Wisconsin's Family Care Program—Lifting the Temporary Caps and Putting the Program on the Path to Long Term Sustainability

Overview

Wisconsin continues to lead the nation in developing effective strategies to address the needs of individuals who rely on public assistance for long-term care (LTC), services, and supports. In total, LTC expenditures will exceed $2.8 billion (all funds) this year, representing about 40% of the State's Medicaid budget. Over the years, Wisconsin has developed a number of optional programs that offer individuals alternatives to the institutionally-based mandates of Medicaid. The State has employed a series of innovative Medicaid waivers to diverge from traditional Medicaid requirements. Family Care is the largest of these programs under the Medicaid umbrella that is designed to serve low-income adults who have a disability or are frail and elderly.

In 2011, two coincident and significant events resulted in a slowing of enrollment into Family Care. First, in April, the nonpartisan Joint Legislative Audit Bureau released its widely anticipated comprehensive audit of the Family Care program as directed by the Legislature in July 2010. While the evaluation documented the popularity of the program and the strong support of a wide range of its members and stakeholders, critical questions were raised regarding the cost-effectiveness and fiscal sustainability of the Family Care program. As a result, the Legislature directed the Department of Health Services (DHS) to study the cost-effectiveness of our LTC programs.

Second, on July 1, 2011, the State experienced a massive reduction in federal funding for its Medicaid program. The loss of $660 million in federal funds for Fiscal Year 2012 and an additional $666 million for FY 2013 imposed an unequivocal threat to the state's ability to sustain the innovative, yet optional LTC programs. Anticipating both of these events, Governor Walker and the Legislature provided an infusion of $1.2 billion in new state funds during the current biennium, to continue enrollment into Family Care and IRIS at existing levels and to support individuals who were in urgent/emergency need of publicly-funded long term support services. The 2011-13 biennial budget, 2011 Wisconsin Act 32, created a temporary enrollment cap for the Family Care, IRIS, PACE and Partnership programs.

It is important to note that the State could have chosen to scale back these waiver programs by reducing benefits. This available choice was reiterated most recently by Solicitor General Donald B. Verrilli during the oral arguments in *Florida, et al. v. Department of Health and Human Services*. Solicitor General Verrilli informed the U.S. Supreme Court that the maintenance-of-effort (MOE) provisions of the Patient Protection and Affordable Care Act (PPACA) do not apply to optional benefits under Medicaid, which, of course, include benefits offered under Family Care. Moreover, as an optional waiver program, the State could have ended the existing waiver and started all over with a new waiver. Other states have used this approach to reduce waiver benefits. The Governor and Legislature, however, categorically rejected these options, choosing instead to protect the benefits to more than 43,000 low-income seniors and individuals with disabilities.

This temporary provision slowed the pace but did not end new enrollment into the State's LTC programs, including Family Care, IRIS, PACE and Partnership. The temporary slowdown was designed to provide DHS and state policymakers an opportunity to explore strategies and identify options to strengthen Wisconsin's

LTC programs. Over a six-month period, DHS completed a comprehensive data analysis and consulted with a wide range of consumers, providers, advocates, tribes, counties, and other stakeholders to identify cost drivers and seek options to improve the cost-effectiveness and future fiscal sustainability of these programs.

During this period, Governor Walker continued to express his strong commitment to Family Care and other LTC programs and publicly stated his intentions to fully resume enrollment. After a package of savings reforms was identified, the Governor called upon the Legislature to lift the temporary provisions. The LTC Sustainability Initiatives identified through this outreach and feedback will provide an estimated $80 million in state savings over the 2011-13 biennium, allowing the State to remove the enrollment cap. These strategies are also designed to ensure that the State's LTC programs are sustainable on an ongoing basis in the future.

Over this time, the Department consulted on many occasions with federal representatives at the Centers for Medicare and Medicaid Services (CMS); the Governor's recommendation to repeal the cap was consistent with discussions with federal officials. Recent communications have focused on services provided during the period of the enrollment cap, which are detailed in this paper.

On April 3, 2012, the temporary enrollment provision was removed (2011 Wisconsin Act 127). This document describes our efforts to expedite enrollment, to build on the health care services and LTC supports provided during the period of the cap, and to implement savings initiatives that ensure LTC services are provided in the most integrated and least restrictive settings in the community.

In particular, this paper will provide a description and status of current efforts, along with information on:

- What individuals experienced between July 1, 2011 and April 3, 2012;
- Wisconsin's action plan to expedite outreach and enrollment into LTC programs;
- What is the wait list, who was enrolled and what are people waiting for; and
- What are the LTC Sustainability Initiatives that generate savings and strengthen LTC programs in 2011-13 and in the future.

What Individuals Experienced Between July 1, 2011 and April 3, 2012

Throughout the period between July 1, 2011 and April 3, 2012, the State continued to serve individuals seeking public assistance for their medical needs and provided information about long term care supports and services. Every individual currently on a wait list received assistance from the State. Moreover, enrollment into the Medicaid program among the elderly, blind, and disabled populations increased every month from July 2011 through March 2012, with the exception of August 2011.

Connecting People to Services. Access into Wisconsin's long term care assistance programs for many individuals begins with Aging and Disability Resource Centers (ADRCs). About 85% of Wisconsin citizens have access to an ADRC in their community. In 2010, ADRCs responded to almost 345,000 requests for assistance, averaging nearly 29,000 per month. More than 73% of ADRC activity related to Information and Assistance. Nearly 38,000 people received services from a benefit specialist. According to the most recent survey, over 93% would recommend the ADRC to others and 90% of ADRC customers said that the ADRC was helpful or very helpful.

ADRCs are welcoming and accessible places where older adults and people with disabilities can obtain information, advice, and assistance in locating services or applying for benefits. ADRCs provide a central

source of reliable and objective information about a broad range of programs and services and help people understand and evaluate various options to make informed decisions about long-term care.

ADRCs provide personalized help in finding and connecting individuals to services that match his or her needs. ADRCs provide information and access to a wide range of services, including in-home supportive and nursing care, housekeeping and chore services, home modifications, caregiver respite, nutrition and home-delivered meals, transportation, assisted living, nursing homes, and financial assistance through Medicare, Medicaid, FoodShare and other aging and benefit programs. As the single point of access for publicly funded long-term care, ADRCs provide eligibility determinations and enrollment counseling for the state's managed long-term care and self-directed supports waivers.

ADRC staff are skilled at recognizing situations that might put someone at risk, such as the sudden loss of a caregiver, and help people to secure appropriate services. ADRCs employ multiple channels (newspaper, radio, other media; physician's offices, hospitals, assisted living and nursing homes; local government agencies; community service organizations; and consumer advocacy) to outreach to client populations. ADRCs also use a variety of approaches to maintain contact with individuals already on a wait list, and provide services by telephone, in the resource center, or in a person's own home.

Services Provided During and After the Cap. While the largest payer of all long-term care services is Medicaid at 42% of total spending, the majority of long-term care services are actually provided on an unpaid basis through a person's natural support system by their family or friends. A November 2011survey of people on the ADRC wait list confirmed the substantial natural supports people received from family and friends and the need for additional help to relieve the burden on these caregivers in the future.

Although the enrollment cap temporarily slowed the pace of LTC program growth, ADRCs continued to:

- Outreach to potential clients in the community and screen people on the wait list;
- Provide information and assistance on a wide range of LTC supports and services;
- Complete functional screens to assess needs;
- Link people to programs and services; and
- Using attrition and urgent needs funding, enroll individuals into publicly-funded LTC programs.

Wisconsin continued to meet immediate needs of people for LTC supports during the time the cap was in place. Specifically:

- ADRCs worked with individuals in need of LTC services to ensure that urgent health and safety needs were identified, and enrolled them into LTC programs using attrition and urgent/emergency funding.
- Many individuals on the wait list indicated they needed services in the future, and others are not yet financially eligible for enrollment.
- The State leveraged existing eligibility for health care programs, including Medicaid and Medicare, to provide health care, and complemented these services with resources from aging and other programs to provide supportive care, caretaker support, nutrition, chore services and transportation.
- The State provided flexibility to continue enrollment using attrition within the budget and through urgent funding. The State slowed, but did not stop new enrollment.

The budget legislation, Act 32, provided $12.6 million in each year of the biennium to meet urgent/emergency needs. On average, twelve people per month were enrolled using the additional funding provided for

urgent/emergency needs, resulting in a total expenditure of approximately $765,000. By leveraging ongoing attrition in the program and urgent/emergency funding, ADRCs were able to enroll individuals most in need of services, in addition to others on the wait list.

Information is available from a number of sources within the State's LTC and health care IT systems and through the wait list survey. To show the services received and the projected need of individuals, DHS analyzed the most recent wait list, enrollment data, and other data available as of February 2012. At that time, there were 6,263 individuals who met the functional eligibility screen requirements to be placed on the ADRC wait list. The following summarizes the status and services received of the individuals on the wait list.

- 100% of the 6,263 individuals on the wait list received a least one type of service from an ADRC.
- 98.6% were enrolled in either Medicare (46.6%) or Medicaid (52%), which provides them with access to health care services.
- 34.6% (2,167) identified a need for services in the future. Some are not likely to meet financial eligibility criteria now, or do not wish to access services now. Spend-down, cost share and estate recovery requirements are important factors in an individual's decision of whether to enroll in publicly-financed LTC programs.
- 29% (1,810) are not currently eligible due to the county phase-in of LTC programs.
- 28% (1,753) had no immediate need, some because they were already receiving services through their local aging office or other programs and supports.
- 6.9% (433) are currently in the process of enrollment using available attrition slots.
- 1.6% (100) received needed services by remaining on the State's Children's Long Term Support Waiver, and will transition to adult programs in the future.

In summary, even during the temporary period of enrollment caps, DHS administered the Family Care, IRIS and other LTC programs in a flexible manner that met the needs of our citizens.

Aggregate Enrollment and Nursing Home Data. Data on Medicaid enrollment of populations that qualify under eligibility criteria as elderly, blind or disabled (EBD) over the period of the temporary cap indicate that from June 2011 to February 2012:

- Enrollment of the total EBD population in Medicaid continued to rise from 206,512 to 211,015 individuals.
- Enrollment of the EBD population in Family Care, IRIS and legacy waivers rose from 48,222 to 48,742 people.

Some expressed concern that during this period, individuals would be forced to seek assistance for their long term care needs in institutional care. This was not the case.

- Enrollment of people in nursing homes and ICFs continued to fall from 17,735 to 17,357 individuals.
- The nursing home population as a percent of the total EBD population declined from 8.59% to 8.23%.

The following charts illustrate that from July 2011 through February 2012:

- The elderly, blind, disabled (EBD) population enrolled in Medicaid continued to grow; and
- The percentage of the EBD population in nursing homes consistently fell during the time of the cap.

Chart 1: Continued Growth in Medicaid EBD Enrollment

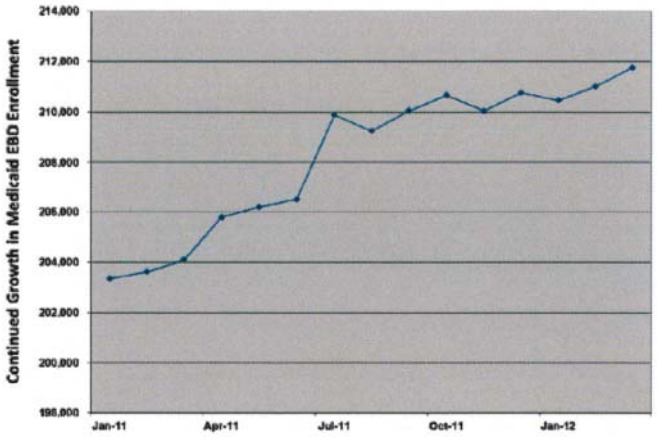
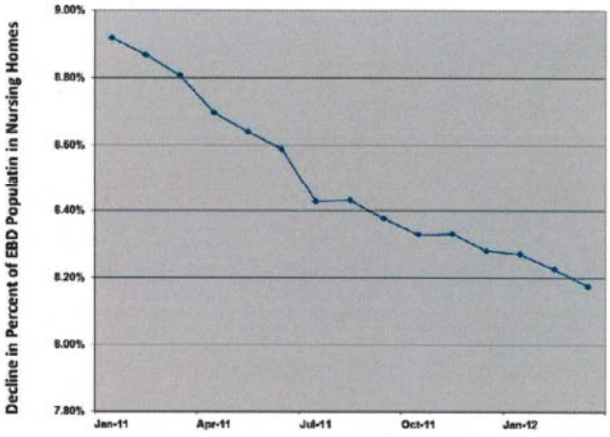


Chart 2: Decline in Percent of EBD Population in Nursing Homes



Relocations to the Community. ADRCs reported that 614 people were relocated from nursing homes and intermediate care facilities (ICFs) to the community and were enrolled into publicly-funded LTC programs from July 2011 to February 2012.

Table 1: Nursing Home and ICF Relocation Data by Month

Month	Count
July 2011	36
August 2011	57
September 2011	72
October 2011	113
November 2011	96
December 2011	116
January 2012	74
February 2012	50
Total	**614**

In addition to the data in Table 1, other nursing home and ICF residents may have been relocated to the community without ADRC assistance.

Wisconsin's Action Plan to Expedite Outreach and Enrollment into LTC Programs

The State has worked closely with the Aging and Disability Resource Centers (ADRCs), Family Care Managed Care Organizations (MCOs), the IRIS Consultant Agency, and Medicaid Income Maintenance (IM) Consortia to process functional and financial eligibility determinations and to provide options, counseling and enrollment for Family Care, IRIS, Partnership and PACE.

Significant enrollment into Wisconsin's LTC programs occurred in the months leading up to enactment of the budget legislation and, since the cap was not a freeze, ADRCs continued enrolling people into these LTC

programs after July 2011. In addition, ADRCs helped people to identify and access a variety of options to provide health care and LTC supports during the period of the enrollment cap.

Once the Governor recommended that the enrollment cap be repealed, the DHS communicated with ADRCs, MCOs, the IRIS Consultant Agency and IM to plan for the prompt and orderly enrollment of new members. This included activities, such contacting people on the wait list to assess their current status and planning with IM for prompt processing of financial eligibility determinations.

With the passage of Act 127, ADRCs and the Department's other partners have expedited processing of financial eligibility determinations, as well as options and enrollment counseling. This has resulted in increased enrollment into Family Care, IRIS, Partnership and PACE.

Specific Components of Action Plan. Currently, ADRCs are reaching out to individuals on the wait list to inform them that the enrollment cap has been repealed. This process uses established protocols that are known to be effective in communicating with frail elders and persons with disabilities. This includes contacting people by letter, phone, and through a one-on-one consultation in their own home or at the ARDC. This assures that people experience a safe, individualized approach tailored to meet their needs.

Further, in order to streamline entry into LTC programs, ADRCs facilitate the process of collecting the information needed for IM financial eligibility determinations. They also provide unbiased enrollment counseling to assure that people are enrolled into the LTC program of their choice. This includes information about spend-down, cost-sharing and estate recovery, factors that influence people's choices about enrollment in publically-funded LTC. In general, people are referred to IM for a financial eligibility determination when their income and assets are within a range to be eligible. There is no way to determine if they would have been eligible had they applied at a different point in time.

DHS Timeline and Action Plan Related to ADRC Functions

January 2012 – April 2012:

- DHS remained in close communication with the ADRCs throughout the time the cap was in place to keep abreast of wait list numbers. ADRCs provided DHS with detailed monthly wait list information by county and to assure adequate staffing and communications that are needed now that the legislation is signed into law.
- DHS provided guidance to ADRCs on the wait list, continued enrollment and use of urgent services funding, with the goal of maximizing enrollment and the use of available attrition openings.
- ADRCs continue to identify and facilitate enrollment for individuals in need of urgent services and to closely monitor data on enrollment.
- Over the last few months, ADRCs contacted individuals on the wait list to get updated information about the person's financial and functional status in order to avoid unnecessary delays once the legislation was enacted. Of the 6,263 individuals on the wait list in February 2012, an estimated 4,453 will be contacted for potential enrollment into LTC Programs. Of these, 1,327 are in the 14 counties that had reached entitlement prior to July 2011; 1,677 are in the 19 counties that reached entitlement at some point during the period of the cap; and 1,449 are in the 25 counties that are in the process of phasing into entitlement – the individuals in these counties reflect the number of people who may be eligible for enrollment at this time.

- ADRCs schedule staff home visits to provide enrollment counseling and make the referral to income maintenance as needed. This process assures continued identification of people who might need to immediately enroll into LTC. Through this process, ADRCs have also learned that many people are not interested in enrolling at this time. These are individuals who wanted the security of being on the wait list in case their current arrangements became inadequate.
- DHS has regular conference calls and meetings with all ADRCs to provide updated information on the status of enrollment to assure the process is expedited.
- DHS regional quality staff have weekly contact with each ADRC to answer questions, provide suggestions, and address issues that might pose barriers to immediate enrollment.
- As ADRCs become aware of any issues that might prevent efficient enrollment, they work with DHS staff to resolve those issues.
- DHS facilitates discussions between the ADRCs and the MCOs to help identify and resolve any issues that could affect enrollment.
- DHS facilitates discussions between the ADRCs and the IRIS Consultant Agency to help identify and resolve any issues that could affect enrollment.
- ADRCs continue to send letters and to call people on the wait list to inform them of the repeal of the enrollment cap and to schedule appointments.
- The DHS public website features information about the lifting the enrollment cap and provides guidance on contact information for ADRCs.
- ADRC websites continue to emphasize that people should contact the ADRCs if they may be in need of LTC services. This activity remained constant throughout the period of the cap.

DHS Timeline and Action Plan Related to MCO Functions

January 2012 – April 2012:

- DHS staff worked with MCO Leadership to prepare for additional enrollment by assessing staffing capacity, geographic considerations, and wait list numbers.
- DHS conducts weekly phone calls with MCOs to in order to promptly troubleshoot any issues or barriers to enrollment.
- DHS staff make individual contacts with each MCO to provide guidance and assistance with any issues, and to facilitate enrollment in each area.
- DHS staff assist with strategies to enhance care plan development, such as having the most experienced staff work with new members to create care plans.
- MCOs initiated increased hiring, expedited staff orientation and initial training to deploy new staff to work with members, and to redeploy more experienced staff to provide orientation and care management to new enrollees.

DHS Timeline and Action Plan Related to the IRIS Consultant Agency

January 2012 – April 2012:

- DHS staff worked with the IRIS Consultant Agency to prepare for additional enrollment by assessing staffing capacity, geographic considerations and wait list numbers.
- DHS conducts weekly phone calls with the IRIS Consultant Agency in order to promptly troubleshoot any issues or barriers to enrollment.

- DHS staff assist with strategies to expedite care plan development and initiate timely provision of services.
- DHS staff provide direction to the IRIS Consultant Agency to address any potential issues, such as having the higher-level Orientation Consultants work with new members to create service plans.

DHS Timeline and Action Plan Related to Income Maintenance

January 2012 – April 2012:

- DLTC and the Division of Health Care Access and Accountability (DHCAA) management and staff have frequent briefings to monitor eligibility determinations and to resolve any potential delays.
- State staff have ongoing telephone contact and meetings with the local IM agencies to discuss ways to streamline and make the financial eligibility process as efficient as possible.
- DLTC and DHCAA assure that the regionalization of IM functions enhances LTC enrollment.
- DHS staff responsible for oversight of IM activities make individual contacts with each IM Consortia to remain alert to any potential enrollment issues.

What Is the Wait List, Who Was Enrolled, and What Are People Waiting For

The enrollment cap was a temporary adjustment that slowed the pace of, but did not end, new enrollment into the State's LTC programs, including Family Care, IRIS, PACE and Partnership. ADRCs continued to ensure that all people received counseling and assistance in accessing services. People with urgent and emergency needs were identified and enrolled. There were also people who did not have urgent needs that were enrolled from the wait list.

The following sections provide information on the wait list, enrollment into the program during the cap, and what people on the wait list are waiting for.

What is the Wait List? Perhaps contrary to public perception, the wait list for Family Care does not mean all people on the wait list are eligible for the program nor is everyone in immediate need of public assistance. To be eligible for Family Care, an individual must meet both functional eligibility and financial eligibility. With the gradual implementation of Family Care and IRIS throughout the State, there was an existing wait list on July 1, 2011 since many counties were not yet at entitlement. Only 14 counties had reached entitlement before the cap was implemented.

With the phase-in of Family Care and IRIS as counties transition from the prior legacy Medicaid waivers, most counties had a wait list prior to July 2011. ADRCs enroll individuals based on state-approved wait list policies, which are "first-come, first-serve" unless the individual meets certain priority criteria. To be on a wait list, individuals must meet the functional eligibility criteria for a nursing home level of care, and meet financial eligibility criteria by the time they expect to enroll. For this reason, people on the wait list may be spending down assets to become financially eligible, or may be seeking the security of being on the list but not yet interested in starting services immediately.

In completing the long term care functional screen, ADRCs assess the needs of each individual, and address any urgent or emergency needs to ensure health and safety. ADRCs also facilitate access to health care, nutrition, caretaker support and transportation services available through Medicare and Medicaid, FoodShare,

and other aging and benefit programs. In addition, ADRCs contact people on the wait list every six months to assess any changing needs and inform individuals of their status.

Wait list policies for ADRCs during the enrollment cap mirrored existing provisions, including the criteria established for urgent/emergency needs. Under the budget legislation that implemented the cap, additional funding of approximately $12.6 million was available in each year of the biennium to fund enrollment of people on the wait list who had an urgent/emergency need for LTC services. By using attrition that occurs on an ongoing basis, along with funding for urgent/emergency needs, ADRCs continued to enroll people into Family Care, IRIS and other long-term care and health care programs during the cap. In addition, the legislation exempted from the cap any relocation to the community from a nursing home or intermediate care facility in which the individual had resided at least 90 days.

Once enrolled, Family Care MCOs or the IRIS Consultant Agency must ensure that a person-centered plan is developed and implemented for the individual.

The wait list is not static; people are added or removed because they enroll, move, pass away, or are no longer eligible. It includes frail elders and persons with developmental or physical disabilities who have met LTC requirements for functional eligibility (essentially nursing home level of care), and who are expected to meet financial eligibility for Family Care, IRIS, PACE and Partnership by the time of enrollment.
As shown in the following Table 2, the wait list totaled 6,263 people as of February 2012.

Table 2: Wait List Data by Month for Wisconsin's LTC Programs

Month	Count	Change in Count
January 2011	7,462	N/A
June 2011	5,049	-2,413
July 2011	5,378	329
August 2011	6,066	688
September 2011	6,148	82
October 2011	6,601	453
November 2011	6,740	139
December 2011	6,694	-46
January 2012	6,730	36
February 2012	6,263	-467

As Table 2 shows, the wait list totaled 7,462 in January 2011 and declined to 5,049, or by 2,413 people, in the months leading up to July 2011. As noted earlier, there was significant enrollment into Wisconsin's community-based LTC programs in advance of the provisions to slow new enrollment in July 2011. Even with this slowing, the wait list in the most recent month was almost 1,200 less than in January 2011.

ADRC Enrollment Data. ADRCs continued to enroll individuals each month during the cap. In general, ADRCs that had been at entitlement prior to the cap enrolled people within a few weeks of determining eligibility. People who had urgent needs were prioritized and enrolled.

As Table 3 illustrates, individuals were enrolled using attrition and urgent/emergency funding provided in the budget. Attrition remaining available reflects individuals in the process of enrollment (financial eligibility /

enrollment counseling / MCO and IRIS enrollment). In accounting for attrition that was in process, the actual growth in the wait list since July 2011 was 781 (Total wait list of 1,214 less 433 remaining attrition available).

Table 3: ADRC Enrollment Data by Month for Wisconsin's LTC Programs

Month	Disenrollment	Attrition Used	Moves (In/Out)	Urgent Enrollment	Urgent to Attrition	Remaining Attrition Available
July 2011	442	80	9/12	0	0	362
August 2011	476	252	16/16	2	2	224
September 2011	421	324	25/21	9	4	92
October 2011	484	407	12/22	5	1	73
November 2011	422	465	19/16	14	2	-55
December 2011	486	589	14/10	39	4	-138
January 2012	434	499	12/20	9	1	-73
February 2012	407	439	18/16	24	4	-52
TOTAL	**3,572**	**3,055**	**125/133**	**102**	**18**	**433**

ADRC Wait List Survey. When the Legislative Audit Bureau conducted their recent evaluation of Family Care, it recommended that the Department explore options to ensure that LTC services be provided in the most cost-effective manner. In November 2011, DHS surveyed potential enrollees on the wait list to better understand the timing, nature and scope of services individuals need to live well in their communities. The survey showed that:

- 81% of individuals on the wait list live in their own home, apartment, or relative's home.
- Most individuals want to stay where they now live once they enroll in Family Care or IRIS.
- Many individuals receive support from family and friends now, but additional supports are needed.
- The top LTC services requested include help with laundry/chore services, meal preparation, supportive/personal care (including care in assisted living facilities), and transportation.
- 51% indicated they get help now from family, friends, neighbors or other programs, such as SSI, Medicare, Medicaid, and for food, nutrition and meals. Of those who do not receive help now, 24% 'manage' with the help of family, 14% are doing 'okay,' and 3% manage with difficulty.
- One-third of the people on the wait list indicated that they need help in the future, not now.

What Are the Long Term Care Sustainability Initiatives

Family Care and other community-based, long term care programs currently serve over 44,000 individuals in Wisconsin. These are people who are both financially and functionally eligible to receive benefits. About 75% of individuals served within these programs are individuals who have a developmental or physical disability, while 25% of individuals are frail elderly enrollees.

Over the past several decades, the payments of long-term care services have shifted from individuals to the taxpayers. Nationally, the largest payer of all long-term care services is Medicaid at 42% of total spending.

While the largest payer of services is the American taxpayer, the majority of long-term care services are actually provided on an unpaid basis through a person's natural support system by their family or friends.

Each year, Wisconsin's Medicaid program spends almost $3.0 billion in long term care, supports, and other services. It is vitally important that the Department ensure that Family Care and its related programs are fiscally sustainable. Moreover, Wisconsin is facing significant growth in the number of people needing long term care. Finding solutions now that can be sustained for years to come is a priority for the Department and the Governor.

In its April 2011 evaluation of the Family Care program, the Wisconsin Legislative Audit Bureau posed critical questions regarding the fiscal sustainability and cost-effectiveness of Family Care and Wisconsin's other LTC programs and identified the need to implement strategies to reduce costs, increase efficiency and improve outcomes. The Governor's recommendation and legislative action to temporarily slow enrollment into Family Care and other long term care programs was designed to give the Department and state policymakers an opportunity to explore strategies and identify options that are fiscally sustainable and cost-effective.

A primary goal of the LTC Sustainability Initiatives is to ensure that Family Care, IRIS and other LTC benefits provide the types of services that are truly needed with the right amount of care, at the right place, and at the right time. Ultimately, that is the essence of an efficient and cost-effective long-term care program. It is also important to support services that help individuals live and work in integrated settings in their own communities.

The LTC Sustainability Initiatives are designed to support the ability of people to live and work in the most integrated and least restrictive settings. For most, that is to remain safe and cared for in their own homes and to work in integrated settings in their own communities. In analyzing existing data on our LTC programs, surveying future enrollees, and seeking input from a wide variety of consumers, stakeholders, and interested parties, options were developed to strengthen Wisconsin's Family Care and IRIS programs and better positions them for the future. These options include:

- Supporting living well at home and in the community;
- Promoting care in more integrated residential settings;
- Enhancing IRIS and self-directed supports and providing greater program integrity;
- Enhancing programs for youth in transition;
- Strengthening employment supports;
- Realigning Family Care benefits; and
- Ensuring Family Care administrative and program efficiencies.

The detailed Sustainability Initiatives can be found on the Department's website at the following address: http://www.dhs.wisconsin.gov/ltcreform/

WISCONSIN DEPARTMENT OF HEALTH SERVICES



2011-2013 Long Term Care Sustainability Plan

Under a broad definition of need for long term care, about 11 million individuals or 3 percent of our total population requires long term care. The majority of long term care, supports, and services is provided on an unpaid basis by family members and friends. It has been estimated that only 23 percent of individuals in need of long term care use paid caregivers.[1] Spending for long term care, supports, and services has fallen disproportionately on the Medicaid program. Nationally, Medicaid is the largest single source of payment for long term care, accounting for 42 percent of total spending, followed by Medicare (25 percent), out-of-pocket spending (22 percent), and private insurance and other sources (11 percent).[2]

In Wisconsin, Medicaid provides long term care, supports, and services for over 75,000 individuals on average each month. In total, we project long term care, supports, and services expenditures will exceed $2.8 billion dollars this year which represents about 40% of the total Medicaid budget.

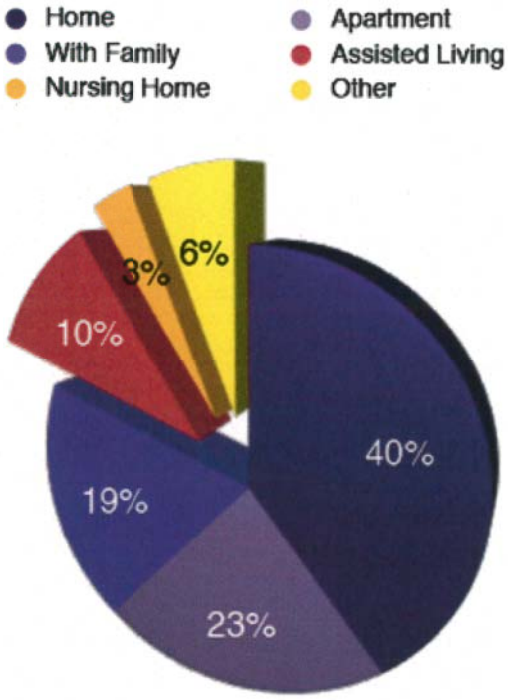
More than 43,000 individuals are enrolled in a managed care arrangement, principally through a Family Care managed care organization but also through PACE, Partnership, or IRIS at a cost of more than $1.3 billion. Medicaid pays for care in nursing home or other institutional setting for more than 17,400 individuals each month at a total cost of $973 million. Our legacy waivers, Community Integration Program (CIP), Community Options Program (COP), and the Children's waiver serve nearly 11,000 individuals, totaling $289 million. Medicaid will also pay approximately $224 million for personal care and home health services on a fee-for-service basis on behalf of an additional 5,000 individuals per month.

The average enrollee in Family Care costs less than the average enrollee in the legacy CIP and COP waivers or IRIS. The average Family Care enrollee had costs of $3,188 per month while IRIS enrollees averaged $4,159 and CIP and COP enrollees averaged $3,761. What this means is that Family Care offers the potential, if its cost effectiveness and fiscal condition can be further improved, to meet the future long term care needs of the state's residents in the coming years. By 2035, Wisconsin's population over age 65 will double. It is essential that we make our long term care programs as cost-effective as possible to meet this growing demand in the coming years.

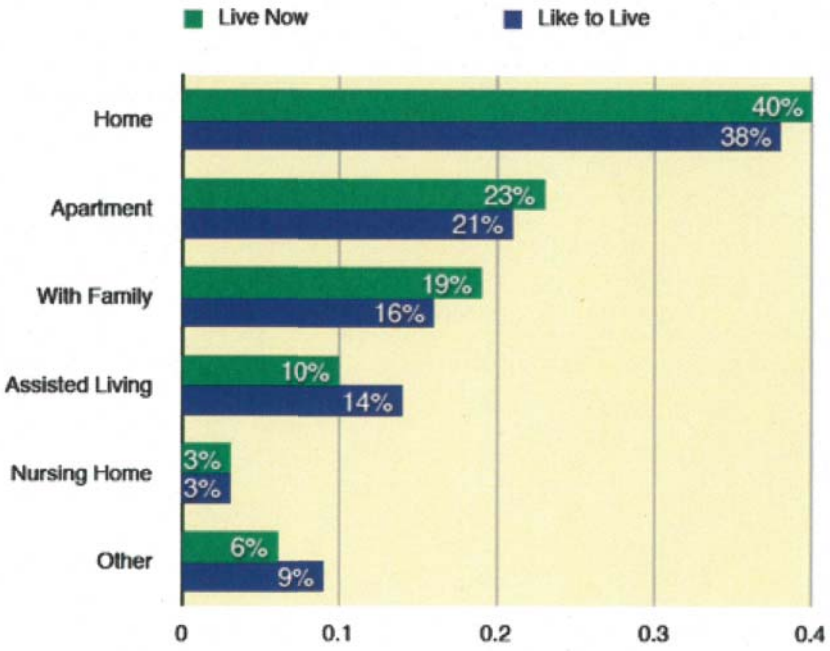
A year ago, Wisconsin faced a significant decline in federal matching funds for Medicaid. Governor Walker and the Legislature committed $1.2 billion in new state funds to Medicaid during the current biennium to help meet those fiscal challenges. But even with those additional funds, population growth and changing demographics will increase demand leaving the long term care programs at risk.

Analysis by both the Legislative Audit Bureau (Full Report, Report Highlights) and the Department point to several important issues and findings to helping the program become financially sustainable:

- The Department's process for setting capitation rates for MCOs had to be improved, to better reflect the acuity mix for the consumers served by each MCO and improve the MCO solvency.
- A significant portion (over a third) of Family Care costs are spent for services to individuals in assisted living or alternative residential settings. Costs for these persons are 2 to 3 times higher than for those living in their own homes. While assisted living is the most appropriate setting for some individuals, helping people remain in their homes is key to improving the cost effectiveness of our long term care programs. Plus, most people have a strong preference to live in their own home, among family and friends.
- A survey of waitlist individuals conducted by ADRCs indicates that 75% of individuals have been waiting less than one year, and 50% for less than six months. About half reported needing assistance with housekeeping, meal preparation, or non-medical transportation. In addition, about half indicated they were managing on the waitlist with help from family and friends.
- The survey identified that a majority of people, who are in need of long term supports, 81 percent, are currently living in their own home, an apartment of with family. Only 13 percent live in an assisted living facility or nursing facility.



- We have also learned that most people who are in need of long term supports indicate that they would like to receive the supports they need in the same setting in which they currently reside.



This is also consistent with the types of support that people indicate that they need in order to meet their long term care needs:

Top Three Areas of Support Needed

Type of Support	%/Frequency
Laundry or chore services	30%
Personal care services (bathing, dressing, eating, toileting, grooming)	28%
Transportation	18%

Over the last year, the Department has been engaged in conversations with consumers, family members, advocates, Managed Care Organizations (MCOs), Aging and Disability Resource Centers (ADRCs), providers, tribes, and other experts about how to improve the program. Building on the audit report's finding and our own review, the Department has assembled a package of reforms and savings measures that will help make the program sustainable on an ongoing basis in the future while keeping consistent with the interests of current and future program participants.

Reforms by Focus Area:

- Employment Supports (PDF, 97 KB)
- Family Care Administrative and Program Efficiencies (PDF, 105 KB)
- Family Care Benefits (PDF, 105 KB)
- IRIS and Self-Directed Supports (PDF, 105 KB)
- Living Well at Home and in the Community (PDF, 109 KB)
- Residential Services (PDF, 110 KB)
- Youth in Transition (PDF, 97 KB)

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1 H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?, Health Affairs, January 2010, Vol. 29, No.1
2 Terence Ng, Charlene Harrington, and Martin Kitchener, "Medicare and Medicaid in Long-Term Care," Health Affairs, January 2010, Vol. 29, No.1

Last Revised: January 24, 2012

2011-2013
Long Term Care Sustainability

Employment Supports

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Employment Supports
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Ensure a continuum of employment supports in Family Care, IRIS, PACE and Partnership.

Main Message Points

- The federal waivers that support Family Care and IRIS require active treatment, including participation in employment and employment-related services for waiver participants.
- Recent CMS guidance highlighted the importance of competitive work and the goal to promote integrated, community-based employment options with an emphasis on person-centered planning.
- Approximately12% of long-term care recipients in Wisconsin participate in competitive-wage, integrated employment and Wisconsin ranks 32nd in the percentage of adults with developmental disabilities in Medicaid who are in supported, community-based employment.
- Research has shown that employment results in cost savings, less reliance on public benefits, and more money going back into the local community.
- Community Rehabilitation Programs (CRPs), in addition to workshop-based services, currently provide 65% of community-based employment supports funded by the Division of Vocational Rehabilitation.
- Given recent federal guidance, opportunities also exist to increase community-based employment for people with disabilities that are supported by Medicaid-funded waiver programs.

Proposed Modifications

1. **Division of Vocational Rehabilitation (DVR) Pilot.** Establish a statewide pilot program to support community-based employment to leverage 80% federal matching funds and the infrastructure and programming in DVR for integrated employment to prioritize services for people with disabilities in Family Care and IRIS.

2. **Infrastructure Grant Funding.** As allowed under grant provisions, allocate $1.6 million of carryover funding from the Medicaid Infrastructure Grant (MIG) to complete activities to:
   - Continue to work with CRPs to create more community-based employment supports.
   - Provide assistive technology and supports for youth with disabilities
   - Continue implementation of Project SEARCH, school to work and initiatives to use natural supports
   - Provide assistance for Vocational Futures Planning and MCO network development
   - Finalize guidance on asset development to assist persons to develop sustainable cash assets and saving
   - Provide support to employers to employ persons with disabilities
   - Improve the Disability Employment Data Infrastructure to:
     - Complete data collection activities to identify expenditures and measure employment outcomes
     - Finalize comprehensive data use agreements between DHS, DVR and DPI

3. **Work Incentive Benefits Counseling**. Ensure work incentive benefits counseling service is available and participation encouraged for LTC participants with an integrated employment goal.
   - Ensure availability of Work Incentive Benefits Specialists and Counseling Services as part of ADRC services. Explore opportunities to:
     - Fund up to 10 specialists to serve a regional system corresponding to Family Care districts.
     - Provide mandatory training, initially and ongoing, to economic support workers on the purpose of the Medicaid Purchase Plan and its effective administration.
   - Add Work Incentive Benefits Counseling Services as a specific service for participants in the Medical Assistance Purchase Plan (MAPP).
   - Explore opportunities for Work Incentive Benefits Counseling providers to be credentialed with the state Work Incentive Benefits Specialist Association.

4. **Improve policies for the Medical Assistance Purchase Plan (MAPP).** Analyze possible changes to the MAPP premium formula to support higher participant earning, saving and financial stability:
   - Consider elimination of the current distinction between earned and unearned income in the premium calculation;
   - Establish an effective definition of "employed" for eligibility purposes that is consistent with national policy and ensures that "in-kind" payments for work-like activities for people of working age (under age 65) does not qualify as employment;
   - Provide for participation in MAPP when substantial work ceases at age 65 or later by creating a definition of "employed" specific to this population;
   - Consider implementation of minimum premiums for all participants with countable income above 150% FPL;
   - Define a maximum premium for participants that removes the disincentive toward higher earnings; and
   - Focus outreach on the SSI 1619(b) population to encourage MAPP participation and create provisions for an "individualized threshold" similar to 1619(b) within MAPP.

5. **MCOs and IRIS Consultant Agencies leverage provision of employment services to collect federal reimbursements under the Ticket to Work program.** Encourage and support LTC management organizations (MCOs and ICAs) to register as Employment Networks (ENs) under the Ticket to Work Act:
   - Provide Technical Assistance to LTC agencies in registering for EN status;
   - Include LTC agencies in "Smartworks" pilot in 2012; and
   - Implement service payment strategies transferring SSA reimbursements to providers that generate quicker and higher quality integrated employment outcomes.

Effect of these changes:

- Wisconsin will leverage state funding to secure federal vocational rehabilitation funding at an improved match rate in order to support employment for people with disabilities.
- The benefits of key initiatives under MIG funding will conclude and Wisconsin will assure that successful initiatives can be replicated in the long term care system.
- Work incentives counseling will be available to assist and promote employment options for people with disabilities.
- The MAPP plan will be strengthen and key definitions of employment will be clarified.
- MCOS and IRIS Consultant Agencies will support and promote employment of people with disabilities.

2011-2013
Long Term Care Sustainability

Family Care Administrative and Program Efficiencies

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Family Care Administrative and Program Efficiencies
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Implement strategies to streamline program and administrative processes in Family Care to better align operations with current and future needs, to improve management, and to reduce program costs.

Main Message Points:

- As of January 2012, ten managed care organizations (MCOs) provide LTC benefits through Family Care, PACE and Partnership. Of these, six are Family Care MCOs, three are Family Care/Partnership MCOs, and one serves people enrolled in Partnership/PACE.
- Most areas of the state are served by one MCO; however enrollees in Milwaukee County have a choice of two MCOs, along with PACE and Partnership.
- The current care management model of an interdisciplinary team within Family Care is intended to ensure that people's individual needs are assessed from multiple perspectives including social work and nursing services. However, there are concerns that the model as specifically defined in contract requirements and as implemented may result in duplication of efforts or more care management than needed by some people.

Proposed Modifications

1. **Streamline and Improve Care Management.** Assure that care management is tailored to the needs of each individual, using a strength-based assessment process that identifies and utilizes natural supports when addressing member outcomes when planning for services and supports.
   - Use a strengths-based assessment process, including building upon natural supports in a person's life to assure that publically-funded supports strengthen rather than supplant unpaid supports and that the service authorization process leads to cost savings while maintaining strong quality outcomes.
   - Modify contractual and procedural requirements to reduce administrative overhead and eliminate care management paperwork.
   - Permit MCOs to develop protocols that account for acuity, level of care and natural supports in order to provide the right amount of care management that is unique to each person's assessed needs.
   - Retain access to registered nurses (RNs) for all members, but allow MCOs to not routinely assign RNs or to provide that the nurse be the primary point of contact for some members, such as medically complex frail elders.
   - Promote a strength-based assessment process by MCOs to:
     - Focus on the skills people have;
     - Identify natural supports; and
     - Account for these strengths when developing the formal care plan.
   - Reduce administrative paperwork and processes, including:
     - Streamlined notice of action and appeals process;

- Reduced and automated paperwork and documentation to eliminate duplication;
- Simplification of the RAD;
- Reduced submissions to DHS to only federally required documentation;
- Evaluation of the impact that the Annual Quality Reviews (AQR) or other reviews in contributing to duplicative or unnecessary work on behalf of the MCOs; and
- Increased use of IT systems in place of paperwork and processes.

- Minimize contractual barriers in Partnership that currently limit the role of Nurse Practitioners as an extension of the Primary Care Physician and ensure that the roles of the Nurse Practitioner and the Nurse are not duplicative.

2. **Streamline Care Management in Residential and Institutional Settings.** Develop standards and strategies for interdisciplinary team oversight to reduce duplication and enhance care management when a member is in a residential care setting, including:
   - Reduce the frequency of oversight in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance;
   - Reduce the number of different teams involved with oversight of members within a single facility; and
   - Increase collaboration with facility staff.

3. **Strengthen Oversight of Service Authorization.** Strengthen MCO authority to institute "checks and balances" to ensure that care plans reflect cost-effective choices.
   - Provide flexibility to establish written protocols to guide interdisciplinary teams (IDTs) in determining acceptable services/products, subject to DHS approval and require that written guidelines do not in any way modify the range of services authorized in the waiver.
   - Revise member informing materials to emphasize that any products/services paid for with public funds must be related to the long term care outcome for the member.
   - Communicate and stress the importance of input from all members of the care planning team to ensure that the care plan reflects cost-effective choices.
   - Allow MCOs to implement a secondary review for high-cost products and services.

4. **Administrative Initiatives.**
   - Streamline reporting requirements and required paperwork to ensure that member outcomes are identified and supported and that member health and safety is ensured.
   - Review current reporting requirements, eliminate unnecessary paperwork, and determine what is necessary to meet DHS requirements for health and safety as well as any requirements established in the waiver or by CMS.

5. **Appeals.** Streamline and simplify the appeals process to ensure timely decision-making for consumers and MCOs.

6. **Business Plan Requirements and Administrative Oversight.** Streamline Business Plan requirements to reduce unnecessary administrative burden on MCOs and DHS.

7. **Member Handbooks and Provider Network Directories.** Minimize administrative burden and costs associated with providing written copies of Member Handbooks and Provider Directories except when requested.

8. **Provider Contracts/Relations.** Require that MCOs:
   - Share proposed contractual changes at least 30 days in advance of implementation, facilitate disclosure of specific changes proposed in provider contracts, and work collaboratively with providers to maintain networks during negotiations;
   - Make timely payments to providers; and
   - Explore opportunities across MCOs to standardize protocols, claims processing and data reporting for providers to the extent possible.

9. **Streamline and Improve the Consistency of Claims Processing and Other IT Functions.** Explore opportunities to leverage IT systems and contracts to improve the uniformity and consistency of data collection, to enhance program

management and program integrity, and to reduce costs.

10. **Increase Competition in MCO Service Areas.** Foster competition within Family Care by allowing existing MCOs organized through Long Term Care Districts to compete in additional counties and service areas, subject to the approval of their Board.

11. **Future Expansion Counties.** Work with persons in legacy waiver programs in advance of the transition to managed LTC programs and IRIS through strength-based care management and the RAD to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

12. **Best Practices and Self-Directed Supports.** Incorporate MCO best practices and enhanced use of self-directed supports in future Family Care MCO procurements.

Effect of this change:

- Reduce administrative burden and administrative costs.
- Improve the efficiency and cost-effectiveness of MCO operations.
- Increase quality and ensure more cost-effective support of people's outcomes.
- Streamline and improve care management practices at the MCO level.
- Eliminate duplication and streamline administrative processes.

2011-2013
Long Term Care Sustainability

Family Care Benefits

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Family Care Benefits
Projected Savings:	$9 million GPR
Proposed Implementation Date:	Spring 2012

Description: Implement strategies to assure that supports and services are tailored to the needs of the individual by focusing on strength-based care plans and by maximizing the use of natural supports.

Main Message Points:

- Individuals must meet functional and financial eligibility standards to enroll in Family Care. In assuring that functional needs are properly determined, people can be referred to the most appropriate benefits within Family Care and to alternative systems of care.
- Individuals who meet eligibility requirements and enroll in Family Care managed care organizations (MCOs) have access to a broad range of services, including services traditionally provided under home and community-based waiver programs, long term care Medicaid card services (supportive home care, care management, home health, employment supports, adult day services, medical supplies, physical therapy, transportation services) and nursing home services. Strength-based assessment processes identify the supports needed to address member outcomes and include the natural supports in a person's life to assure that public funding augments, rather than supplants unpaid supports.

Proposed Modifications

1. **Balance Cost Effectiveness with Choice.** Strengthen the care management planning process to require that members be presented with information regarding care options and the cost of those options to promote cost-effective decisions about care management.
   - Require care managers to disclose costs associated with service options to members as part of the care planning process.
   - Revise member informing materials to articulate the importance of cost effectiveness when care planning.
   - Allow MCOs to communicate to members that State-paid capitation rates reflect an average of overall costs for all members and not budget amounts for each individual member.
   - Revise policies and procedures to reinforce this strategy, emphasizing that care and services should be provided in the least restrictive and most cost effective environment necessary to meet the needs to the member.
   - Facilitate training to MCOs to ensure appropriate use of strength-based care management and of Resource Allocation Decision-making (RAD) guidelines so that a member's needs are properly identified and build upon natural supports.

2. **Focus on Strength-Based Care Plans and a Continuum of Supports.** Maximize the use of family caregivers and other natural supports and build capacity within communities to increase utilization of natural supports. Assure a

continuum of supports that recognize that service plans range from minimal to comprehensive supports based upon the person's needs and natural supports.

- Strengthen protocols to identify natural supports available to a member as early as possible.
- Establish and communicate the importance of and need for natural supports.
- Work with advocacy groups, parents, guardians and MCOs to develop and communicate policies.
- Develop and implement innovative programming that will provide supports to families whose adult children remain at home while developing their employment skills.
- Assist MCOs in improving their ability to more fully leverage natural supports to:
  - Discuss the costs of services and supports as part of the care planning process.
  - Improve education for caregivers about other supports and services available to assist members and their caregivers.
  - Collaborate with the local business communities to build capacity for natural support opportunities.
- Clarify that program payment for social activities is limited to activities directly related to the long term care needs of the eligible person.
- Clarify requirements for the use of a member's resources to purchase services in the Family Care Benefit Plan when such services are not related to the established long term care outcome and care plan.

3. **Over-the-Counter (OTC) Medications.** Explore opportunities to facilitate and streamline coverage of OTCs within Family Care.

4. **LTC Functional Screen.** Explore options to improve the LTC functional screen for target group determinations and for the assessment of acuity.

5. **Crisis Intervention and Stabilization.** Improve the capacity of MCOs and community-based providers to support individuals with complex mental health needs and challenging behaviors.
   - Identify critical expertise in specialty areas that result in more cost effective service planning and intervention for people with complex needs, including access to behavioral health professionals and use of trauma-informed care.
   - Develop the capacity for comprehensive community crisis response.
     - Facilitate collaborative relationships between county mental health staff and MCOs to assure that each at-risk member has an effective response plan, which defines roles and responsibilities of all involved entities.
     - Facilitate the development of regional resources for mobile crisis response teams.
     - Utilize DD Coordinator positions within DLTC to divert admissions, assist in discharge planning and provide community resources.
   - Increase capacity and expertise of MCOs in developing and maintaining effective behavior support plans and stable community settings.
     - Provide targeted training to MCO identified behavioral support specialists.
     - Promote development of back-up plans to reduce use of hospitals and institutions.
     - Provide targeted technical assistance expertise to MCOs and community providers as necessary.
   - Develop resources to support relocation planning from institutional to community based settings.
     - Identify efficiencies and opportunities related to recruitment of providers and to develop appropriate community settings.
     - Assure that relocation plans and behavioral support plans contain specific strategies and projected timelines for gradually reduce, or "fade" the amount of support over time as individuals are supported and stabilized in the community.
   - Explore partnering with the Waisman Center for Excellence in Developmental Disabilities to provide training and technical assistance to Family Care, IRIS and Partnership staff, and to provide assistance with relocation teams.

6. **Cost Share and Room and Board Payments.** Identify best practice protocols to ensure that members pay any required cost sharing and room and board obligations, and provide training for MCOs on best practices and options to pursue collections.

7. **Coordination of Benefits.** Require that individuals continue to access available benefits from other sources to

support their care, such as LTC insurance and Veterans' Aid and Attendance benefits, and require ADRCs and MCOs to ensure coordination of benefits with other payers.

8. **Nursing Facility Modernization.** Explore opportunities with the nursing home industry to provide a financial incentive to diversify and modernize facilities, with incentives to fund renovations and increase occupancy rates.

Effect of these changes:

- Ensure that services are individualized and leverage natural supports in coordination with public benefits.
- Assist individuals in understanding the cost of services in order to make informed choices.
- Ensure that service costs reflect a balance between cost-effectiveness and choice.
- Improve capacity building and crisis intervention in community settings for people whose needs are complex and service costs are high.
- Increase MCO and community capacity to effectively support people in the most integrated community settings.
- Assure that Medicaid is the payer of last resort by strengthening personal accountability and by improving coordination of benefits with other payers.

2011-2013
Long Term Care Sustainability

IRIS and Self-Directed Supports

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Strengthen the IRIS Program and Self-Directed Supports
Projected Savings:	$1.3 million GPR
Proposed Implementation Date:	Spring 2012

Description: Strengthen program integrity and accountability of the IRIS program and ensure that self-direction in IRIS and Family Care maximize natural supports and the ability of consumers to choose the most integrated, community-based and cost-effective services.

Main Message Points

- The IRIS Program has experienced significant growth with almost 6,000 people currently enrolled since it was first available on July 1, 2008. As required under federal waivers, IRIS provides an alternative choice to managed LTC in Family Care.
- IRIS is unique from Family Care through its use of:
  - A combination of waiver funding and Medicaid fee-for-service "card" services;
  - An individual budget allocation and flexibility to develop a person-centered plan; and
  - An IRIS consultant to assist in defining outcomes and identifying paid and informal services and supports.
- The goal of the IRIS Program is to ensure consumer-directed planning to maximize independence, support meaningful participation in the community, and promote individual responsibility and self-determination.

Proposed Modifications

1. **IRIS Program Integrity and Accountability.** Implement safeguards to ensure the appropriate expenditure of state and federal funds, as recommended by the Legislative Audit Bureau, and modify the program design, infrastructure and organizational support for IRIS to ensure program integrity and accountability.
   - Through a competitive procurement for IRIS consultant and claims payment services, ensure development of:
     - A comprehensive, consumer accessible, integrated information technology platform, with capacity to:
       - Support individual budget allocations;
       - Incorporate guidelines and estimation tools into budget development;
       - Link to Support Brokers to create cost-effective, community-based supports and services; and
       - Perform monthly and annual reconciliations of individual budget allocations;
     - Web-based access to individualized budgets and monthly expenditures; and
     - Program management and monitoring tools, including fraud and abuse prevention and detection capabilities.
   - Ensure quality oversight and management by dedicating state staff positions to support IRIS operations, quality management and program integrity functions.

2. **Strengthen Self-Direction in IRIS.** Implement changes to the IRIS program based on the experience and guidelines of the *National Center for Self-Direction* to maximize self-determination, including initiatives to:
   - Reduce complexity, bureaucracy and centralization of IRIS and create greater transparency and a more participant-friendly process in the IRIS program.

- Support individuals to understand and implement the principles of self-direction.
- Assure that IRIS participants receive the necessary continuum of support through their IRIS experience.
- Ensure appropriate, cost-effective supports, leveraging natural and community resources, whenever possible.
- Avoid cost-shifting and promote cost-effective choices in accessing Medicaid fee-for-service benefits.
- Streamline administrative structures and requirements and ensure choice and local access to claims processing for participants, if possible.
- Assure that IRIS staff are knowledgeable regarding local services, supports and resources.
- Assure that each step of the IRIS process is conducted in a timely manner.
- Provide IRIS participants with clear and complete information about self-direction and the parameters of the program, including the expectation that people will utilize natural unpaid supports and establish the most cost-effective plan necessary to meet their needs.
- Streamline the initial service planning process for IRIS participants to:
  - Develop tools to triage IRIS participants to determine the amount of support needed to self-direct and to include an active guardian or other decision-making support if the person needs assistance in consumer-direction.
  - Assist in the initial service planning process to create an appropriate support plan that builds around natural supports to the greatest extent possible.
  - Develop a robust support broker system and peer-to-peer mentoring to enable people to secure assistance when needed.
  - Provide tools to promote independence and personal responsibility, such as a web portal for service and budget management, an hours/payment estimating tool for supportive home care, and tools/guidelines to ensure appropriate use of customized goods and services.
  - Provide information on potential services and providers and guidance on how to select a service provider.
  - Bring service plan approval closer to the participant in order to ensure participant flexibility in plan development and implementation.
- Develop processes to allow for more flexibility to adjust payments, plans and budgets from month to month.
- Identify options to allow for more flexible and cost-effective staffing.
- Identify technology and home modification options to ensure health and safety while reducing the need for staff.

3. IRIS Budget Allocation Alignment.

- Leverage budget allocation improvements to ensure accurate individual budgeting, review plans to ensure that program allocations are fairly determined for persons within IRIS and as compared to Family Care.
- Evaluate allocations for people that enrolled prior to July 2010, and during their annual review work with participants to bring costs in alignment with those enrolled after that date, creating better alignment of costs for people who have selected IRIS with those receiving services through Family Care.
- Assure that paid supports are focused and do not supplant informal and natural community-based supports.
- Develop community supports and enhanced training for crisis intervention and stabilization to keep people in the community, and not in more intensive settings.
- Promote the use of technology and intermittent supports to move away from 24/7 one-to-one staffing whenever feasible to meet a person's needs.
- Use information technology to provide budget and payment control to participants through a web-based system of budget and expenditure tracking, service payment authorization and direct payment for recurrent services.
- Assure that participants have access to a monthly budget ledger and complete annual reconciliation to support self-direction, personal responsibility, and accountability.

4. Assure that IRIS Participants, not Providers, Direct their Services and Supports.

- Ensure that providers do not inappropriately limit choice, take control of funds, or raise costs for participants.
- Require consumers/guardians to play an active role, and limit delegation of decision-making to providers.
- Limit the use of residential options for those whose assessment does not support such settings.
- Ensure alignment of reimbursement in IRIS that is consistent with that provided under Family Care.
- Promote use of employment supports to foster integrated work outcomes, as recommended by federal guidelines.
- Educate providers on self-direction and encourage options that allow for maximum consumer control.

- Assure that supports are focused and do not supplant informal and natural community-based supports.

Effect of this change:

- Assure program integrity and accountability in the operations and management of the IRIS Program.
- Strengthen the framework of IRIS to better support choice, self-determination and more cost-effective options.
- Align budget allocations to be more consistent within IRIS and with Family Care.
- Support people in the most integrated, community-based and cost-effective settings.

2011-2013
Long Term Care Sustainability

Living Well at Home and in the Community

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Living Well at Home and in the Community
Projected Savings:	$54.5 million GPR
Proposed Implementation Date:	Spring 2012

Description: Increase the availability of timely and easy access to less intensive and more flexible supports to help people and their caregivers to remain healthy and safe at home and in the community without the need for more comprehensive LTC supports and services.

Main Message Points

- Aging and Disability Resource Centers (ADRCs) provide a central source of reliable and objective information about a broad range of programs and services and help people understand and evaluate the various options available to them. In particular, ADRCs:
  - Serve as the single point of access for publicly-funded LTC, providing eligibility determination and enrollment counseling.
  - Provide options counseling to identify other available programs and resources for those not eligible for Family Care, IRIS, PACE or Partnership.
  - Offer intervention activities such as programs to review medications or nutrition, teach people how to manage chronic conditions like diabetes or heart disease, or engage people in programs to eliminate home hazards and prevent falls.
- In identifying resources and making informed decisions about long term care, seniors and persons with disabilities can conserve their personal resources, maintain self-sufficiency, and delay or prevent the need for potentially expensive long term care.

Proposed Modifications

1. **Medication Compliance.** Provide automated, in-home medication dispensing systems for frail seniors, persons with disabilities, and high-risk persons on Medicaid to keep people living independently in the community and to reduce emergency room visits, inpatient hospital stays and nursing home and LTC residential admissions from non-compliance and errors in dispensing prescription medications.
   - Utilize existing data and analytical tools to systematically identify at-risk individuals on Medicaid with multiple medical conditions, multiple medications, some form of cognitive impairment, a history of negative health outcomes from not taking medications, and need for assistance in a relatively high number of activities of daily living.
     - Medication compliance by frail seniors is typically below 15%, but rises to about 98% with automated dispensing.
     - Research shows that up to 23% of nursing home admissions are due to medication non-compliance by seniors, while over 10% of hospital admissions are due to medication non-compliance.
   - Facilitate access to secure in-home medication dispensing systems with personal resources for seniors and persons with disabilities who are at risk of entering a residential or institutional placement or of becoming eligible for more costly LTC programs.

- Automated dispensing reduces the need for services in more intensive LTC settings; the inability to follow medication therapy is sufficient reason for admission in these settings.

- Use supportive home care workers, families, nurses, and pharmacists to load prescriptions in machines.
  - The device holds a month's supply of prescribed drugs;
  - Visually and audibly notifies the person when it is time to take their medication;
  - Dispenses medications at the correct time of day, in correct combinations, in correct quantities, and with correct instructions (e.g., take with food); and
  - Sends warning alerts to caregivers over the phone line, continuously tracks medication compliance, and provides data for care management.
- Implement the pilot within three months on a voluntary basis, and generate net savings quickly from avoidable hospital, ER and LTC placements in residential and institutional settings.
  - Proactively identify 40,000 Medicaid beneficiaries through predictive modeling of the high risk of hospitalization/institutionalization of those who are at extremely high risk of medication non-compliance due to a high number of active prescriptions, multiple morbidities, age, prior adverse events from non-compliance and other risk factors, such as cognitive impairment or functional limitations.
  - Certify qualified providers to provide automated dispensing, with savings used to fund implementation and ongoing costs for Medicaid eligibles and with competitive rates for those at risk of becoming eligible for LTC programs.
  - Explore the opportunity of a grant with the CMS Innovation Center to share the costs and savings from Medicare beneficiaries in the demonstration pilot.
- Provide additional supports, such as ensuring home-delivered meals for individuals that need adequate nutrition for effective medication management.

2. **Nursing Home and Assisted Living Intervention and Diversion.** Counsel new residentss and their families in nursing home and assisted living about LTC services in the community, assist them in arranging those services and help existing institutionalized Medicaid residents leave a facility for services at home.
   - Deploy staff in nursing home and residential facilities to provide information within seven days of admission to residents who are on Medicaid and those likely to become eligible for Medicaid within six months to conduct an assessment and discuss LTC options at home and in the community.
   - Intervene early in a stay, focusing mainly on those who continue to have available housing and willing support systems, providing assistance to remain in their own homes or delay or prevent residential or institutional placement.
   - Similar initiatives in Washington, Oregon and New Jersey have demonstrated savings of 35% to 60% from reduced nursing home admissions over a 10 to 15 year period.

3. **Falls Prevention.** Expand the number of high-risk persons participating in evidence-based prevention programs to reduce hospitalization and/or need for long-term care.
   - Reduce falling among older people in every county to reduce by 20% hospitalization and long-term injury among older people due to falls.
   - Develop outreach to health systems and to people to promote referrals and participation in falls prevention by 25% each year.
   - Support occupational and physical therapy participation in falls prevention.
   - Work with health systems and MCOs to develop additional programs for members.

4. **Chronic Disease Self-Management.** Expand the number of high-risk persons with multiple chronic diseases that participate in peer-led chronic disease self-management.
   - Support outreach to adults with chronic illness to participate in a seven-week peer-directed class in self-management of chronic conditions in order to improve health and well-being.
   - Increase participation by 25% each year in every county.
   - Focus efforts on diabetic and cardio-pulmonary conditions.
   - Work with health systems, MCOs, and other federal and state initiatives to promote referrals and to develop

additional programs.

5. **Short-term Community Intervention.** Arrange for short-term practical community interventions to support people with modest means to remain at home.
   - Problem solve with elders and people with disabilities who are at risk of moving to residential settings by arranging volunteer help; low cost technologies; minor home repair and cleaning or other affordable solutions to problems with the current home environment.
   - Identify and mobilize social supports and community connections to reduce isolation and risk for people living alone.
   - Secure affordable housing and arrange for low-cost services for elders, people with disabilities and their families that do not need residential care but who are struggling to maintain independence at home.
   - Conserve individuals' personal funds for people that do not require residential care by advising about purchasing in-home or community-based services.

6. **Alzheimer's Disease and Other Dementia.** Screen and treat vulnerable individuals to identify those diagnosed with Alzheimer's disease or other dementia, to delay institutional placement by an average of 18 months.
   - Conduct a brief screen at ADRCs to identify persons at risk.
   - Refer those who may be at risk for dementia to diagnostic clinics (21 available around the state) that are affiliated with Alzheimer's Institute.
   - Using the evidence-based model of Memory Care connections, connect individuals and families with social supports, education, caregiver support and respite.
   - Provide contact and help to caregivers using the evidence-based Mittleman model.
   - Engage persons with dementia and caregivers in a program of moderate physical and mental exercise to reduce isolation, improve function, and provide respite (LEEP model).

7. **Care Transitions.** Assist seniors and persons with disabilities leaving hospitals and making a transition to home.
   - Pilot the evidence-based Coleman model of effective hospital transitions with several major hospitals or health systems.
     - Provide for individuals who are screened at discharge as at risk of returning to the hospital by providing a transition "coach" to facilitate effective transition for the person and caregiver.
     - Using a combination of home visits and telephone contacts, monitor compliance with the discharge plan for up to three months.
     - Measure effectiveness and cost-savings and determine how to finance expansion of the model, if successful in Wisconsin.
   - Strengthen relationships between ADRCs and hospital discharge units to improve information and assistance about community resources.
   - Pilot the Peer Link model which uses certified peer specialists to assist with transitions from the hospital to the community for individuals with mental health concerns and which has shown a 46% decrease in hospitalizations for members in the program.

Effect of this change:

- Delay or prevent people's entry to long term care.
- Assist more people to manage within their own personal resources.
- Avert unnecessary hospitalizations, ER visits, and nursing home placements, reducing public and private expenditures for primary, acute and LTC.
- Ensure that caregivers receive critical support to be able to maintain their role as a caregiver while remaining healthy.

2011-2013
Long Term Care Sustainability

Residential Services

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Residential Services
Projected Savings:	$14 million GPR
Proposed Implementation Date:	Spring 2012

Description: Ensure that people with long-term care needs are safe and cared for in their own homes and community settings as long as possible, with services provided in residential settings only when it is the least restrictive and most integrated location to meet the person's needs.

Main Message Points

- The cost of care provided in residential settings, which includes Adult Family Homes (AFHs), Community-Based Residential Facilities (CBRFs), Residential Care Apartment Complexes (RCACs) and Assisted Living, is a significant cost driver in Family Care, IRIS, PACE and Partnership:
  - In Family Care, care provided in residential settings represents 53% of costs for members with a developmental disability, 41% of costs for members with a physical disability, and 60% of costs for frail elders.
  - For members with a developmental disability, the lowest one-third cost group expends about $200 per member per month (PMPM) for supportive care in their own home. In contrast, the highest one-third cost group expends $4,387 PMPM for home care provided in residential settings. Similar differences also occur for persons with physical disabilities and for frail elders.

- The most integrated, community-based, and cost-effective setting to receive LTC services for most people is in their own home or apartment in the community. To support these principles, this initiative is designed to:
  - Provide information and counseling on care in residential settings, including assisted living;
  - Use technology and other community-based services to support people in their own homes;
  - Align access and payment for residential care with members' functional needs leveraging flexibility identified by the Centers for Medicare and Medicaid Services (CMS) to set utilization criteria to control waiver costs;
  - Require that self-directed care be provided in settings in which the consumer directs the provision of care; and
  - Ensure the right support, in the right amount, at the right time, allowing people to be supported to live in their own homes and natural settings as long as possible while assuring health and safety.

Proposed Modifications

1. **Establish Criteria for Residential Care as an Allowable Service within the Family Care Benefit Package.**
   - Specify acuity-based guidelines for utilization of more restrictive residential settings.
   - Ensure that members with low acuity do not generate a rate to support costly, more restrictive residential settings.
   - Establish an upper payment limit for members in assisted living that do not have exceptional needs.
   - Require that LTC services and Medicaid-supported personal care support living at home, and not to provide housing or substitute care. Utilize residential settings for individuals whose health and safety cannot reasonably be met in natural residential settings such as homes or apartments.

2. **Limit the Use of Restrictive Residential Settings that are Inconsistent with Self-Direction in IRIS.**
   - Limit the use of more restrictive residential settings in IRIS (including 8-bed CBRFs, 3-4 bed AFHs, RCACs, and assisted living facilities) to no more than needed to address participant health or safety needs on a short-term basis. This is consistent with the IRIS Advisory Committee recommendations to assure that a person is in a setting consistent with full self-direction.
   - Provide options counseling to transition IRIS participants from restrictive to integrated settings in the community within 12 months of this change, and allow members who wish do not wish to move to transition to a program that permits more restrictive residential settings.
   - Assist IRIS participants with information on potential service providers and guidance on how to select providers to deliver self-directed care in less restrictive residential settings.
   - Educate providers on self-direction and encourage providers to develop options that allow for maximum consumer control.

3. **Emphasize the Importance of Natural Supports within Family Care and IRIS.**
   - Require a comprehensive assessment of members' informal support networks to assure that Medicaid does not supplant that support.
   - Build on best practices which show that people with unpaid supports, in addition to publically-funded supports, are safer and more included within their community.

4. **Ensure Informed Decision-Making Regarding the Use of Assisted Living.**
   - Maximize the use of personal resources to support LTC and reduce the number of people that enter publicly-funded LTC from assisted living facilities.
   - Work with Aging and Disability Resource Centers (ADRCs) and Assisted Living facilities to help consumers and their families to make informed choices about the most cost-effective long term care options, using a standard Consumer Bill of Rights and Responsibilities to ensure that people understand:
     - The options for caregiver support and services in their own home, including the availability of medication management technology, falls prevention, and assistance with care management;
     - The estimated impact of moving to assisted living on their personal finances;
     - The criteria for living in such a setting when public funds are utilized; and
     - If private funds are exhausted, that a move may be required if care in the assisted living facility is not consistent with acuity-based guidelines or LTC residential rates for public programs.
   - Define the scope of services for which public funding would be used to support care (e.g., exclude amenities).
   - Publish assisted living facility rates to assist consumers in understanding how quickly their personal resources would be spent and whether public funding may be available if they become eligible for Medicaid LTC services.
   - Require facilities to notify people if they do not accept public rates within their facility.

5. **Align the IRIS Program Rates to be Comparable to Allowable for Residential Services within Family Care.**
   - Establish rate bands to ensure alignment of IRIS acuity measures and rates with local MCOs services and rates.
   - Require that members who transfer to IRIS to retain their provider receive a budget allocation that is comparable to the rate offered by the MCO.

6. **Support More Integrated, Cost-Effective Options in Place of 24/7 Staffing.**
   - Implement supported living within Family Care and IRIS to ensure that people receive care in their own homes and apartments in partnership with an agency that will arrange and support a range of services that support person-centered outcomes and self-directed care, including:
     - Leverage technologies, such as alert systems and rapid response, for supports for people with an intermittent and/or unpredictable need for supports.
     - Use assistive technology and home modification devices to promote independence in accomplishing daily activities.
     - Utilize medication management systems to assure accurate use of prescription drugs and to monitor instances when the person needs an on-sight visit for professional staff to meet their needs.
     - Promote MCO and IRIS consumer efforts to develop cost-effective models for providing 24/7 in-home care

that is not based on shift work or per-hour work.
  - Establish a clear definition of supported living arrangements and provide the necessary infrastructure to facilitate the use of such supports.

7. **Develop more cost effective housing options for people with long term support needs.**
   - Support more affordable housing initiatives, and explore options to develop individualized, integrated, accessible, affordable and safe housing for people living independently but with intermittent support needs.
   - Provide affordable housing options for support staff to live proximate to the people in need of support.
   - Support efforts to identify and develop cost-effective settings for people to live and receive care.
   - Support efforts to locate compatible roommates, identify home/apartment settings to share living expenses and increase access to support.
   - Increase use of and support for natural, unpaid supports in people's lives.
   - Transition Family Care from primarily using licensed, regulated settings to supporting people in their own homes or apartments with services from a provider who is not also the homeowner.
   - Leverage the recently-approved grant of $330,000 to build sustainable partnerships in housing to:
     - Create a new and innovative partnership between DHS and WHEDA to evaluate HUD Section 811 opportunities to develop affordable housing projects;
     - Create a new Section 811 independent housing referral process utilizing the LTC infrastructure;
     - Establish a new housing counseling curriculum for agencies serving members in the community; and
     - Educate developers on the benefits of Section 811 program reforms and opportunities for LTC clients.

8. **Utilize Enhanced Federal Match through Money Follows the Person (MFP) to Relocate and Divert Individuals from Institutions (Nursing Facilities and ICFs-MR) to More Integrated Settings in the Community.**
   - Ensure that consumers/families sign up for MFP before the transition to the community:
     - Require ADRC and institutional staff to inform residents of the availability of MFP prior to relocation.
     - Ensure that individuals who agree to participate are assisted in completing the quality of life survey prior to transitioning from the institution.
     - Explore opportunities to allocate a portion of enhanced federal funding to MCOs that relocate or divert individuals to the community.
   - Enhance the system to track and follow-up with individuals who agree to participate in MFP.
   - Require institutional facilities, ADRCs, MCOs and counties to fully cooperate with MFP.
   - Maximize the use of 100% federal funding for MFP administrative costs.

9. **Outreach to Ensure Understanding of Community Supports.** Ensure outreach to physicians, nurse practitioners, hospital and nursing home social workers, and other medical and social service professionals to increase understanding of supports available within the community.

Effect of this change:

- Support the most integrated, community-based, and cost-effective setting for LTC supports and services which, for most people, is in their own home or apartment.
- Provide information and counseling to help seniors and their families make better and less costly long term care choices.
- Limit the growth in future Family Care, IRIS, PACE and Partnership costs by providing care in more cost-effective home and community settings.
- Ensure the right support, in the right amount, at the right time, allowing people to be supported to live in their own homes and natural settings as long as possible while assuring health and safety.

2011-2013
Long Term Care Sustainability

Youth in Transition

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Youth in Transition
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Develop and maintain community employment and living settings for youth that transition from children's to adult services, and address the needs of families so they can continue to work after their child graduates from school.

Main Message Points

- The transition of young adults with disabilities from high school into the adult service system provides a critical opportunity to support community employment with earnings and community living settings.
  - By establishing a timeline, policies and supports for youth in transition, more cost-effective employment and housing is possible, ensuring the fiscal sustainability of Family Care and IRIS.
  - By focusing on employment first, youth can attain a sense of achievement and purpose and leverage paid employment to support their financial stability (including housing) and their social opportunities.
- The most integrated, community-based, and cost-effective strategies to support youth in transition include options to:
  - Ensure graduation at age 20-21 with a high school diploma and placement in integrated work in the community.
  - Provide support to maintain work, including supported employment services, transportation, and vocational support, utilizing natural supports wherever possible.
  - Incorporate best practices to match youth with positions where they can work independently with the least amount of paid support, using alternative work schedules, as needed, and natural inclusion in the work environment.
  - Ensure the transition to community-based living settings.
- The experience of graduates with developmental disabilities in Dane County in the Spring of 2011 indicates that 29 of 33, or 88%, worked in community employment at a median hourly wage of $7.25. At 15 hours worked each week, graduates earned an average of $477 per month. The average cost of a graduate in supported employment with blended funding from LTC and DVR funding totaled $13,700 per year or $1,142 per month.
- These provisions are designed to support youth in transition to develop the skills needed to achieve community connections, employment and living arrangements that are the least restrictive/most inclusive settings possible.

Proposed Modifications

1. **Establish Policy Guidelines and Criteria to Promote Community Employment and Living.** For youth in transition (ages 18 – 25 years) in Family Care and IRIS focus first on ensuring community employment and supports to live at home with one's family, and subsequently develop options to ensure housing in the community. Specify that the LTC service package include:
   - ***Employment-related services***
     - Service coordination
     - Self-directed support broker services
     - Customized and supported employment services
     - Futures planning

- Job coaching
- Assistive technology and home modifications, when necessary for employment and community participation
- Daily living skills training
- Consumer education and training
- Non-medical transportation for school and work and community participation (leveraging natural supports)

- ***Family Support-related services***
  - Consumer/family education and training
  - Respite care
  - Supportive home care
- ***Medicaid card services***, to the extent such services are allowable.
- ***Utilization of Services from DVR, DPI, and schools*** to assess, plan and develop community employment options prior to graduation and as youth transition from school to adult services.

2. **Division of Vocational Rehabilitation (DVR) Pilot.** Establish a statewide pilot program to support community-based employment to leverage 80% federal matching funds and the infrastructure and programming in DVR for integrated employment to prioritize services for youth with disabilities in Family Care and IRIS.

3. **School Services, Counseling, and Career Planning.**
   - Encourage youth with disabilities to access public school benefits to which they are entitled to between the ages of 18 – 21 years of age.
   - Expand and promote disability and work incentive benefits counseling so that youth with disabilities and their families are aware of the opportunities for being employed while retaining access to important public benefits.
   - Develop career planning tools that staff in the Children's Long-Term Care system can use in working with families to develop an early expectation and vision for paid work in the community.
   - Provide family-oriented training on the transition process and facilitation of skills development for their youth.
   - Expand, publicize and promote disability benefits counseling for youth in transition.
   - Explore incentives to providers to promote more integrated and cost-effective community outcomes.

4. **"Let's Get to Work" Grant.** Leverage $1.8 million over five years in recently-approved grant funding to the Wisconsin Board for People with Developmental Disabilities, with the support of DHS, DVR, DPI and numerous stakeholders to develop and implement provisions to initiate statewide school pilot sites to test a set of evidence-based practices to expand competitive employment in community settings and to disseminate policies and practices based on the pilots.

Effect of this change:

- Utilize the most integrated, community-based, and cost-effective living and employment settings for youth in transition.
- Focus first on employment for youth leaving school, using earnings to support living expenses.
- Through a pilot with DVR, negotiate a statewide rate to contribute the full amount allowed for youth in transition to support the move from school to paid employment.