in Sept for review. Kyle will provide update on SPA today. SDPC oversight discussion first. Then brought back for discussion w/committee. Oct/Nov will be Budget Amendment discussion. One of the most complicated/challenging efforts w/ICA. Will continue to work through. Dec - participant rights. Jan - BA policy, building out for one time expense policy. Lot

of nuance with the OTE. Jan - finalized draft language for review from IAC. Review of remaining policies in 2023. Background check in 1st/2nd Q as there is pending language with OLC waiting for their determination.

No policies will go unchecked.

Anne had a question regarding training documents. Given discussions, does DHS provide training slide deck so everyone gets the same information? Amy confirmed that that is the goal. DHS is scheduling trainings with the ICAs. It will be a “train the trainer” format. Videos have been created. Any slide deck will be shared with them as well.

Mitch asked for IRIS PDN priority one within the policy. It's been problematic since issued. Amy said it will be taken back and woven in. This tracker is a living, breathing document. So it means there will be adjustments. Kathi finds the links helpful.

Contract change requests are much higher than what we generally experience.

ISSP Update presented by Kim Jewett

The draft the committee received has been reformatted from the previous ISSP Development Policy that was drafted. This policy has now been divided into subchapters for easier readability and comprehension. The primary chapter will be IRIS Service Plan and will include the following subchapters:

- IRIS Service Plan Development
- ISSP Development Planning & Development
- Long-Term Care Needs Panel
- Individualized Backup Plan
- Service Authorization
- Essential Service Provider Agreements
- Participant Provider Service Agreements

We have done outreach, had discussions, and received feedback from the contractors, focusing on the following points within the draft policy:

- Areas that cause confusion and need clarification
- Areas that are burdensome for the participant
- Areas that are burdensome to the ICA/FEA
- Areas that are prone to Fair Hearing Appeals or grievances

In March, the committee expressed concern regarding verbiage used in the ISSP plan development and that DHS must be sensitive to the language of Plan of Care vs. Care Plan being used.

The contractors shared the same opinion, and the policy team proposed using the term "IRIS Service Plan" to package the three components (ISSP, LTC Needs Panel and the Individualized Backup Plan). There was consensus from the contractors with this approach.

Policy Update presented by Kyle Novak

Kyle: Service Authorization (SA) draft is minimal and was sent. It is not what it will look like when complete. It will be part of the ISSP development. One of the subchapters is Service Authorizations. We are developing the SA in a clearer, more streamlined way. We are working with contractors now to see what they need. The goal is to make sure the contractors are heard, and feedback is received on what needs to be improved. You will get the finalized draft after feedback and conversations with contractors. It's a new topic being developed from the ground up.

Mitch asked if the committee received a document we got for this meeting. Amy indicated it would be sent following the meeting. This was historically treated as a systems issue, and we are trying to help with that. Kyle said that there is confusion about what the SA is and how a participant need makes its journey to a Service Authorization.

Committee Business presented by Christian Moran

Thank you for feedback re rates, usual/customary, caregiver crisis. Will provide thoughts at next meeting. There will be an update on Molina/MCW in September.

Mitch inquired about the timeline and tool in the SA Request Policy. Kyle said the tool was too complicated. The bullet points in final draft represent the tools. The document is cleaner and more straightforward. Criteria is much more streamlined and mirrored the SharePoint site. Kathi thanked Kyle for hearing the committee's feedback. She appreciates the feedback being considered.

Adjourn

Meeting unanimously adjourned at 1:27pm

Prepared by: Shelly Glenn on 7/29/2022.
These minutes are in draft form. They will be presented for approval by the governmental body on: 9/13/2022

WISCONSIN DEPARTMENT of HEALTH SERVICES

IRIS IBA Model Update Implementation

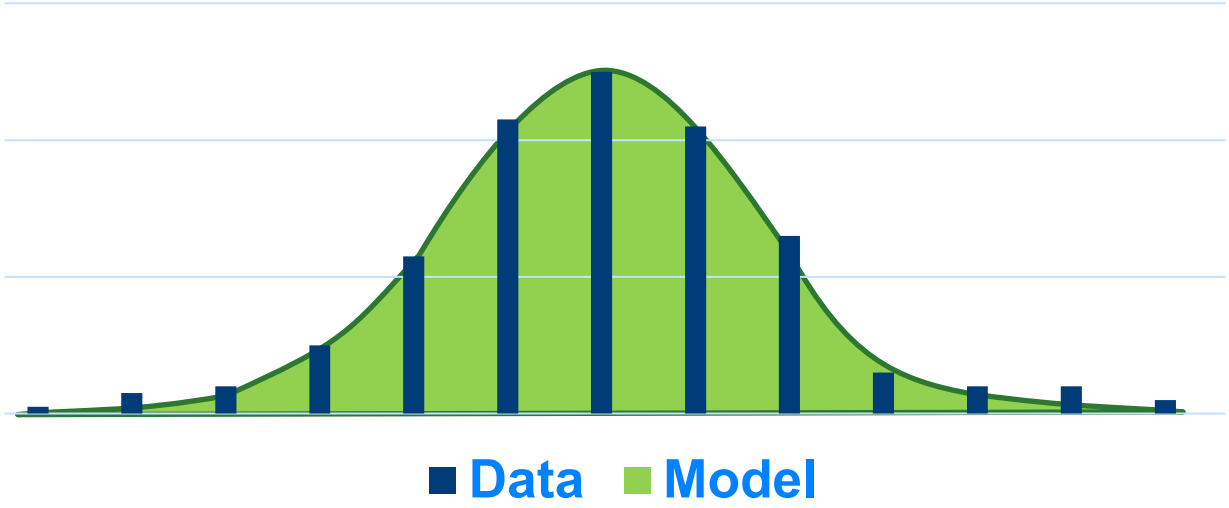
Daniel Bush
Manager, IRIS Fiscal Management Section
Bureau of Rate Setting, Division of Medicaid Services
IRIS Advisory Committee – September 27, 2022

Goals

- Develop more accurate IBA model from first truly statewide IRIS data set (2018)
- Reduce number of budget amendments caused by age of the current model
  - Focus BAs on original purpose—needs exceed calculation
- Establish cadence of regular updates to keep IBA model more current

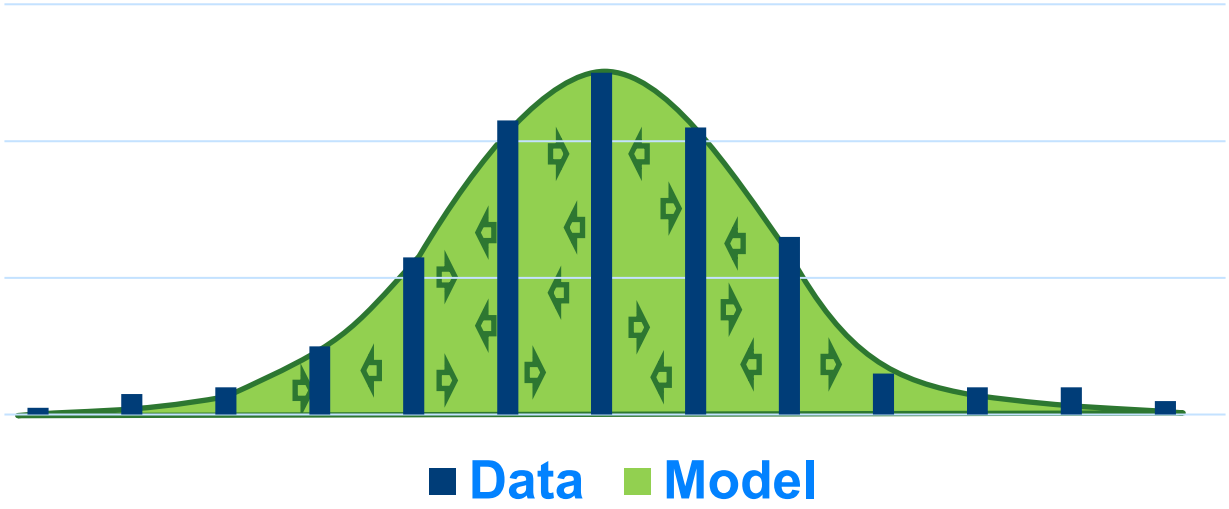
From Model to Calculation

1. Model predicts average cost based on need (as measured by LTC Functional Screen)



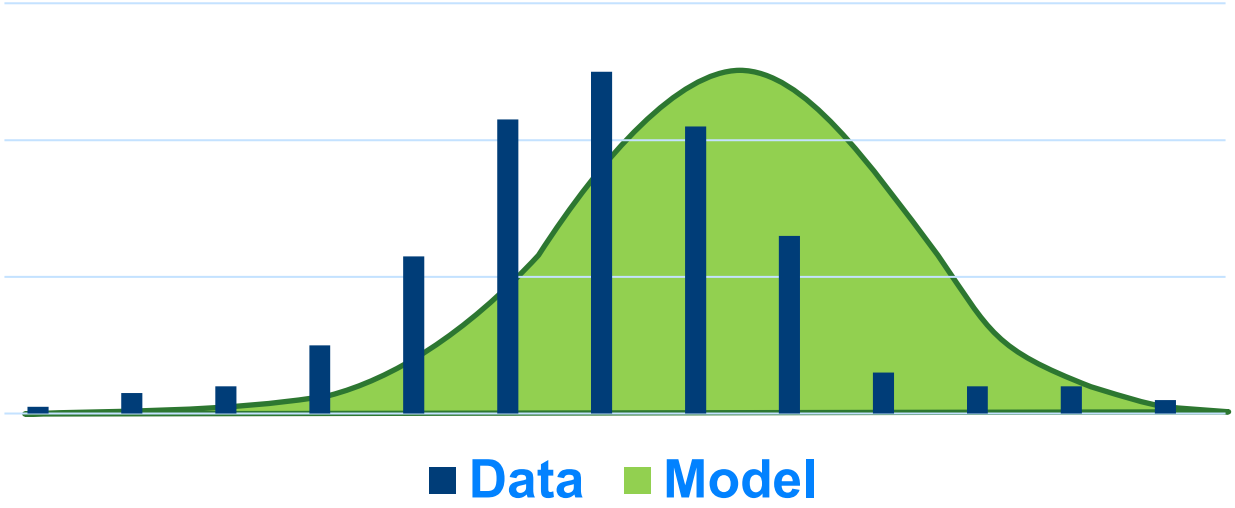
From Model to Calculation

2. Regional adjustments account for local variations in service costs



From Model to Calculation

3. Scaling factors shift results upward to cover most needs for most participants



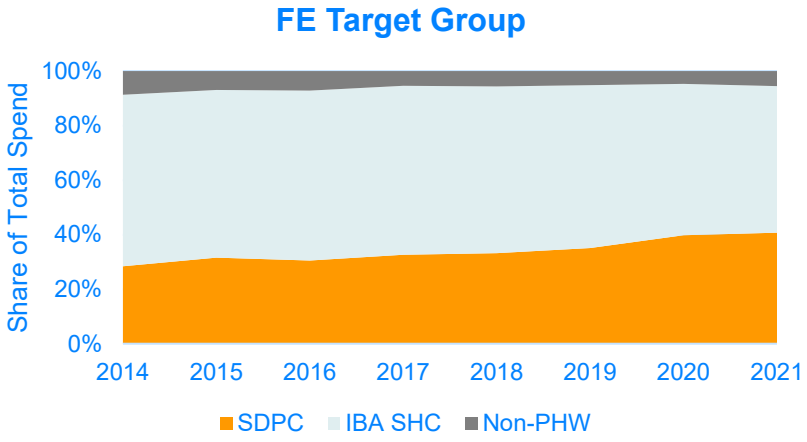
From Model to Calculation

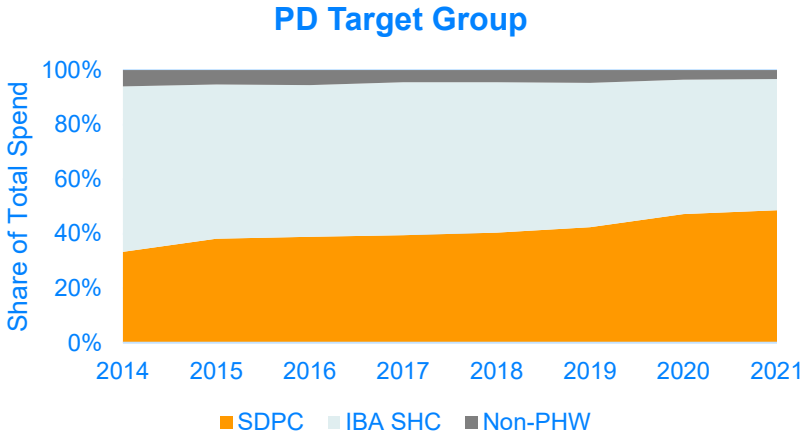
4. Final adjustments bring results up to date
   - Cost trends from 2018-2023
   - ARPA 5%
   - Personal care worker increases in state budget

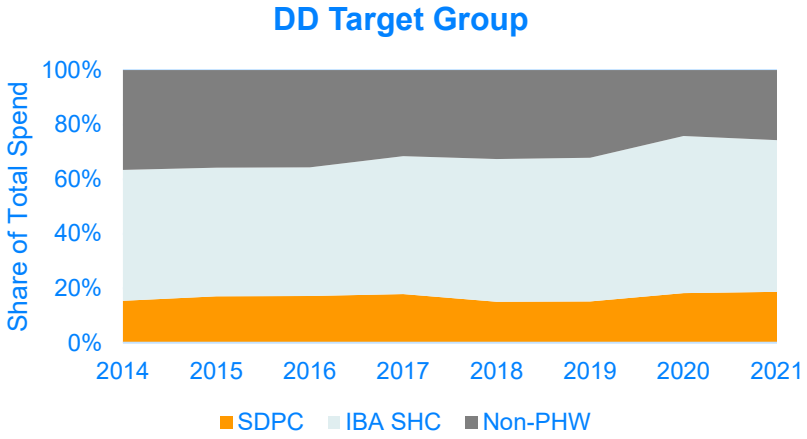
Model Update Impact

- Both old and updated models predict an average "participant" for all 3 target groups
- Monthly impact of model and full calculation can be shown for modeled average "participant"
- **Important: Every IBA is specific to the participant so the impacts are specific as well**
- **No guaranteed or across-the-board changes for participants with the model update**

Trend:
PHW costs shifting to SDPC for the FE and PD target groups

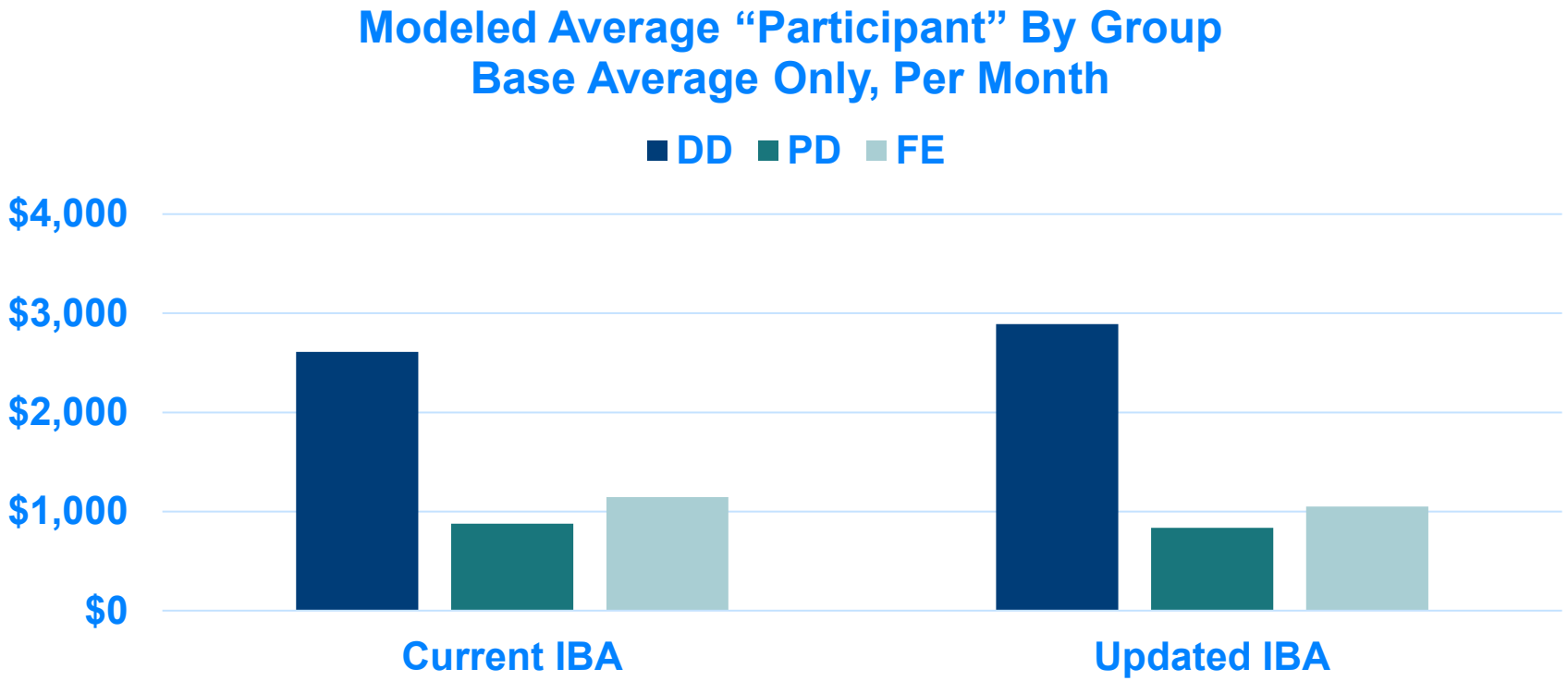




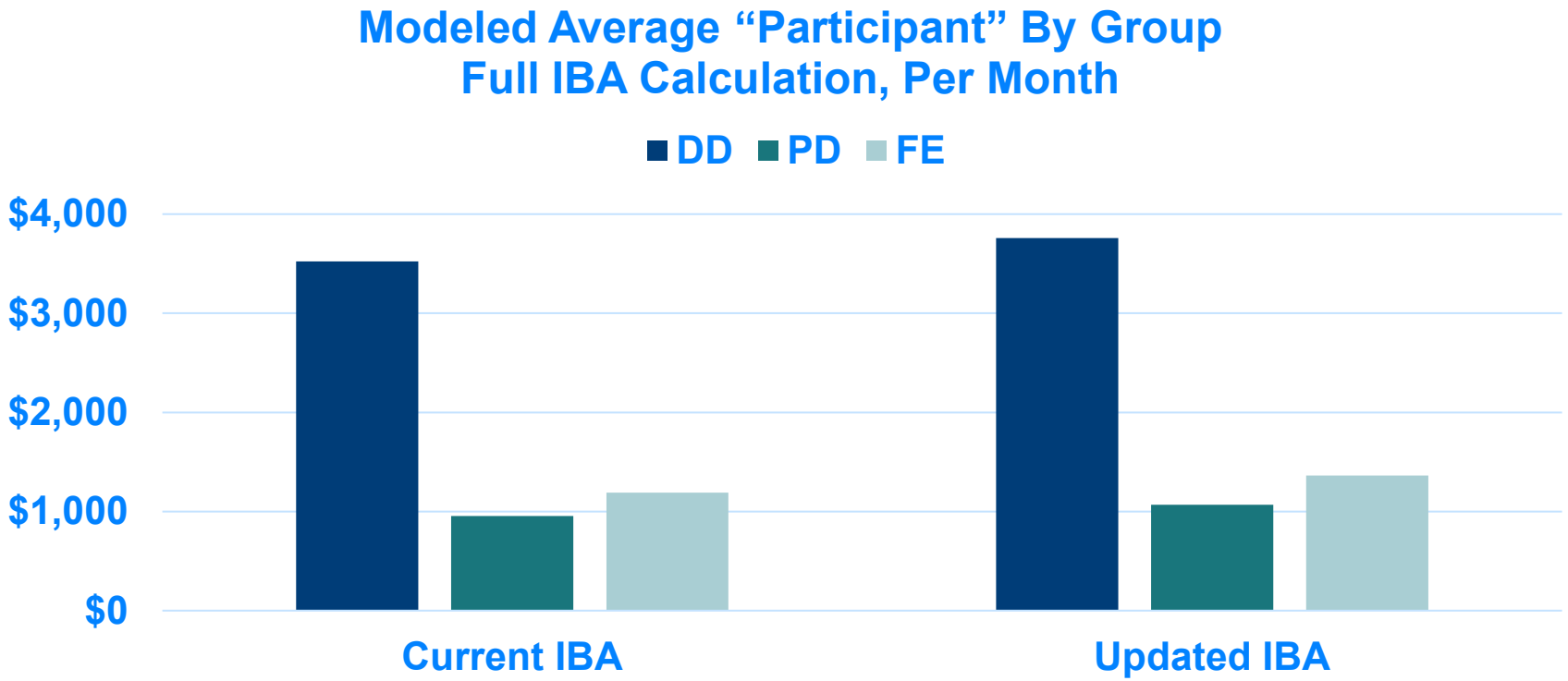


Source: IRIS encounter data in DHS Data Warehouse for waiver services within participant IBAs plus SDPC

Model Update Impact



Model Update Impact



Implementation Challenges

- IBA calculation runs in Functional Screen app (FSIA)
  - Implementing updated model is an IT development project
  - No “back end” where FSIA calculation results are stored
- IBA calculation is unique to the participant
  - Not an across-the-board change like ARPA 5%
  - LTCFS rescreen can also change a participant’s IBA
- IBA calculation is meaningless in isolation
  - IBA sets overall budget parameter—support/service plan is the actual budget
  - ICAs must meet with each participant to develop the plan

IBAs Are Updated Manually

Timeline

- **Now—October**: FSIA development
- **November—December**: Testing and validation
- **Monday, January 9**: Updated model live in FSIA
- **Next participant screens/rescreens in 2023**: IRIS consultants get new IBA from FSIA and discuss service/support plan with participants

IBA Increases & Recurring BAs

- Participants with recurring BAs will have IBA increases first applied to offset those BAs
- Example:

	2022 Budget	2023 Budget
Calculated IBA	$2,000	$2,500
Recurring BA	$1,000	$500
Total Plan Budget	**$3,000**	**$3,000**

2023 “Hold Harmless” Provision

- If the IBA calculated in 2023 is less than 2022’s, then use the 2022 amount for one more year
- Example:

	2022 IBA Budget	2023 IBA Calculation	2023 IBA Budget
Participant A	$2,000	**$2,500**	**$2,500**
Participant B	**$3,200**	$2,800	**$3,200**

2023 “Hold Harmless” Provision

- For IBAs calculated in 2024, any decreases due to the IBA model update will take effect

Key Messaging

- Current participants will have their IBA updated at the time of their annual re-screen, unless they meet the criteria for a change in condition screen
- Updated IBA doesn't take effect until participant and consultant review & update the support/ service plan

Key Messaging

- New participants will receive the updated IBA for their initial plan development

Communication & Training Plan

- Recorded webinar for ICAs/FEAs with Q&A opportunity
- Scheduling for go-live on/after Monday, Jan. 9
- DHS is developing communications plan to include participants, ICAs, ADRCs, MetaStar and the Ombudsmen

Questions?

dhsiris@dhs.wisconsin.gov

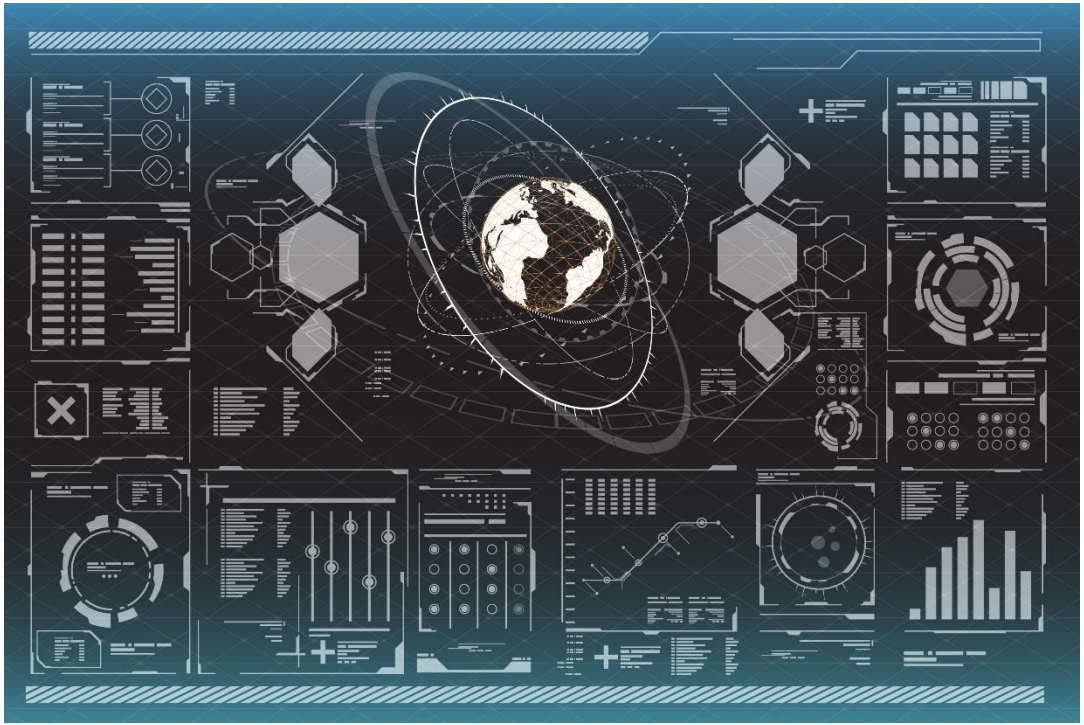
ARPA HCBS Workforce & Innovation Grants Updates

Kevin Coughlin, Policy Initiatives Advisor, DHS, DMS

September 2022

Innovation Grants

GrantsConnect Dashboard

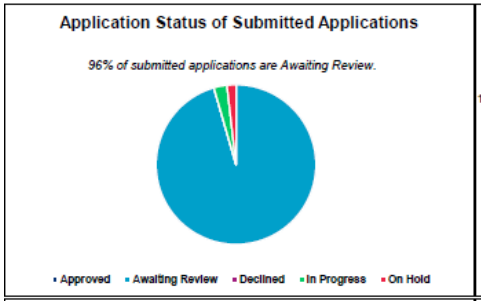


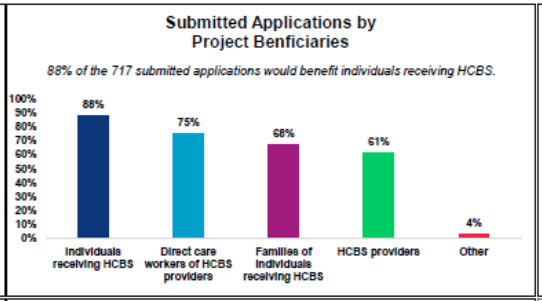
Grants Dashboard

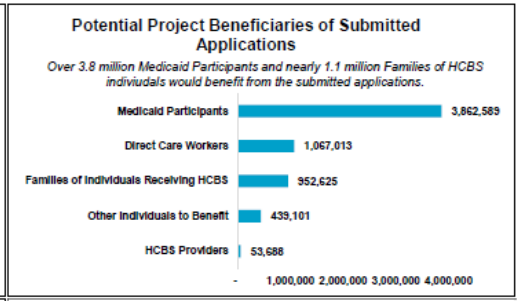
Data is up to date as of: 9/13/22 12:00 am CST

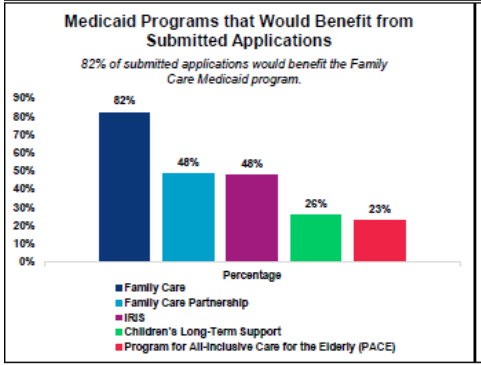
Applications Created	Total Applications Submitted*	Cash Amount Requested from Submitted Applications	Average Cash Amount Requested
1,151	717	$216,145,842.32	$301,458.64

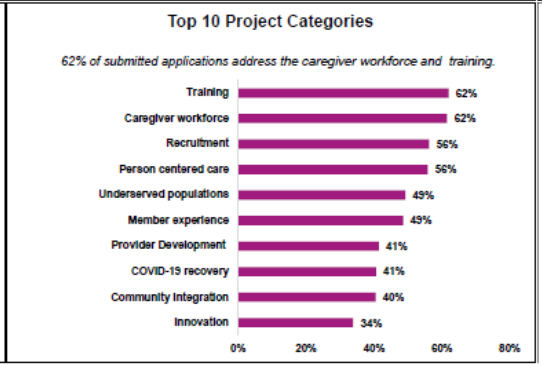
*Applications with a budget exceeding $2M or of $0 have been removed from analysis

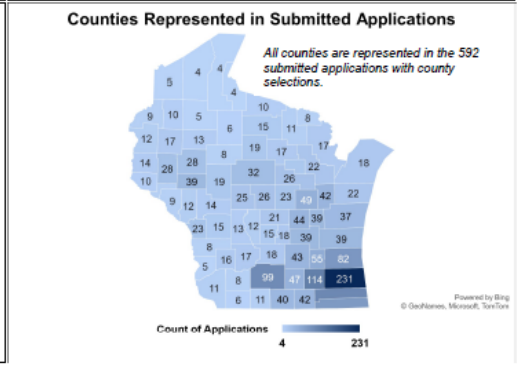












Workforce - Three Components

- Staff Stability Surveys
- Certified Direct Care Professional program and marketing
- WisCaregiver Connections – IT Platform

Staff Stability Survey

Assess the HCBS workforce across Wisconsin

- Direct care workforce participation (FT/PT)
- Turnover
- Worker tenure
- Wages
- Benefits
- Agency recruitment and retention strategies

Staff Stability Survey

- Adults with Intellectual and Developmental Disabilities – 2022 National Core Indicators (NCI) Staff Stability Survey
  - Calendar Year 2021 data
  - April-July 2022 – Survey portal open for upload – **204 participants**
  - September – incentives paid for participation - $250-$1,000 depending on the number of Direct Care Workers employed (DCW) - **$71,250**
  - Currently - analyzing Wisconsin masked data
  - January 2023 – National report.

Staff Stability Survey

- Adults who are Aging or Physically Disabled – Pilot in 2022
  - Working with ADvancing States and four other states
  - May-June - Collecting agency/providers name and email to upload into the system
  - July-August – Messaging and informational webinars
  - September 2nd – Survey portal open for upload through 10/31/2022. Sent to **2,485 providers/agencies**
  - November-December – Paying incentives for participation - $250-$1,000 depending on the number of Direct Care Workers employed (DCW)
  - December – January 2023 - analyze Wisconsin masked data
  - January 2023- technical report on pilot findings from NCI-AD

Staff Stability Survey

- Adults who self direct (IRIS) – in discussions with the goal to have during ARPA funding window.
- Children's LTC - in discussions with the goal to have during ARPA funding window.
- Long term goal – one survey for all HCBS.

WisCaregiver Careers

A professional workforce advancement program.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

UNIVERSITY *of* WISCONSIN GREEN BAY

Certified Direct Care Professional (CDCP) - UWGB

- Competencies: listening sessions and survey – Over 500 responses
- The CDCP competencies exceed national recommendations for direct care worker training – publication coming soon
- Curriculum is under development – UWGB, The Division of Continuing Education and Community Engagement
- Proctored exam and tracking system under development

Badging and Micro-credentialling

- A micro-credential is like a mini-certification. The idea is that they are usually digital, short, and relatively low-cost courses that have a specific focus on demonstrating proficiency in a particular skill.
- Digital badges are simply a visual representation of a micro-credential. Once learners have demonstrated proficiency in the required skill, they're provided with a digital badge. Badges can be shared on social media, added to email signatures, displayed on resumes, and added to digital badge wallets.
- Leverage courses that already exist.

Why Certification - CDCP

- The CDCP competencies are based on national recommendations for direct care worker training
- The training results in an assessment process
- The program assesses the mastery of the competencies, which is measured with an exam
- The CDCP is approved for three-year periods and must be renewed
- Standards are set state-wide through the program to allow for consistency

Marketing Plan – Pigorsch Media

- Recruit direct care worker *"Stars"* who want to be in a promotional video.
- Videos, ads, print assets, communication, etc. will be created this fall and early winter.
- Fall Conferences – DQA FOCUS 2022, HOSA Conferences
- Marketing launch early spring 2023
- Recruit 10,000 individuals to become certified direct care professionals (CDCP)

Financial Incentives

- Vouchers for ~10,000 Certified Direct Care Professionals (CDCP)
- Sign on and 6-month retention bonus for CDCP ($250 each)

WisCaregiver Career Connections – IT Platform

- Dashboards to show program success and data
- Resource library for employers and employees
- Trainings, registries, etc.
- Marketing materials
- Job matching services – matches CDCP up to CNAs with potential jobs
- Information page on various initiatives
- Evaluation and reporting system
- Soon we will be recruiting providers/agencies

Questions?

Contact

Kevin Coughlin

Policy Initiatives Advisor-Executive

Division of Medicaid Services

Wisconsin Department of Health Services

✉ kevin.coughlin@dhs.wisconsin.gov

☎ (608) 509-3398

HCBS Settings Rule: Proposed Updates to HCBS Non-Residential Benchmarks

Lindsey Kreitzman
Community Inclusion & Innovation Manager
Bureau of Quality and Oversight
September 2022

BACKGROUND

Background

- The Medicaid Home and Community-Based Services (HCBS) waiver program was authorized under Section 1915(c) of the Social Security Act.

- Home and community-based services waivers provide opportunities for Medicaid beneficiaries to receive services in their community rather than in institutions or other isolated settings.

Overview of Federal Regulation

- In 2014, the Centers for Medicare & Medicaid Services (CMS) released new federal requirements regarding the qualities of settings that are **eligible for reimbursement** for Medicaid home and community-based services (HCBS).
- The federal requirements are referred to as the HCBS Settings Rule.
- CMS requires all states that operate HCBS waivers to comply with the federal settings rule.

Settings Rule Applies To…

Wisconsin Long-Term Support Programs

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

Nonresidential Waiver Settings

- Adult Day Care Centers (ADCC)
- Prevocational Services
- Children's Day Services Settings (CLTS)
- Group Supported Employment (GSE)
- Day Habilitation Services (ADS)

Settings Rule Intent

The intent of the HCBS Settings Rule is to maximize opportunities for individuals receiving Medicaid-funded HCBS to receive those services in a manner that:

- Protects and enhances individual choice
- Promotes community integration
- Improves quality of services
- Provides additional protections

Benchmark Requirements

Benchmark Requirements

Per CMS, any non-residential setting where individuals receive HCBS must have the following five qualities:

1. Is integrated in and supports full access of individuals to the greater community:
   - Provides opportunities for individuals to seek employment, work in competitive integrated settings, engage in community life, and control personal resources.
   - Ensures that individuals receive services in and access to the greater community, to the same degree of access as individuals not receiving HCBS.

Benchmark Requirements

2. Is selected by the individual from among setting options including non-disability specific settings:
   - Person-centered service plans document the options based on the individual's needs and preferences.

3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Benchmark Requirements

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

5. Optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Review and Remediation

Evolution of Review Process

- Self-Assessments sent to known providers in 2016.
- Process began in 2019 using Public Consulting Group (PCG) to conduct onsite reviews.
- Process transitioned from PCG to DHS in January 2020.
- Onsite visits paused in March 2020 due to COVID.

Review Process

- Email notification of HCBS Review and applicable documents to provider
- 30 days to submit required documentation
- Desk review completed
- Onsite review conducted (resumed, Sept. 2021)
- Compliance determination made
- Provider receives one of the following:
  - Notice to Remediate
  - Notice of Compliance

Remediation Process

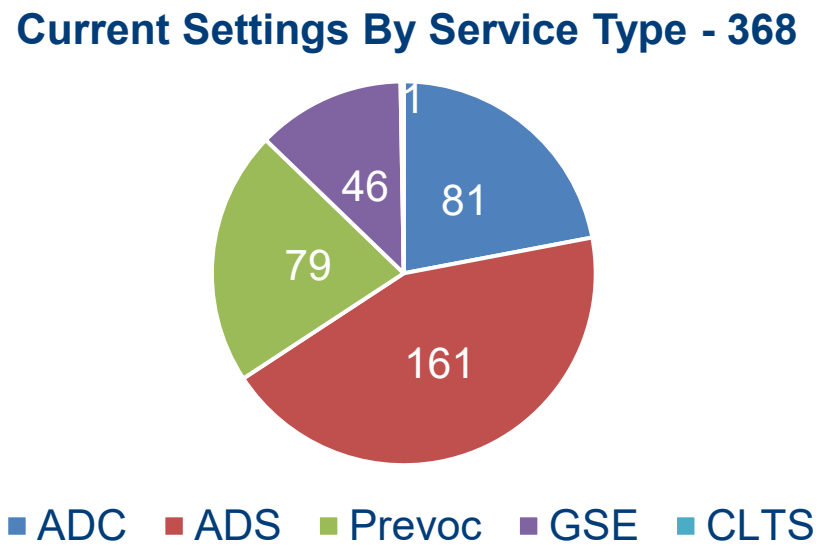
- Provider receives Notice to Remediate, where applicable
- Submits Remediation Plan within 45 days
- Submits evidence that Remediation Plan was implemented within 6 months of Plan acceptance
- Provider receives Notice of Compliance
- If remediation is not possible, provider receives Notice of Non-Compliance
  - Relocates waiver participants

Settings by the Numbers

Number of Settings Reviewed

As of July 2022, 368 settings received reviews.

*No non-residential settings were found to require additional Heightened Scrutiny.



Settings in Remediation

- 310 of the 368 providers received Notices to Remediate
- 310 Remediation Plans were received
- 310 Remediation Plans were accepted
- 310 Providers received Notices of Compliance
- 58 Providers had no areas of Remediation and received Notices of Compliance

In total, DHS reviewed over 400 settings. Several providers closed operations or moved to new locations after having completed the review process.

Learning from the Process

What We've Learned

- Feedback on benchmarks and review process received from providers and advocacy groups.
- Reviewer team identified areas for process improvement.
- Opportunities for consolidating benchmarks with similar requirements.
- Need to clarify which benchmarks do not apply to certain providers.

Benchmark Proposal

Benchmark Proposal

- Incorporate feedback from stakeholders.
- Create a distinct tool for each setting type.
- Include only relevant benchmarks for each setting type.
- Consolidate benchmarks with similar themes.
- Reduce number of benchmarks for Day Habilitation and CLTS settings from 72 to 34.
- Reduce number of benchmarks for Prevocational settings from 81 to 37.
- Ensure that all aspects of HCBS Settings Rule are still reflected in the new benchmarks.

Additional Changes

- Adult Day Care Center reviews will be conducted by the Division of Quality Assurance in order to streamline the certification/ recertification process with the HCBS review process.

- Review process for ADCCs will look different, but ADCCs will still be required to meet all aspects of the HCBS Settings Rule.

Public Comment

- Non-Residential HCBS Benchmark Proposals will be out for public comment very soon.

Contact Information

Lindsey Kreitzman
Community Inclusion & Innovation Manager
Lindsey.Kreitzman@dhs.Wisconsin.gov

Judy Kujoth
Lead Quality Reviewer
Judy.Kujoth@dhs.Wisconsin.gov

		IRIS Contractors (Policy and Implementation every month)			IRIS Advisory Committee (IAC) (Meet every other month; email policy/content in off months)		
Policy / Content	**Month**	**Materials Sent to Contractors**	**Present at Meeting**	**Feedback Due** (email)	**Materials Sent to IAC**	**Present at Meeting**	**Feedback Due** (email)
• State Plan Amendment (SDPC Personal Care Services)	**May**	5/11/22	5/18/22	6/1/22	5/11/22	5/24/22	6/1/22
• Eligibility (Contractor Discussion) • ISSP Plan Development (Contractor Discussion)	**June**	6/08/22	6/15/22	7/1/22 (Additional time provided based on the volume of policy)	6/8/22	Off Month	7/1/22 (Additional time provided based on the volume of policy)
• ISSP Plan Development (Draft language for review #1) • Enrollment (Contractor Discussion) • ISSP Service Authorization Development (Contractor Discussion)	**July**	7/13/22	7/20/22	8/03/22	7/19/22	7/26/22	8/03/22
• ISSP Development (Draft language for review #2) • Eligibility (Draft language for review) • ISSP Service Authorization Development (Contractor Discussion #2) • Enrollment (Draft language for review #1)	**August**	8/10/22	8/17/22	8/31/22	8/10/22	Off Month	8/31/22
• Budget Amendment (Contractor Introduction) • ISSP Plan Development (Internal Review Completed) • Eligibility (Internal Review Completed)	**September**	9/14/22	9/21/22	10/05/22	9/20/22	9/27/22	10/05/22

• ISSP Service Authorization Development (Draft language for review #1)							
• ISSP Service Authorization Development (Additional Draft Language Discussion) • ISSP Service Authorization Development (Internal Review Completed)	**October**	10/05/22	10/12/22	10/26/22	10/18/22	Off Month	10/26/22
• EVV Updates • Enrollment (Draft Language Review #1) • ISSP Service Authorization Development (Draft Language Review #2/Begin Final Review Routing) • Budget Amendment (Contractor Discussion #1)		10/18/22	10/25/22	11/08/22			
• SDPC Personal Care Services (Draft language for review) • Enrollment (Internal Review Completed) • Budget Amendment (Contractor Discussion #2) • Participant Rights (Contractor Discussion)	**November**	11/2/22	11/9/22	11/23/22	11/8/22	11/15/22	11/23/22
• Budget Amendment (Draft Language Review #1) • OTE (Contractor Discussion #1) • Participant Rights (Draft language for review) • SDPC Personal Care Services (Internal Review Completed)	**December**	12/14/22	12/21/22	1/4/23	12/14/22	Off Month	1/4/22
• Budget Amendment (Draft Language Review #2) • OTE (Contractor Discussion #2/Draft Language for Review) • Participant Rights (Internal Review Completed)	**January 2023**	1/11/23	1/18/23	2/1/23	1/17/23	1/24/23	2/1/23

Remaining Policies to Discuss in 2023: • IRIS Providers • Participant Safeguards/Health & Safety • IRIS Participant Hired Worker Background Check • Employment Planning	**Q1 & Q2 2023**		2/15/23 3/15/23 4/19/23 5/17/23 6/21/23			Off Month 3/21/23 Off Month 5/23/23 Off Month	

Policies and Content Reviewed and Published:

- Electronic Visit Verification in IRIS (P-03113)
- IRIS Support Services Provider Training Standards (P-03071)
- Fiscal Employer Agent (FEA) Enrollments and Transfers (P-03107)
- Remote Services (P-03081) *(Effective January 1, 2022)*
- Vulnerable and High Risk Participants (P-03128) *(Effective January 1, 2022)*
- Reporting and Follow-up for Immediate Reportable and Critical Incidents (P-03131) (*Effective January 1, 2022)*
- Service Authorization Request Process (P-03237) *(Effective November 1, 2022)*

Still in Process:

- 2023 – 2024 IRIS Contractor Provider Agreement Changes

*Schedules are subject to change

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

***Schedules are subject to change**

YearlyTopic Items*						
	January	March	May	July	September	November
IBA (Individual Budget Allocation)			x			X
Monthly Rate of Service (MROS) Change Reminder			x			X
ARPA 5%	X					

*Schedules are subject to change

Current Reports								Report Links
	Comments	January	March	May	July	September	November	
Enrollment numbers	could send bi-monthly with IRIS agendas	X	X	X	X	X	X	Enrollment Reports
372 reports						X		372 Reports
NCI data						X		NCI Data
Employment Data	from Act 178							Employment Data
Participant Satisfaction				X				Participant Satisfaction Survey

IRIS Advisory Committee Page
IRIS Manuals, Resources, Reports

IAC Requested Topics	
Standardized Monthly Budget Statements	Pending - resources not available at this time.
Background Checks	Pending - resources not available at this time.
Relocations/Transitions	Pending - resources not available at this time.
P4Ps	Pending - resources not available at this time.

IRIS Service Plan

A. IRIS Service Plan: Background

The Centers for Medicare & Medicaid Services (CMS) requires each IRIS participant to develop and maintain a written plan of care that ensures their health and safety and assists with achieving their long-term care needs. The IRIS program will use the IRIS Service Plan, which consists of the participant's Individual Support and Service Plan (ISSP), the Long-Term Care Needs Panel, and an individualized back-up plan to satisfy this element.

The IRIS Service Plan reflects the full range of a participant's support and service needs, desired long-term care outcomes, including both Medicaid and non-Medicaid services, informal supports, chosen lifestyle, culture, and functional and social needs, for the participant to live successfully in the community and, therefore, avoid institutionalization. Participant needs are identified in several ways including the Long-Term Care Functional Screen (LTCFS), Personal Care Screening Tool (PCST), and through interactions between the IRIS consultant (IC) and the participant.

Participation in IRIS, a self-directed waiver program, provides participants with new opportunities, responsibilities, and risks. People participating in the IRIS program make a choice to self-direct all long-term care services and supports, providing the person with a high degree of choice, control, and responsibility over services and supports received. The IC supports the participant through the development of an IRIS Service Plan using a person-centered planning process, that assesses, identifies, and documents the participant's meaningful long-term care needs and outcomes based on the kind of life the participant wants to live, and the supports needed to do so. Finding the right balance between the participants' right to make choices regarding their IRIS Service Plan with the IRIS program's obligation to ensure the participant's health, safety and well-being requires special consideration and careful planning.

The IRIS program is the funding source of last resort. IRIS participants must first use any available Medicaid card services (Wisconsin Medicaid State Plan), and services provided by other funding sources before accessing IRIS funded services and supports. The IC will assist the participant to identify natural supports and other resources outside the IRIS program that may aid in meeting his or her needs.

B. IRIS Service Plan Development

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

a. General Provisions

To create or update a participant's ISSP, the IC meets face-to-face with the participant and their legal representative, if applicable, with the optional support of any individual of the participant's choosing. Face-to-face meetings must occur at a time and location that is convenient for the participant and their legal representative, if applicable. For new IRIS

program enrollments, the ISSP must be completed during the 60-day IRIS program orientation period.

During these face-to-face meetings, the IC explores with the participant and their legal representative, if applicable, 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.

Additionally, the IC uses the information obtained during these exploratory, the most recent LTCFS, and if necessary, a behavioral support plan (BSP), to comprehensively assess and identify the participant's:

- service and support needs,
- 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, and
- other factors that may impact their health and welfare.

The participant, in collaboration with the IC, plans and develops the ISSP within their monthly budget allocation and self-directs all long-term care services and supports identified in the ISSP. The ISSP contains the type, scope, amount, duration, and frequency of authorized services and supports. The ISSP cannot exceed the participant's monthly budget allocation.

When creating or modifying the ISSP, the IC ensures the existence of a clear link between the services and supports authorized and the participant's identified long-term care outcomes. The IC must document all conflicts of interest identified during the ISSP development process and will support the participant in mitigating the conflict by reviewing the Participant Education Manual and completing a conflict of interest form.

ICs are also required to collaborate with participants and their legal representative, if applicable, to identify potential risks and to help identify and implement strategies to mitigate those identified risks. ICAs can define their own practices for assessing risks and corresponding mitigation strategies.

ICs are required to consult with the IRIS Nurse Consultant 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.

Before agency providers and participant-hired workers can be selected for the ISSP, they must first be approved by Fiscal Employer Agents (FEA) to provide services and supports in the IRIS program. FEAs are responsible for all financial transactions on the participant's behalf, including but not limited to paying for goods and services, processing payroll for participant-hired workers and processing agency provider invoices.

b. Long-Term Care Outcome(s) Development

i. Long-Term Care Outcome(s) Overview

During the ISSP development process, the IC collaborates with the participant and their legal representative, if applicable, to determine their long-term care outcomes by identifying IRIS funded services and supports that promote community participation, lead to competitive and integrated employment, and/or safe housing. Long-term care outcomes are each evaluated according to whether they ensure participant's health and safety as assessed by the participant's most recent LTCFS, provide access to transportation, and promote positive and meaningful relationships.

ii. Long-Term Care Outcome(s) Development

1. The IC assists the participant in identifying the participant's needs, long-term care outcomes, and goals.
2. To achieve the participant's desired long-term care outcome(s), the IC, in collaboration with the participant, uses different strategies and approaches.
3. Prior to identifying the appropriate strategy and/or approach the participant must establish a long-term outcome. Long-term outcomes must be directly related to the following in order of prioritization:
    a. Establishing or maintaining a **living arrangement of one's own**.
    b. Obtaining or maintaining **community-integrated employment**.
    c. Establishing or maintaining **community inclusion**.
4. When developing a long-term care related outcome, the IC must assess and collaboratively develop solutions according to all the following requirements:
    a. Ensuring health and safety.
    b. Building positive relationships.
    c. Having control of, and access to, transportation.
5. Long-term care outcomes must have a direct correlation to the participant's most recent LTCFS.
6. Once the participant has identified their long-term care outcome(s), strategies, and approaches to establishing, obtaining, and/or maintaining their long-term care outcome(s), the IC assists the participant with support, service, and goods prioritization.

c. Procedures

IRIS Service Plan: Long-Term Care Outcomes Development

Step	Responsible Partner(s)	Detail
1	IRIS Consultant, Participant	The IC and IRIS participant meet to discuss and determine the participant's desired long-term care outcomes, as well as the supports, services, and/or goods to support the long-term care outcomes. Long-term care outcomes must correlate to the participant's most recent LTCFS and be directly related to the following, in order of prioritization: 1. Establishing or maintaining a **living arrangement of one's own**. 2. Obtaining or maintaining **community-integrated employment**. 3. Establishing or maintaining **community inclusion**. For each long-term care outcome, the IC and participant collaboratively develop solutions according to all the following considerations: • Ensuring health and safety.

		• Building positive relationships. • Having control of, and access to, transportation.
2	IRIS Consultant, Participant	The IC and participant collaboratively determine which long-term care outcomes, as assessed by the participant's most recent LTCFS, are related to ensuring the participant's health, safety, and independence related to achieving, maintaining, or obtaining a living arrangement of one's choice. If the long-term care outcome requires IRIS waiver funds to purchase the supports, services, and/or goods, these must be deducted from the participant's budget estimate.
3	IRIS Consultant, Participant	The IC and participant collaboratively determine which long-term care outcomes, as assessed by the participant's most recent LTCFS, to ensure the participant's health, safety, and independence related to achieving, maintaining, or obtaining community-integrated employment. If the long-term care outcome requires IRIS waiver funds to purchase the supports, services, and/or goods, these must be deducted from the participant's budget estimate.
4	IRIS Consultant, Participant	The IC and participant collaboratively determine which long-term care outcomes, as assessed by the participant's most recent LTCFS, are related to ensuring the participant's health, safety, and independence related to achieving, maintaining, or obtaining community inclusion. If the long-term care outcome requires IRIS Waiver funds to purchase the supports, services, and/or goods, these must be deducted from the participant's budget estimate.
5	IRIS Consultant, Participant	The IC and participant determine meaningful long-term care outcomes, as assessed by the participant's most recent LTCFS, by determining the kind of life the participant wants to live, and the supports needed to do so.
6	IRIS Consultant, Participant	The IC and participant determine what **strategy** is needed to achieve, maintain, or obtain the identified long-term care outcome(s). Strategies can vary and should identify how the participant is going to achieve, maintain, or obtain the identified long-term care outcome. Strategy examples include: • Utilizing an individual to assist with supportive home care tasks. • Utilizing a church's van/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.
7	IRIS Consultant, Participant	The IC and participant determine what **approach** will be used to achieve, maintain, or obtain the identified long-term care outcome. Approach examples include: • Natural supports • Medicaid or Medicare • Community services such as the participant's church or community center • IRIS Waiver Services **Note: Only IRIS waiver services and supports are documented on the ISSP. The LTC Needs Panel list all the needs of the participant and how each of those needs are being met and funded.**

8	IRIS Consultant, FEA, Participant	When it's determined that **IRIS waiver services** are needed to meet the long-term care outcomes, the participant and IC will determine the following: • Identify the **type** of support/service/good needed. • Identify the **amount** of support/service/good needed. • Identify the **cost** of the support/service/good needed. • Identify the **provider** of the support/service/good. **Note: Before providers can be authorized to provide IRIS waiver services on any IRIS Service Plan, an FEA, either in the past or present, must have verified they meet the provider qualifications.**
9	IRIS Consultant, Participant	The IC completes the **LTC Needs Panel** to identify and confirm how all identified **waiver and non-waiver services and supports** are met. See the **LTC Needs Panel** procedures below.

2. Long-Term Care (LTC) Needs Panel

a. Overview

In tandem with the ISSP development process, the IC also completes the participant's LTC Needs Panel. The LTC Needs Panel is accessible to ICs within the Department's case management system, WISITS. It documents the participant's identified long-term care needs and how each of those needs are being met. This 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. In particular, the IC creates or updates the LTC Needs Panel to further document how the participant's identified long-term care service and supports needs are being met by non-IRIS funded sources.

b. Procedures

IRIS Service Plan: Long-term Care Needs Panel

Step	Responsible Partner(s)	Detail

1	IRIS Consultant	In WISITS, the Long-term Care Needs Panel (LTC Needs Panel) is completed or updated at all the following times:
		• Prior to program enrollment.
		• Annually at Service Plan renewal.
		• When there is a documented positive or negative change in condition, within the participant's most recent LTCFS, the IC and participant have a discussion to determine if the Service Plan is still accurate. If it is not, then it will be updated.
		• If the Service Plan is determined to be out of compliance. This can happen if the Service Plan doesn't sufficiently address:
		  • Participant needs as indicated by the Long-Term Care Functional Screen
		  • Identified health and safety risks
		  • Participant identified outcomes/goals

2	IRIS Consultant	The LTC Needs Panel consists of several sections, each with varying questions, all of which must be completed before the panel's assessment status can be changed.

		The IC, in collaboration with the participant, determines and updates the following sections of the LTC Needs panel: • Activities of Daily Living (ADLs) • Instrumental Activities of Daily Living (IADLs) • Additional Supports • Health Related Services • Behavioral and Mental Health Once all the sections and their accompanying questions have been completed, the IC and the participant conducts an overall review of the LTC Needs Panel answers and does an assessment of the most recent LTCFS.
3	IRIS Consultant	Once all the sections and their accompanying questions have been completed, the IC changes the panel's assessment status to Completed and saves the completed assessment to the participant's document console in the Department's case management system (WISITS). When the LTC Needs Panel is updated or reviewed annually, the IC saves the changes and adds the assessment to the participant's document console".

3. Individualized Back-up Plan

a. Overview

The IC collaborates with the participant to create an individualized back-up plan (back-up plan) to ensure there is a back-up provider that is able to provide care and maintain the participant's health and safety if 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 participant and the IC review the accuracy and effectiveness of the back-up plan at a minimum once per quarter, and as needed when there is a change in the participant's circumstances, to ensure that the information is current. The participant is responsible for notifying the IC of any changes to their back-up plan.

b. Process

1. The individualized back-up plan (back-up plan) must be developed during the 60-day IRIS program orientation period.
2. Each IRIS consultant agency (ICA) must have its own DHS approved back-up plan format or template, at a minimum, containing:
    a. Contact information for the participant's legal representative, if applicable, and IRIS consultant.[1]
    b. Contact information for people who are willing to provide care if a participant-hired worker is unavailable or does not report to work as scheduled.
    c. Contact information for suppliers and repairers of medical supplies.
    d. Information related to the participant's daily schedule.
    e. Information to use in the event of an emergency medical situation.
    f. Information to use in the event of a home emergency or disaster.

[1] Individual 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.

g. Location of additional participant-specific information within the residence; and
h. Dates and signatures of the participant or legal representative, if applicable, and IRIS consultant.

3. Modifications to a back-up plan template must be approved by DHS before implementation by the ICA.
4. The IRIS consultant and participant must review the back-up plan at a minimum once per quarter, and as needed when there is a change in the participant's circumstances, to ensure that the information is current. A new back-up plan should be reviewed, signed, and dated, at minimum, one time each calendar year.
5. The content of the old back-up plan should be transferred to a new ICA's back-up plan format, when a participant transfers between ICAs.
6. The IRIS consultant agencies maintain responsibility to educate participants on the requirement of maintaining an accurate and functional back-up plan. This information is in the Participant Education Manual (P-01704) and discussed with the participant during orientation and annually thereafter.
7. 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.[2]
8. 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.[3] The IRIS SDPC nurse reviews the back-up plan to validate the plan's compliance with the IRIS SDPC program.
9. IRIS consultants are responsible for ensuring participants understand how to access funding for the individuals and agencies, excluding provider agencies, identified on the back-up plan if they will not be providing natural or unpaid supports.
10. Participant-hired workers and agencies identified on the back-up plan that will provide paid services and supports must be established in the IRIS case management's system (WISITS) as a provider prior to the implementation of the back-up plan.
11. Participant-hired workers who are already providing full-time/primary care on the participant's current ISSP should not be designated as a back-up plan provider.

c. Procedures

IRIS Service Plan: Individualized Back-up Plan Education

Step	Responsible Partner(s)	Detail
1	IRIS Consultant	The IRIS consultant educates the participant and/or legal representative, if applicable, regarding the requirements of maintaining an accurate and effective individualized back-up plan at the time of enrollment and on an annual basis using the Participant Education Manual (P-01704).

IRIS Service Plan: Individualized Back-up Plan Completion

Step	Responsible Partner(s)	Detail

[2] Add IRIS Policy: Involuntary Disenrollment Chapter Link when available
[3] Add IRIS Policy: SDPC Individualized Back-up Plan Requirements Link when available

1	IRIS Consultant, Participant	The IC and participant complete each section of the individualized back-up plan with accurate information.
2	Participant	The participant ensures that individuals and agencies identified on the individualized back-up plan are agreeable to their role. **Note: Participant-hired workers who are already providing full-time/primary care on the participant's current ISSP should not be designated as a back-up plan provider.**
3	IRIS Consultant, FEA	The IC 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 natural supports. **Note: Before providers can be authorized to provide IRIS waiver services on any IRIS Service Plan, an FEA, either in the past or present, must have verified they meet the provider qualifications.**
4	IRIS Consultant	The IC reviews the content of the individualized back-up plan with the participant at a minimum once per quarter, and as needed when there is a change in the participant's circumstances, and documents this conversation in case notes.
5	IRIS Consultant, Participant	The IC and participant complete each section of the individualized back-up plan with accurate information.
6	IRIS Consultant, Participant	Once completed, the IC and the participant reviews the content of the individualized back-up plan and it is signed and dated by the participant or their legal representative, as applicable, and uploaded to the participant's document console in WISITS.

IRIS Service Plan: Individualized Back-up Plan Modification

Step	Responsible Partner(s)	Detail
1	Participant	The participant maintains the responsibility to inform the IC of any changes needed to the individualized back-up plan.
2	IRIS Consultant, Participant	The IC and participant update each section of the individualized back-up plan with new and accurate information.
3	Participant	The participant ensures that individuals and agencies identified on the individualized back-up plan are agreeable to their role. This means that providers must first be approved by the FEA and are established in WISITS as allowable providers. **Note: Participant-hired workers who are already providing full-time/primary care on the participant's current ISSP should not be designated as a back-up plan provider.**
4	IRIS Consultant, FEA	The IC 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 natural supports. **Note: Before providers can be authorized to provide IRIS waiver services on any IRIS Service Plan, an FEA, either in the past or present, must have verified they meet the provider qualifications.**
5	IRIS Consultant	The IC reviews the content of the individualized back-up plan with the participant at a minimum once per quarter, and as needed when there is a

		change in the participant's circumstances, and documents this conversation in case notes.
6	IRIS Consultant, Participant	Once completed, the IC and the participant reviews the content of the individualized back-up plan and it is signed and dated by the participant or their legal representative, as applicable, and uploaded to the participant's document console in WISITS.

IRIS Service Plan: Individualized Back-up Plan Annual Review

Step	Responsible Partner(s)	Detail
1	IRIS Consultant, Participant	The IC and participant update each section of the individualized back-up plan with new and accurate information, if necessary. Annually, at a minimum, the individualized back-up plan is signed and dated by the participant or their legal representative, if applicable.
2	Participant	The participant ensures that individuals and agencies identified on the individualized back-up plan are agreeable to their role. This means that providers must first be approved by the FEA and are established in WISITS as allowable providers.
3	IRIS Consultant, FEA	The IC 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 natural supports. **Note: Before providers can be authorized to provide IRIS waiver services on any IRIS Service Plan, an FEA, either in the past or present, must have verified they meet the provider qualifications.**

IRIS Service Plan: Individualized Back-up Plan Data Collection, Reporting, and Monitoring

Step	Responsible Partner(s)	Detail
1	DHS	The Department of Health Services (DHS) verifies the completion of Chapter 3.0 of the Participant Education Manual (P-01704) using the IRIS Participant Education Manual Acknowledgement form (F-01947) and development of an accurate individualized back-up plan through the record review process.

4. Resources

- Participant Education Manual, P-01704, https://www.dhs.wisconsin.gov/library/p-01704.htm
- ISSP Signature Letter, F02839, https://www.dhs.wisconsin.gov/forms/f02839.docx
- IRIS Participant Education Manual Acknowledgement form, F-01947, https://www.dhs.wisconsin.gov/forms/f01947.docx

C. IRIS Service Plan Guidance

1. Required IRIS Service Plan Implementation and Update Timeframes

The IRIS Service Plan must be completed or updated at all the following times:

a. During the 60-day orientation period, prior to program enrollment.
b. Annually at IRIS Service Plan renewal.
c. When there is a documented change in condition within the participant's most recent LTCFS, the IC and participant have a discussion to determine if the IRIS Service Plan is still sufficient. If it is not, then it will be updated.
d. If the IC determines the IRIS Service Plan is out of compliance, during the monthly or quarterly contact with the participant.

2. Considerations when Completing or Updating the IRIS Service Plan

When completing or updating the IRIS Service Plan:

a. The participant's needs and preferences are first assessed.
b. During an IRIS Service Plan update, if there are changes in the participant's condition, a new LTCFS may be required. A change in condition may require consultations with the IRIS SDPC nurse or nurse consultants.
c. Identify, complete, and/or update the participant's long-term care outcomes, as previously highlighted.
d. Once the participant has identified their long-term care outcome(s), strategies, and approaches to establishing, obtaining, and/or maintaining their long-term care outcome(s), the IC assists the participant with support, service, and goods prioritization.
e. Update the participant's LTC Needs Panel to confirm that all the participant's identified long-term care needs are being met. This 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.
f. The IC, in collaboration with the participant, processes the Essential Service Provider Agreement and Participant Provider Service Agreement, if applicable.
g. When the participant's IRIS Service Plan is agreed to and completed, it must be signed by the IRIS consultant, the participant, and their legal representative, as applicable.

3. Procedures

IRIS Service Plan: Implementation and Updates

Step	Responsible Partner(s)	Detail
1	IRIS consultant, Participant	The IC provides the final approved IRIS Service Plan to the participant and legal representative, as applicable, for their review and signature. Upon receiving the dated signature(s) of the participant and/or their legal representative, as applicable, the IC signs and dates the document as well. All signature pages, as well as the approved IRIS Service Plan are uploaded to the participant's document console in the Department's case management system (WISITS).

4. Resources

- Participant Education Manual, P-01704, https://www.dhs.wisconsin.gov/library/p-01704.htm

- ISSP Signature Letter, F02839, https://www.dhs.wisconsin.gov/forms/f02839.docx
- IRIS Participant Education Manual Acknowledgement form, F-01947, https://www.dhs.wisconsin.gov/forms/f01947.docx

D. Service Authorization (Placeholder)

E. Essential Service Provider Agreements (Placeholder)

F. Participant Provider Service Agreements (Placeholder)

Eligibility

A. Eligibility: Functional, Financial, and Non-Financial Eligibility Requirements

Include, Respect, I Self-direct (IRIS) is a federally approved Home and Community-Based Services (HCBS) Waiver Program. All participants must meet functional, financial, and non-financial eligibility requirements for enrollment in IRIS.

To be eligible to participate in IRIS, participants must meet each of the following eight criteria:

1. Must be at least 18 years of age
2. Meet applicable requirements for Wisconsin residency
3. Meet the definition of an eligible population (i.e., target group)
4. Meet functional eligibility including Nursing Home or Intermediate Care Facility-Intellectual Developmental Disability level of care assignment
5. Meet the financial eligibility criteria for Medicaid
6. Meet the non-financial eligibility criteria for Medicaid
7. Reside in a program-eligible setting or living arrangement
8. Have a need for long-term care supports and services

1. Eligible Age

Description

Enrollment in the IRIS program is limited to adults (individuals 18 years of age or older). Prospective IRIS participants may be referred to the Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (Tribal ADRS) as early as 17-1/2 years of age for enrollment counseling.

2. Residency

Description

IRIS program residency requirements are the same as the Wisconsin Medicaid rules. The participant must maintain residency in Wisconsin as determined by the Department of Health Services (DHS) or by the local Income Maintenance (IM) Agency, a subunit of a county, consortia, or tribal government responsible for administering IM Programs including Wisconsin Medicaid.

3. Eligible Population (Target Group)

Description

Participants must meet the definition of an eligible target group population to obtain services from the IRIS program.

Wisconsin Adult Long-Term Care Functional Screen (LTCFS)

Target Group eligibility for the IRIS program is determined using the Long-Term Care Functional Screen (LTCFS). Target Group determinations may only be completed by an individual trained and certified to administer the LTCFS.

To determine eligibility for one or more of the eligible target groups, a qualified screener with the ADRC conducts a face-to-face interview with the participant and completes the Wisconsin LTCFS. The functional screen process gathers relevant information from the participant, their family, formal and informal caregivers, health care professionals and other relevant sources, as necessary. Upon completion of the screening process, the collected information is entered into the LTCFS, and the functional screen logic determines whether the participant meets the criteria for at least one eligible target group.

Target Group

Eligible target populations include adults with a developmental disability (DD), adults with a physical disability (PD) and frail elders (FE).

i. Developmental Disability (DD):

Under federal rules, 42 U.S.C. § 15002(8)(A), a developmental disability (DD) means a severe and chronic disability of an individual which:

1) Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
2) Is manifested before age 22;
3) Is likely to continue indefinitely;
4) Results in a substantial functional limitation in three or more of the following areas of major life activity:
    a) Self-Care;
    b) Receptive or expressive language;
    c) Learning;
    d) Mobility;
    e) Self-direction;
    f) Capacity for independent living;
    g) Economic self-sufficiency; and
5) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

Note: Wisconsin's definition of DD is broader than the federal definition. If a person meets only the state's definition of DD, the person will not meet the federal DD definition. A person must meet the federal DD definition to be eligible for services from the IRIS program.

ii. Physical Disability (PD)

Physical Disability is defined as a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory, or cardiovascular impairment, which results from injury, disease, or congenital disorder and which significantly impairs at least one major life activity.

iii. Frail Elder (FE)

Frail Elder is defined as an individual aged 65 years or older who has a physical disability, or an irreversible dementia that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

4. Functional Eligibility

Description

This section describes the functional eligibility requirements for the IRIS program. To be eligible to enroll in the IRIS program, the participant must have a level of care assignment that would allow admission to a Nursing Home (NH) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The long-term care eligibility condition must be expected to last more than 12 months.

Wisconsin Adult Long-term Care Functional Screen (LTCFS)

Functional eligibility for the IRIS program is determined using the Long-Term Care Functional Screen (LTCFS). Level of care determinations may only be completed by an individual trained and certified to administer the LTCFS. Refer to A.9. Resources for more information about Wisconsin's Functional Screen system.

Functional eligibility for the IRIS program is established when the participant meets an eligible level of care. To determine the level of care, a qualified screener with the ADRC conducts a face-to-face interview with the participant and completes the Wisconsin LTCFS. The functional screen process gathers relevant information from the person, their family, formal and informal caregivers, health care professionals, and other relevant sources, as necessary. Upon completion of the screening process, the collected information is entered into the LTCFS, and the functional screen logic determines whether the participant's needs meet an eligible level of care.

Level of Care

In addition to LTCFS documentation of the participant's long-term care needs, all IRIS program enrollees must qualify for one of two levels of care. For elders and persons with a PD this is a Nursing Home Level of Care. For individuals with a DD the level of care assignment must be ICF-IID. In each of these situations the level of care verifies that the participant meets the functional eligibility requirements to live in either a Nursing Home or an ICF-IID.

5. Financial Eligibility

a. Description

To enroll in the IRIS program, participants must be determined to be financially eligible for a full-benefit Medicaid plan. The list of the allowable benefit plans along with the medical status codes that are not full-benefit Medicaid, which are not valid for IRIS enrollment, can be found in the IRIS Waiver Agency User Guide located on the secure Waiver Agency page of the ForwardHealth Portal.

In the IRIS program, as in Wisconsin's other Medicaid HCBS waiver programs, the Medicaid eligibility limits are somewhat broader than those in the traditional Medicaid fee-for-service programs. Eligibility for the waiver programs is like eligibility for institutional Medicaid. Please consult with the IM agency or the Medicaid Eligibility Handbook (A.9. Resources) for more information for current limits and restrictions.

Financial eligibility is determined by the local Income Maintenance (IM) Agency, a subunit of a county, consortia, or tribal government responsible for administering IM Programs including Wisconsin Medicaid. IM staff determine financial eligibility using the state's Client Assistance for Reemployment and Economic Support (CARES) system. All Medicaid cost share calculations are made by the IM agency. Medicaid eligibility is verified using the Department's Medicaid Management Information System (MMIS), ForwardHealth interChange (iC).

b. Assets

Asset eligibility for the IRIS program is based on the type of Medicaid for which the participant is eligible. For participants receiving SSI, 1619(a), and 1619(b), asset eligibility determinations are made by the Social Security Administration. The IM agency determines asset eligibility for most other participants.

For participants who are married, spousal impoverishment asset protections also apply to IRIS program applicants/participants. Spousal impoverishment is addressed in more detail below (5.d.).

For more information about assets and exemptions, IRIS program participants should consult with an ADRC benefit specialist, the IM agency, or refer to the Medicaid Eligibility Handbook (A.9. Resources).

c. Income

Income eligibility for IRIS program participation is based on state and federal Medicaid criteria and Wisconsin's federally approved Medicaid HCBS waivers. Income eligibility limits for Medicaid HCBS waiver programs are broader than other types of Medicaid. As a result, many people residing in the community who are otherwise ineligible for Medicaid may become financially eligible when enrolled in a Medicaid HCBS waiver program. Financial eligibility may occur in one of three income-based categories referred to as Group A, Group B, and Group B+. Financial eligibility criteria specific to each of these groups is described below.

Participants meeting the eligibility requirements who are employed, or seeking employment, are eligible for the IRIS program if their earnings are within the Medicaid allowable monthly earnings limits. If an employment outcome is established in a person's plan, then the participant can request Work Incentive Benefits Counseling as a waiver allowable service. The benefits specialist will assist the participant in determining the impact of work and earnings on the participant's financial eligibility.

i. Waiver Financial Eligibility Groups

1) Group A

Waiver financial eligibility Group A includes persons aged 18 years and older who are financially eligible for full-benefit Medicaid without using the broader Medicaid HCBS income eligibility limits.

Participants may attain full-benefit Medicaid financial eligibility through meeting a deductible. Such participants are eligible in Group A without a cost share for the remainder of the deductible period.

Participants who meet a nursing home level of care and who are newly enrolling in the IRIS program may have met a Medicaid deductible prior to enrollment and become financially eligible for the remainder of the six-month deductible period. Such persons have no cost share. At the end of the deductible period the IM agency will re-determine the participant's financial eligibility, which in almost all cases will be under the special HCBS waiver eligibility Group B or B+, explained below. The participant will then not have to meet a deductible but may have to pay a cost share depending on income and allowable deductions. The ICA shall explain these circumstances to the participant and assist the participant with the financial eligibility re-determination by the income maintenance agency at the end of the deductible period.

Participants eligible as Group A have no cost share obligation, although MAPP and BadgerCare Plus participants may pay a premium for those programs based on income.

For all Group A financially eligible persons choosing to participate in the IRIS program, the ADRC verifies Medicaid eligibility and initiates a referral to the ICA to complete the IRIS program enrollment and service planning process.

2) Group B

Waiver financial eligibility Group B includes persons aged 18 years and older who are not in Group A, meet the non-financial requirements to receive HCBS waiver services, and have a gross monthly income not greater than the special income limit equal to 300% of the SSI federal benefit rate for an individual. This amount is adjusted annually. For current income levels, refer to the Medicaid Eligibility Handbook (A.9. Resources).

IRIS program participants in financial eligibility Group B are allowed certain deductions from their income in the eligibility and post-eligibility determination processes. When applicable, married Group B participants may also have spousal impoverishment protections applied.

At the initial application stage, the ADRC staff assists the IRIS program participant to gather supporting documentation to verify countable deductions and exemptions from income. Examples of these include monthly medical and remedial expenses, special exempt income, applicable housing costs, and other deductible expenses. The ADRC staff then provides these figures to the IM agency and assists the participant to set up an appointment with IM staff to complete the Medicaid application. At the time of the Medicaid application, the IM staff verifies the information provided and enters the income, allowable expenses, applicable disregards, and allowances into the CARES system for the Group B financial eligibility and cost sharing determination. Please consult with the IM agency or the Medicaid Eligibility Handbook (A.9. Resources) for more information about Group B financial eligibility.

3) Group B+

Waiver financial eligibility Group B+ includes persons aged 18 years and older who are not in Group A, meeting all requirements for Group B except for income, whose monthly income after subtracting the cost of institutional care is at or below the medically needy income limit. This amount is adjusted annually. For current income levels, refer to the Medicaid Eligibility Handbook (A.9. Resources).

Persons eligible under this group have a cost share obligation which is calculated based on income and allowable deductions like those in Group B. The participant's monthly cost share obligation must be paid timely each month to remain eligible. Please consult with the IM agency or the Medicaid Eligibility Handbook (A.9. Resources) for more information on Group B+ financial eligibility.

ii. Groups B and B+ Medical and Remedial Expenses

IRIS program participants in financial eligibility Groups B and B+ are allowed certain deductions from their income in the eligibility and post-eligibility determination

processes. When applicable, married Group B and B+ participants may also be eligible for spousal impoverishment protections. At the initial application stage, the ADRC staff assists the participant to gather supporting documentation to verify applicable deductions and exemptions from income. Examples include monthly medical and remedial expenses, special exempt income, applicable housing costs, and other deductible expenses. The ADRC staff provides this information to the IM agency and assists the participant to set an appointment with IM staff to complete the Medicaid application.

At the time of application, the IM staff verifies the information provided and enters the income, allowable expenses, applicable disregards, and allowances into the CARES system for the Group B financial eligibility and cost sharing determination. Refer to the Medicaid Eligibility Handbook or consult with the IM agency (A.9. Resources) for more information about Group B financial eligibility.

Medical and remedial expenses for Group B are those recurring, monthly costs that directly relate to the participant's care needs and/or costs incurred while treating or preventing or minimizing the effects of illness, injury, or other impairments to physical or mental health. Allowable medical and remedial expenses include items and services that are purchased by the participant and that are not covered by the Medicaid state plan, by Medicare, or by a private health plan and are not paid for by the IRIS program or by another funding source. **Items or services that can be purchased under the IRIS program should not be counted as a medical or remedial expense.**

1) Group B and B+ Medical Expenses

Medical expenses include costs incurred for items or services that are prescribed or recommended by a medical practitioner licensed to practice in Wisconsin or another state. Medical expenses also include costs incurred for items or services that are prescribed or recommended by a practitioner of the healing arts who engages in the practice of their profession within the scope of their license, permit, or certification in the State of Wisconsin or another state.

Countable medical expenses may include over-the-counter remedies, medical or therapeutic supplies, as well as deductibles or co-payments for Medicaid, Medicare, or another health plan. Allowable expenses may also include bills for durable medical equipment, items, or services that are not covered by Medicaid or by another payer or bills for such medical costs that were incurred prior to Medicaid eligibility, and which are being paid by the participant.

Note: Certain medical bills cannot be counted as medical or remedial expenses. These include:

- Medical bills which remain unpaid, but were used previously to meet a Medicaid deductible
- Bills which were incurred for institutional care provided during a previous Medicaid divestment penalty period
- Bills that represent a patient liability amount/cost share incurred during some previous period of institutionalization or an unpaid Medicaid HCBS Waiver cost share obligation
- Medical bills which will be paid by a legally liable third party (e.g. private health insurance, Medicare or Medicaid)
- Bills which were previously allowed as a medical/remedial expense and counted to reduce a waiver cost share or used to reduce a nursing home patient liability obligation

2) Group B and B+ Remedial Expenses

Remedial expenses for Groups B and B+ include services or items that are identified in the individual's assessment, deemed necessary to assist the person in community living and may be included on the support and service plan, but will not be covered by Medicaid, the IRIS program, or another payer. Note: Room and board costs may not be counted as a medical or remedial expense.

When determining the person's monthly total amount of medical and remedial expenses for Group B financial eligibility, only those allowable expenses that are both incurred and paid by the participant can be counted. Items or services that were bought for someone else (a spouse, child, etc.) or paid for by another person, or by the IRIS program, the Medicaid card, a private health plan or any other program are not counted.

d. Spousal Impoverishment

Spousal Impoverishment refers to how income and assets of a legally married couple are treated to prevent the impoverishment of the participant's spouse while the participant receives long-term care services. The IRIS participant is known as the institutionalized spouse, while their spouse is called the community spouse. The rules allow the participant to transfer a portion of their assets and income to their spouse except when the participant's spouse resides in a nursing home, ICF/IID or medical institution and has lived there for 30 or more consecutive days. When both spouses are IRIS program participants, each spouse may allocate resources to the other. Refer to the Wisconsin Medicaid Spousal Impoverishment Protection publication, the Medicaid Eligibility Handbook or consult with the IM agency (A.9. Resources) for more information about spousal impoverishment.

i. Asset Assessment and Asset Transfer

The term "asset allocation" refers to the way assets may be divided between each spouse for the purpose of establishing Medicaid eligibility under spousal impoverishment rules. The asset allocation process determines the amount of assets the married participant may keep to still be considered eligible for Medicaid. Assets are counted on the date the participant first requests Medicaid HCBS waiver services, or when they are institutionalized for 30 days or more, whichever is earlier.

Asset allocation will establish the Community Spouse Asset Share (CSAS). That is the amount of countable assets greater than the $2,000 limit that the participant's community spouse is allowed to retain. Spousal impoverishment asset limits are adjusted annually, and the maximum amount the participant's spouse may allocate varies depending on the couple's total assets. In addition, when the community spouse asset share is a court-ordered amount or set by an administrative hearing, the total amount of assets allowed may be greater than the spousal impoverishment limit.

ii. Income Allocation

Income allocation occurs after the IRIS program participant is determined to be Medicaid eligible. The IM worker completes the Spousal Impoverishment Income Allocation Worksheet to determine the amount of monthly income the participant may allocate to his/her community spouse. Depending on the amount, the income allocation may reduce or eliminate the participant's cost share.

After the eligibility determination, the participant may choose to allocate all, part, or none of their available income to their spouse who, in turn, may choose to accept all,

part, or none of the allocation. For the allocation to be applied to the cost share, the participant must demonstrate the income was made available to their community spouse. If SSI or Medicaid eligibility would be jeopardized, then the spouse may forego the allocation. If both spouses are IRIS program participants, each may allocate income to the other.

The maximum amount of income that may be allocated to the community spouse is adjusted annually.

6. Medicaid Non-Financial Eligibility

Description

To enroll in the IRIS program, participants must be determined non-financially eligible for Medicaid.

IM determines whether a participant meets all non-financial criteria:

1. Be in a qualifying coverage group for BadgerCare Plus or Medicaid
2. Be a Wisconsin resident
3. Be a U.S. citizen or qualifying immigrant
4. Cooperate with establishing medical support
5. Cooperate with third-party liability requirements
6. Meet Social Security number requirements
7. Cooperate with verification requests of information
8. Meet health insurance assess and coverage requirements
9. Pay a premium, if assessed
10. Pay a community waiver cost share, if assessed

7. Program Eligible Living Arrangements

a. Description

Participants must reside in an eligible living arrangement to be eligible to participate in the IRIS program. The participant's living arrangement refers to their permanent residence. A participant who routinely visits friends or relatives out of state does not give up their permanent residence. For example, the IRIS program participant who visits a relative in Arizona for several months each winter, does not impact their state residency. Similarly, an IRIS program participant who attends a college and resides on campus during the school year does not give up their permanent residence.

b. Community Living Arrangements

While the arrangements below are generally permitted, there are some restrictions. For example, IRIS program funds may not be used to pay for Community Based Residential Facilities (CBRFs). IRIS program participants and their legal representatives need to be aware of these limitations and should contact the ICA with questions regarding allowable living arrangements.

i) Permanent Eligible Living Arrangements

1) DD Target Group

Eligible living arrangements for participants with a DD include:

- A house, apartment, condominium, or other private residence
- A rooming/boarding house
- A certified Adult Family Home (1-2 bed)
- A licensed Adult Family Home (3-4 beds)

2) PD and FE Target Groups

Eligible living arrangements for participants with a PD or are FE include:

- A house, apartment, condominium, or other private residence
- A rooming/boarding house
- A certified Adult Family Home (1-2 bed)
- A licensed Adult Family Home (3-4 beds)
- A certified RCAC

ii) Temporary Living Arrangements

Participants not residing in one of the eligible settings listed above at the time of application may seek enrollment in the IRIS program. In transitional situations, a participant may reside in a hotel, motel, homeless shelter, or other type of transitional housing. However, final enrollment cannot be established, and IRIS program services may not begin until the person lives in an eligible setting.

iii) Short Term Institutional Stays

An IRIS program participant's admission to an institutional setting, such as a hospital, nursing facility or an institution for mental disease, for short-term acute care and/or rehabilitative services, does not change the participant's permanent residence or living arrangement and the participant retains continued eligibility for enrollment in the IRIS program.

IRIS program services, however, must be suspended while the participant is in this short-term setting. The participant is required to report any institutional stay to IM within 10 days as well as to the ICA. When the ICA is informed of the admission, the ICA staff will notify IM using the Family Care, Partnership, PACE, or IRIS Change Routing (F-02404) (see Change Reporting Process to IM B.2.b. below).

The ICA staff will assist the participant with planning and relocation activities for the participant to return to an eligible community living arrangement.

A temporary stay that becomes permanent, triggers a program requested disenrollment from the IRIS program because these facilities are ineligible living settings for IRIS participants. A participant who has an institutional stay that extends beyond 90 days following the admission date to the facility must be disenrolled from the IRIS program (see Enrollment – Disenrollments and Suspensions (TBD)).

iv) Incarceration

If a participant is incarcerated in a jail, prison, or other correctional facility for 30 days or more, the ICA will notify IM using the Family Care, Partnership, PACE, or IRIS Change Routing (F-02404) (see Change Reporting Process to IM B.2.b. below) and initiate disenrollment from the IRIS program since this is not an eligible living arrangement (see Enrollment – Disenrollments and Suspensions (TBD)).

8. Need for Services

Need for Services

Participants who have met all eligibility criteria must also have an assessed need for waiver services to be eligible for participation in the IRIS program. The Centers for Medicare and Medicaid Services define "reasonable need" as follows: "In order for an individual to be

determined to need waiver [IRIS] services, an individual must require (a) the provision of at least one HCBS waiver service, as documented in the service plan, and (b) the provision of HCBS waiver services occurs at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan."

IRIS Program Availability

The IRIS program is an adult long-term care option available to persons residing in any of Wisconsin's 72 counties as well as tribal nations where managed long-term care programs are also operating.

9. Resources

- Find an Aging and Disability Resource Center (ADRC), https://www.dhs.wisconsin.gov/adrc/consumer/index.htm
- Find an Aging and Disability Resource Specialist (ADRS) for tribal members, https://www.dhs.wisconsin.gov/adrc/consumer/tribes.htm
- Wisconsin's Functional Screen, https://www.dhs.wisconsin.gov/functionalscreen/index.htm
- Income Maintenance and Tribal Agency Contact Information, https://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Medicaid Eligibility Handbook, P-10030 https://www.dhs.wisconsin.gov/library/P-10030.htm
- Federal Poverty Level Guidelines, https://www.dhs.wisconsin.gov/medicaid/fpl.htm
- Wisconsin Medicaid – Spousal Impoverishment Protection https://www.dhs.wisconsin.gov/library/p-10063.htm
- Medical and Remedial Expense Checklist, F-00295 www.dhs.wisconsin.gov/forms/f0/f00295.doc
- Frequently Asked Questions (FAQ) - Medical and Remedial Expenses in the Family Care, Partnership, PACE, and IRIS Programs, P-02006 https://www.dhs.wisconsin.gov/publications/p02006.pdf
- Medical and Remedial Expenses in Family Care, Partnership, PACE, and IRIS, DMS Memo 2017-03 https://www.dhs.wisconsin.gov/dms/memos/num/2017-03.pdf
- Family Care, Partnership, PACE, or IRIS Change Routing, F-02404 www.dhs.wisconsin.gov/forms/f0/f02404.docx

B. Eligibility: Ongoing Eligibility Requirements

The IRIS program is a federally approved Home and Community-Based Services (HCBS) Waiver Program. All participants must maintain functional, financial, and non-financial eligibility requirements to maintain enrollment in the IRIS program.

1. Annual Eligibility Reviews

Description

Once participants have met the initial eligibility requirements, they must complete certain activities to maintain Medicaid eligibility and avoid disenrollment from the program.

i. Functional Eligibility Review

Functional eligibility redeterminations are made with the completion of a new LTCFS. The screens are conducted by qualified ICA staff in a face-to-face interview with the participant, in their place of residence, if possible. To maintain functional eligibility, the participant must continue to require an eligible level of care (LOC) at review. If continued functional eligibility is not established at recertification, the participant becomes ineligible for the program and will be disenrolled (see Enrollment – Disenrollments and Suspensions (TBD)).

ii. Medicaid Eligibility Renewal

Once enrolled in BadgerCare Plus or Medicaid, a renewal must be completed at least once each year. The IM agency will mail a letter to the participant the month before the renewal is due. The renewal is conducted by the IM agency and can be done online at access.wisconsin.gov, by phone, by mail, by fax, or in person. The renewal ensures the participant continues to meet all program rules and is receiving appropriate benefits. If continued financial eligibility for Medicaid is not confirmed, then the participant becomes ineligible for the program and will be disenrolled (see Enrollment – Disenrollments and Suspensions (TBD)).

2. Reporting Changes

a. Description

Once enrolled in the IRIS program, IRIS participants must complete certain activities to maintain Medicaid eligibility to avoid disenrollment from the program.

Participants who don't receive SSI benefits are responsible to report to the IM agency any changes in the make up of their household, a change in address, income, assets or employment status within ten (10) calendar days of the change. Other changes such as medical or shelter costs should also be reported to ensure accurate cost share calculations. The IM staff will enter the reported changes in the CARES system. If the new information impacts the participant's Medicaid eligibility or cost share obligation, CARES will generate a ten-day written notice informing the participant of the change and of their right to appeal the determination.

Failure to report changes promptly may affect ongoing eligibility and may result in a Medicaid and/or cost share overpayment.

Participants who receive SSI benefits are required to report changes to the Social Security Administration rather than the local IM agency. Failure to report changes timely may result in an overpayment, which may need to be paid back. Contact information for the Social Security Administration is:

- Phone: 1–800–772–1213
- TTY: 1–800–325–0778
- WEBSITE: www.ssa.gov
- Local Social Security Office (https://secure.ssa.gov/ICON/main.jsp)

b. Procedures

Change Reporting Process to IM

Step	Responsible Partner(s)	Detail
1	Participant	Reports change to the ICA that may impact Medicaid eligibility.

Step	Responsible Partner(s)	Detail
2	ICA	Reports the change to IM by completing the Family Care, Partnership, PACE, or IRIS Change Routing (F-02404), and submits the form along with supporting verifications via fax.
3	ICA	The ICA verifies the reported change in the ForwardHealth portal 14 days after submission. If the reported change results in a disenrollment for the Participant, the ICA will route the entire form to the ADRC to perform disenrollment counseling.

3. Supplemental Security Income Exceptional Expense (SSI-E)

b. Description

Wis. Stat. § 49.77 specifies that persons receiving Supplemental Security Income (SSI) may be eligible for an exceptional "E" payment which is referred to as Supplemental Security Income Exceptional Expense (SSI-E). The payment is added to an individual's monthly SSI benefit payment, once determined eligible. This section explains the roles and responsibilities for establishing an IRIS program participant's SSI-E payment.

The ICA completes eligibility screening for participants who may have become eligible for SSI-E after enrolling in the IRIS program and monitors the condition of SSI-E eligible persons to ensure the eligibility criteria are continuously met. The ICA is also required to cancel eligibility for persons who no longer meet SSI-E eligibility requirements.

The Department of Health Services' (DHS) SSI-E Handbook describes the rules and eligibility requirements for the SSI-E benefit. It is important to understand that the 40 hours per month of care requirement is based on the participant's need for care, not on services provided.

ForwardHealth interChange (iC) is the system of record that maintains the SSI-E certification information for participants. Each ICA is responsible for obtaining information from this system to verify SSI-E enrollment. Refer to the SSI-E Policy Handbook (B.4. Resources).

c. Procedures

SSI-E Eligibility Determination Process

Step	Responsible Partner(s)	Detail
1	ADRC	The ADRC provides enrollment/options counseling, including the completion of a LTCFS. For those interested in SSI-E, may determine eligibility. Send the G-1 or G-2 letter, included in the SSI-E Handbook, informing the participant of the decision.
2	ADRC	The ADRC indicates the IRIS program participant's SSI-E status on the IRIS Authorization form (F-00075).
3	ICA	The ICA will monitor referral form information indicating SSI-E status, and ensure ongoing SSI-E eligibility monitoring.
4	ICA	Remains aware of which participants are certified for SSI-E and reports any changes in the criteria that might affect eligibility to the ICA LTCFS Liaison.
5	ICA	The ICA completes the SSI-E eligibility assessment for participants that subsequently become SSI-E eligible following their IRIS program enrollment and desire to receive the SSI-E benefit. Within 30 days after

Step	Responsible Partner(s)	Detail
		completing the new LTCFS, forms F-20817 and F-20812 are completed to determine if the changes make the individual eligible for SSI-E.
6	ICA	Completes form F-20818 to process all new SSI-E certifications and distributes the form as listed on the bottom of the form.
7	ICA	Send the G-1 or G-2 letter, included in the SSI-E Handbook, informing the participant of the decision.
8	ICA	Monitors the status of all SSI-E eligible individuals by using documentation in the LTCFS and from other sources in the participant record to ensure continued eligibility.
9	DHS	DHS annually reviews the eligibility of **state-only SSI** recipients and terminates the SSI and SSI-E for persons no longer eligible for **state-only SSI**.
10	ICA	Decertifies the SSI-E for all persons whose condition or situation changes according to the rules specified on F-20818 and in the SSI-E Handbook. Note that special consideration applies to death-related decertification.
11	ICA	Sends written notification to all participants who are decertified for SSI-E using letter G-2 as specified in the SSI-E Handbook.
12	ICA	Informs DHS of all SSI-E eligible persons who move to/from a natural residential arrangement and to/from a qualified substitute care arrangement by completing form F-20818.
13	ICA	Reviews the person's SSI-E status for each program disenrollment or transfer and communicates this to the ADRC or ICA.

SSI-E Benefit Monitoring

Step	Responsible Partner(s)	Detail
1	ICA	Monitors to ensure tasks to start or terminate SSI-E benefits are completed in a timely manner. The ICA provides oversight activities to ensure continued eligibility.
2	DHS	Review reports requested from ICAs on new certifications, changes in living arrangement, decertification, and moves from substitute care to natural residential settings.

4. Resources

- Medicaid Eligibility Handbook, P-10030, https://www.dhs.wisconsin.gov/library/P-10030.htm
- Family Care, Partnership, PACE, or IRIS Change Routing, F-02404 www.dhs.wisconsin.gov/forms/f0/f02404.docx
- Income Maintenance and Tribal Agency Contact Information, https://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Understanding Supplemental Security Income Reporting Responsibilities, https://www.ssa.gov/ssi/text-report-ussi.htm
- SSI-E Policy Handbook, P-20679, https://www.dhs.wisconsin.gov/library/P-20679.htm
- SSI-E Natural Residential Setting Application Checklist, F-20812, https://www.dhs.wisconsin.gov/library/F-20812.htm
- Assessment Worksheet for Natural Residential Setting, F-20817, https://www.dhs.wisconsin.gov/library/F-20817.htm

- Certification for SSI-E Exceptional Expense Supplement, F-20818, https://www.dhs.wisconsin.gov/library/F-20818.htm