Eligibility

A. Eligibility: Initial Eligibility Determination

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 to enroll in IRIS.

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

1. Be at least 18 years of age
2. Meet applicable requirements for Wisconsin residency
3. Meet the definition of an eligible population (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

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 17.5 years of age for enrollment counseling.

2. Residency

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. The IM Agency is a subunit of a county, consortia, or tribal government responsible for administering IM Programs including Wisconsin Medicaid.

3. Eligible Population (Target Group)

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

Long Term Care Functional Screen (LTCFS): Target Group

Target Group eligibility for the IRIS program is determined using the Long Term Care Functional Screen (LTCFS). Only individuals trained and certified to administer the LTCFS can complete Target Group determinations.

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.

Eligible target populations include adults with developmental disabilities (DD), adults with physical disabilities (PD), and frail elders (FE). These target groups are defined by the functional screen instructions and determined by the information that the certified screener inputs into the functional screen application. Refer to section A.9. (Resources) below for more information about Wisconsin's Functional Screen system.

4. Functional Eligibility

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 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.

LTCFS: Level of Care

Functional eligibility for the IRIS program is determined using the Long-Term Care Functional Screen (LTCFS). Only individuals trained and certified to administer the LTCFS can complete level of care determinations. Refer to section 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 initial 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.

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 frail 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

To enroll in the IRIS program, participants must be determined financially eligible for a full-benefit Medicaid plan with a valid medical status code. A medical status code is a two-digit, alphanumeric code that the Department uses in the Medicaid Management Information System to define the type of Medicaid eligibility a participant has. There are some medical status codes that are associated with the full-benefit BadgerCare Plus Standard Plan, Wisconsin Medicaid, and Wisconsin Well Woman Medicaid benefit plans that are not valid for IRIS participant enrollment. Generally, these medical status codes are used to provide limited benefits to people who are immigrants and/or who are incarcerated. The list of the allowable benefit plans, along with the medical status codes that are not full-benefit Medicaid, can be found in the IRIS Waiver Agency User Guide located on the secure Waiver Agency page of the ForwardHealth Portal.

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).

When determining financial eligibility, IM agencies evaluate various financial factors, including a participant's assets, income, and spousal impoverishment. Each of these factors are reviewed, as applicable, and are utilized to determine a participant's financial eligibility for the IRIS program.

For additional information regarding financial eligibility and types of Medicaid eligibility that allow a participant to enroll in the IRIS program, refer to section A.9. (Resources) for more information about the Medicaid Eligibility Handbook.

6. Medicaid Non-Financial Eligibility

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

The IM agency determines whether a participant meets all non-financial criteria. The participant must:

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 access and coverage requirements
9. Pay a premium, if assessed
10. Pay a community waiver cost share, if assessed

7. Program Eligible Living Arrangements

a. Program Requirement

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, visiting a relative in Arizona for several months each winter does not impact an IRIS program participant's state residency status. 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 about allowable living arrangements.

i) Permanent Eligible Living Arrangements

1) Developmental Disability (DD) Target Group

Eligible living arrangements for participants with a DD include:

- House, apartment, condominium, or other private residence
- Rooming or boarding house
- Certified Adult Family Home (1-2 bed)
- Licensed Adult Family Home (3-4 beds)

2) Physical Disability (PD) and Frail Elder (FE) Target Groups

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

- House, apartment, condominium, or other private residence
- Rooming or boarding house
- Certified Adult Family Home (1-2 bed)
- Licensed Adult Family Home (3-4 beds)
- Certified Residential Care Apartment Complex (RCAC)

ii) Temporary Living Arrangements

Participants not residing in one of the eligible settings listed above when they apply may still 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

Institutional settings include hospitals, nursing facilities, or other long-term care institutions. An IRIS program participant's permanent residence or living arrangement doesn't change if they are admitted to an institutional setting for short-term acute care or rehabilitative services. They remain eligible for 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. Upon request of the participant, the ICA can assist with reporting this change in living arrangement to IM (see Process for Reporting a Change to the IM Agency B.2.b. below).

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

A temporary stay that becomes permanent triggers a program requested disenrollment from the IRIS program. This happens 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.

iv) Incarceration and IMD Admission

If a participant is incarcerated in a jail, prison, or other correctional facility or admitted to an IMD the ICA will notify IM using the Change Routing Form (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.

8. 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 & 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."

9. Resources

- Find an Aging and Disability Resource Center (ADRC), www.dhs.wisconsin.gov/adrc/consumer/index.htm
- Find an Aging and Disability Resource Specialist (ADRS) for tribal members, www.dhs.wisconsin.gov/adrc/consumer/tribes.htm
- Wisconsin's Functional Screen, www.dhs.wisconsin.gov/functionalscreen/index.htm
- Income Maintenance and Tribal Agency Contact Information, www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Medicaid Eligibility Handbook, P-10030, www.dhs.wisconsin.gov/library/P-10030.htm
- Wisconsin Medicaid/BadgerCare Plus Deductible Plans dhs.wisconsin.gov/publications/p1/p10052.pdf
- Federal Poverty Level Guidelines, www.dhs.wisconsin.gov/medicaid/fpl.htm
- Wisconsin Medicaid – Spousal Impoverishment Protection 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 www.dhs.wisconsin.gov/publications/p02006.pdf
- Medical and Remedial Expenses in Family Care, Partnership, PACE, and IRIS, DMS Memo 2017-03 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

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

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 Long Term Care Functional Screen (LTCFS). The screen is conducted within 364 days of the previous LTCFS by a 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.

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.wi.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 – Disenrollment and Suspensions).

2. Reporting Changes

a. Change Reporting Requirements

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

Participants who do not 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 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 10-day written notice informing the participant of the change and 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 can report changes to IM in one of the following ways:

- **Online —** Visit access.wi.gov and log into your ACCESS account. Select My Changes. If you do not have an account, you can create one on the site.
- **Phone —** Call your IM or Tribal agency (www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm).
- **Fax or mail —** send a Medicaid Change Report, F-10137, using the instructions on the form.
- **In person —** Visit your IM or Tribal agency (www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm).

Participants who receive SSI benefits must 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: 800–772–1213
- TTY: 800–325–0778
- Website: www.ssa.gov
- Local Social Security Office: https://secure.ssa.gov/ICON/main.jsp

b. Procedures

Process for Reporting a Change to the IM Agency

Step	Responsible Partner(s)	Detail
1	Participant	Reports change to the ICA that may affect Medicaid eligibility and, if necessary, requests that the IC help them complete the necessary steps to report the change.
2	ICA	Supports the participant in reporting the change and any applicable verifications to IM, as needed. This may include: • Helping participant with the access.wi.gov website or MyACCESS mobile app. • Supplying IM contact information. • Facilitating a phone call to IM. • Providing the participant with the Medicaid Change Report Form for them to send to IM.
3	ICA	Completes the Family Care, Partnership, PACE, or IRIS Change Routing Form, F-02404, when applicable, according to the guidance of the Adult Long-Term Care Programs: Enrollment and Disenrollment Resource Guide, P-02997 or the Enrollment and Disenrollment Process Desk Aid for Publicly Funded Long-Term Care Programs, P-02915.

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

a. SSI-E Requirements

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) Supplemental Security Income Exceptional Expense (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.

The MMIS is the system of record that keeps 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 Handbook.

b. Procedures

SSI-E Eligibility Determination Process

Step	Responsible Partner(s)	Detail
1	ADRC	The ADRC provides enrollment and options counseling, including the completion of an initial LTCFS. For those interested in SSI-E, the ADRC 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 check referral form information showing 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 who later become SSI-E eligible following their IRIS program enrollment and want to receive the SSI-E benefit. Within 30 days of 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	Sends the G-1 or G-2 letter, referenced 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 or from a natural residential arrangement and to or 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, www.dhs.wisconsin.gov/library/collection/P-10030
- 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, www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm
- Understanding Supplemental Security Income Reporting Responsibilities, www.ssa.gov/ssi/text-report-ussi.htm
- Enrollment and Disenrollment Process Desk Aid for Publicly Funded Long-Term Care Programs, P-02915, www.dhs.wisconsin.gov/publications/p02915.pdf
- Adult Long-Term Care Programs: Enrollment and Disenrollment Resource Guide, P-02997, www.dhs.wisconsin.gov/publications/p02997.pdf
- ForwardHealth Enrollment and Benefits Handbook, P-00079, www.dhs.wisconsin.gov/library/collection/p-00079
- ForwardHealth: Reporting Changes for Benefits, www.dhs.wisconsin.gov/forwardhealth/change-report.htm
- ACCESS, access.wisconsin.gov/access/
- SSI-E Policy Handbook, P-20679, www.dhs.wisconsin.gov/library/P-20679.htm
- SSI-E Natural Residential Setting Application Checklist, F-20812, www.dhs.wisconsin.gov/library/collection/F-20812
- Assessment Worksheet for Natural Residential Setting, F-20817, www.dhs.wisconsin.gov/library/collection/F-20817
- Certification for SSI-E Exceptional Expense Supplement, F-20818, www.dhs.wisconsin.gov/library/collection/F-20818