Survival Coalition
of Wisconsin Disability Organizations

101 East Wilson Street, Room 219, Madison, Wisconsin 53703
Voice: 608/266-7826 Fax: 608/267-3906

October 30, 2015

Department of Health Services
Secretary Kitty Rhoades
Family Care and IRIS 2.0
P.O. Box 7851, Room 550
Madison, WI 53707-7851

Dear Secretary Rhoades:

Survival Coalition has prepared the following comments outlining concerns the disability community feels are critical to address in Wisconsin's long term care system redesign. We have also included discussion and recommendations on the specific questions DHS posed to generate stakeholder testimony.

For convenience, we have organized information and recommendations topically.

Community living and integrated employment have already been proven to be cost effective strategies. These should be the cornerstones and expectations of the new system. Long-term care—the right amount of support at the right time—is the difference between independence and dependence; between community and isolation; between working and unemployment.

Fiscal sustainability also means program quality. Cost control does not have to come at the expense of participants not achieving outcomes they need—independent living, integrated employment, self-direction, and supporting people to have valued social roles in their communities. Wisconsin's current managed long term care system is a national model. The development of a new integrated long-term care system is an opportunity to improve upon what is already working well.

Sincerely,

Survival Co-Chairs:

Maureen Ryan, moryan@charter.net; (608) 444-3842;
Beth Swedeen, beth.swedeen@wisconsin.gov; (608) 266-1166;
Kristin M. Kerschensteiner, kitk@drwi.org; (608) 267-0214

Contents

Community First—Ensuring everyone has the right to live and be served in the community. 4

De-incentivize and reduce Institutional placements 4

Recommendations: De-incentivize and reduce institutional placements 4

Address the Workforce Crises 6

Recommendations: Address the Workforce Crisis 6

Same Service types at the same levels 8

Recommendations: Same Service Types at the same levels 8

Integrated Employment 9

Recommendations: Integrated employment 10

Transportation 11

Recommendations: Transportation 11

IHA Innovation, use of new technology, & leveraging local resources 13

Recommendations: Use of Innovative Technologies and leverage of local resources 13

Provider and Network Capacity 14

Recommendations: Provider and network capacity 15

Program Integration 17

Prevention of over-medicalization of the LTC model 17

Recommendations: Prevention of over-medicalization of the LTC model 17

Independent readiness assessment, staged transition. 18

Recommendations: Independent readiness assessment, staged transition 18

Behavioral Health 20

Recommendations: Behavioral Health 20

Quality Outcomes and Measurements 24

Recommendations: Quality Outcomes and Measurements 24

Recommendations: Administrative & general contract provisions 25

Participant protections and rights 27

Recommendations: Participant protections and rights 27

Ongoing participant and advocate engagement 29

Recommendations: Ongoing Participant and advocate engagement 29

Local communities, local relationships 31

Provision of services on a regional basis 31

Recommendations: Provision of services on a regional basis 31

ADRC's role in fiscal sustainability of the LTC system 33

Recommendations: ADRC's role in fiscal sustainability of the LTC system 33

Self-Direction under managed care 34

Recommendations: Self-Direction under managed care 34

Appendix A: Quality metrics for community integrated employment 37

Appendix B: Time and Distance & Network Adequacy Standards 38

Community First—Ensuring everyone has the right to live and be served in the community.

De-incentivize and reduce Institutional placements

Survival Coalition is concerned—unless the new system is structured otherwise—that IHAs may have a financial incentive to self-select the lowest-risk, lowest-cost pool, and might use institutional settings as a mechanism to transfer high-cost, high-risk, or individuals with challenging behaviors out of Family Care as a risk pool management strategy in order to maximize profitability.

Family Care has successfully supported people with complex needs in their own homes and community. Prevention and reduction of institutional placements is a primary source of the cost savings that the current system has generated.

Mechanisms to de-incentivize institutionalization and incentivize the fastest possible return to the community in the event of a temporary institutional placement must be included in the structure of the new system. Continued emphasis on facility and institutional down-sizing and assurance that the new system will continue to operate in a way that ensures all individuals have the right to live and be served in the community must be foundational values on which the new system is based.

If institutional placements rise the cost-savings associated with long term care programs will evaporate and reverse. A reduction in the numbers of people served in long term care by virtue of diverting people from the community and into institutional settings will lead to an exponential increase in other areas of the Medicaid budget that far surpasses current spending on community based supports.

The National Council on Disability (NCD) technical assistance for states[1] finds that inclusion of specific strategies for preventing unnecessary or premature institutionalization and facilitating the transition of eligible people from institutional to Home and Community Based Services (HCBS) settings is critical to include in Medicaid managed care systems to minimize the number of people who require services in the most expensive care settings (i.e. institutions).

Recommendations: De-incentivize and reduce institutional placements

1. **Close the state's remaining facilities regulated as institutions (ICF-IDDs and IMHDs)**, and require IHAs to transition residents into HCBS within the first full contract period after statewide Family Care implementation.

2. **Use** the **same reimbursement rate for institutional and Home and Community Based (HCBS) services.** The average per capita cost of institutional services typically is considerably higher than that of HCBS. When a state establishes the same acuity-adjusted Per Member Per Month (PMPM) payment rate for institutional and HCBS services, at-risk MCOs have

[1] Medicaid Managed Care for People With Disabilities http://www.ncd.gov/publications/2013/20130315/

strong incentives to avoid institutional placements and to transition Nursing Facility and other institutional residents to HCBS settings[2].

3. **Reward health plans with high community transition rates.** In addition to holding health plans at full risk for Nursing Facility admissions, employ an HCBS reconciliation process to encourage plans to return institution residents to the community with appropriate services and supports[3].

4. **Include the current institutionalized population in the state centers for the developmentally disabled and other ICF-IDs in the capitated rate**, creating an incentive to deinstitutionalize that population.

5. **Create an incentive payment structure for IHAs to reimburse costs associated with the care planning that takes place before individuals enroll in Family Care and relocate from institutions, as well as actual relocation costs.**

6. **Use partially capitated rates for institutional care.** In situations where the state concludes that full-risk sharing would destabilize the finances of private health plans, partial capitation of institutional services may be an alternative.[4]

7. **Expand access to the Adaptive Aids program and diagnostic capacity housed within Central Wisconsin Center to all state residents.**

8. **Develop alternatives to Intensive Treatment Plan beds housed in Southern Center for people with Developmental Disabilities experiencing mental health crises.** Recommendations include expanding the number and use of Community Consultation Teams, trained mobile crisis, and small community based crisis facilities. (See also Behavioral Health Services recommendations)

[2] New Mexico adopted this strategy when it launched its Coordination of Long-Term Services (CoLTS) program. The CoLTS program uses a blended payment rate that incorporates NF and HCBS payment data for all beneficiaries who meet nursing home level of care criteria. This payment rate is not adjusted when a beneficiary enters an NF; consequently, participating, at-risk health plans have strong incentives to provide the additional supports that high-need enrollees require to avoid admission to a nursing home or to transition from a nursing home to the community. CoLTS payment rates are renegotiated annually based on service patterns. Arizona uses a similar approach in managing its Arizona Long Term Care System. (http://www.ncd.gov/publications/2013/20130315/, page 98).

[3] In addition to holding health plans at full risk for NF admissions, the Arizona Long Term Care System (ALTCS) program employs an HCBS reconciliation process to encourage plans to return NF residents to the community with appropriate services and supports. The state establishes an assumed, plan-specific ratio of HCBS recipients to NF residents by geographic area. If a health plan serves a higher ratio of enrollees in HCB settings than the state benchmark, Arizona reimburses the plan for a portion of the savings achieved through a reconciliation process. Conversely, if a plan falls below the state-established target ratio, the state may recoup a portion of the differences in rates paid to the plan. (http://www.ncd.gov/publications/2013/20130315/, page 99).

[4] Health plans participating in Minnesota's Senior Health Options (MSHO) program, receive a blended PMPM payment rate that requires them to pay 180 days of NF care on behalf of any enrollee placed in an NF. After 180 days, the NF's per diem costs are reimbursed directly by the state on an FFS basis. To encourage health plans to serve high-need beneficiaries in HCB settings, Minnesota pays plans a "nursing facility add-on" rate. This supplemental payment ceases when a beneficiary is placed in an NF, and the plan must cover the higher facility costs out of the previous revenues it has received from the state for the initial 180 days. (http://www.ncd.gov/publications/2013/20130315/, page 98).

Address the Workforce Crises

Increased institutional placements may be an unintended consequence of the current personal care and home health nurse workforce crisis. Workers are leaving the profession to take higher paying jobs, reduce expenses incurred from traveling to multiple worksites, and have predicable numbers of hours and shifts. Some personal care workers are continuing with their profession, but are moving from community based services into institutional settings. If there are not enough workers to support people in the community, older adults and people with disabilities may have no alternative to residence at a nursing home or other institution.

Direct-care workers are the state's frontline paid caregivers providing daily living services and supports to elders and those with physical or intellectual/developmental disabilities. Personal care workers jobs can be physically demanding and require personal hygiene tasks, such as bathing, feed, toileting, and other nurse delegated tasks. The current Medicaid reimbursement rates result in poverty level wages for the community care workers that provide some of the most intimate care LTC participants rely on.

The current workforce capacity is inadequate, and the turnover rate is reported by Wisconsin Personal Services Association (WPSA) members as 35–60% annually[5]. There are currently 3,000 additional positions that are unfilled, and by 2020 the number of workers needed is projected to increase by 36%. Reasons for the high turnover rate of personal care workers include, low wages, restrictions on the number of hours given to workers, and lack of training/career path advancement opportunities.

High turnover rates create constant administrative costs associated with recruitment and hiring processes, and considerable inconvenience and destabilization of LTC participant's lives. Reduction of turnover is a cost-effective strategy for the fiscal sustainability of the LTC system.

Recommendations: Address the Workforce Crisis

1. **DHS should authorize a retention payment strategy to stabilize workforce numbers through the completion of the transition to the new system.** Low rates, uncertainty about the changes to the LTC system, and removal of the "any willing provider" clause are directly influencing worker's career decisions. Many workers feel their jobs are at risk and are taking other opportunities as they arise. Unless this trend is reversed, IHAs may come into the new system without enough workers to operate it.

2. **DHS's Family Care contract should establish a Medicaid reimbursement rate for transportation costs associated with personal care workers commuting to client homes.** These costs should at minimum include gas, millage, and public transit system fares[6]. Alternatively, DHS could increase hourly salary adequately so the workforce could cover these additional expenses that travel time does not.

5 There are currently about 90,000 personal care workers in Wisconsin; a 35% annual turnover rate equates to 31,500 positions that must be refilled every year.

[6] Currently, the workforce is only reimbursed for travel time and not mileage. Travel time reimbursement often does not cover the cost of gas and wear and tear on the vehicle.

3. **DHS should establish a statewide contract with a proven interface[7] used by all IHAs that enables LTC participants to match their needs with available workers, schedule support, and track hours.** Applications have been developed that match participants and workers by via profile information (care needed, geography, availability), enable participants to self-direct and hire workers that fit their needs and personality, enable personal care agencies and workers to track hours to prevent incurring overtime expenses, and enable provider agencies and managed care organizations to reduce administrative overhead while tracking workflow and billable Medicaid expenses. Adequate rates would allow for providers to invest in technology to more efficiently schedule workers, provide visit verification to prevent and detect fraud, and automate billing and payroll functions that would create a timesheet to be easier for personal care workers to complete and reportable to the state.

4. **DHS's Family Care waiver should continue to permit LTC participants to hire "individual" service providers so that participants can continue to choose agency or participant hired workers, including relatives and friends not affiliated with agencies.** Continuing to use willing workers connected to an individual's network expands the pool of available workers.

5. **DHS should require improvements to workforce training programs to provide employees with a transferable certificate that lead to a viable and sustainable career pathway.** Currently, the Personal Care workers are typically unlicensed and uncertified; training is inconsistent across providers. Lack of training has been identified as one reason for a high turnover rate.

6. **DHS's Family Care waiver should include training available to all LTC participants (Family Care and Self-Directed option) on establishing boundaries, employer/employee expectations, interpersonal communication skills, conflict-management skills, and maintaining positive relationships with workers.** Consumer training on how to interact, communicate with, and treat personal care workers is a cost-effective strategy that can offer return on investment in the form of consistent, uninterrupted services and better overall workforce retention.

7. **To further assist in retention and recruitment of workers there is an opportunity for DHS, providers, and IHA's to create a statewide image campaign that recognizes the contribution and value direct care workers add to long term care recipients lives.**

[7] My Support (http://www.mysupport.com/) is an example of a platform currently operating in California, New Jersey, and preparing to launch in January in Iowa.

Same Service types at the same levels

Wisconsin's long term care system is relied on daily by thousands of people. It cannot be emphasized enough that for people living with disabilities and older adults long term care is the difference between being able to get out of bed or not, be employed or not, live at home rather than an institution, and a thousand other little things that help people gain or retain independence that people without disabilities don't have to think about.

Seemingly small changes to the types of services offered and the levels of service provided can have profound impacts on people with disabilities lives and the lives of their families and caretakers. The questions Survival Coalition member continue to hear from LTC participants touch the daily lives of many people who depend on answers to live productive, participating lives asking questions such as:

- Will I get the same supports to get up in the morning, take a shower, and use the bathroom?
- Will I be able to stay in the same home?
- Will I have to live with new people?
- Will transportation still be available to get to work?
- Can I keep my job or will my job supports go away?

Survival Coalition has consistently requested assurances from DHS to LTC participants that the same services will be offered at the same levels.

Recommendations: Same Service Types at the same levels

1. **DHS's Family Care waiver should establish that a person's services should not be reduced, changed, or ended without a documented change in their needs that can be independently reviewed and challenged.**

2. **DHS's Family Care contract should include the same service types that are offered in the current LTC system and the same primary, acute, and behavioral health services offered in Medicaid Fee For Service will be included in the new LTC system, and participants will be able to access the same levels of those services.**

Integrated Employment

Survival Coalition sees the redesign of Wisconsin's long term care system as an opportunity to orient the entire system on achieving integrated, competitive employment and independent, integrated community living outcomes as the first and preferred option for people with I/DD. The new system should use a strategically targeted approach and outcome based reimbursement model to provide accountability and incentives.

Paid community integrated employment is significantly related to better health outcomes and lower per person Medicaid expenditures. Other states have used revisions to Home and Community Based waivers as a mechanism to implement integrated employment strategies that will result in cost-savings as a long term fiscal sustainability strategy.

Tennessee's Employment and Community First CHOICES waiver incorporates strategies that have been proven to improve employment outcomes, independence, and promote full participate in community life. Tennessee's services are designed to produce specific, measureable outcomes, and the system is geared to provide accountability and incentivize results. The Tennessee waiver does the following, and Survival Coalition finds this approach to be applicable, beneficial, and replicable in Wisconsin's Family Care waiver:

- Service definitions are oriented in an outcome-based reimbursement approach that will provide accountability as well as monetary incentive for completed steps on the path to employment.
- Services are exclusively focused on obtaining and/or maintaining a competitive or customized job, or self-employment, an integrated community setting for which the individual is compensated at or above minimum wage.
- Includes an introduction to benefits planning and the variety of work incentives available to individuals receiving SSI and/or SSDI, Medicaid, and/or Medicare.
- Many services are one-time, time-limited, and targeted for a specific purpose to achieve specific, defined measurable outcomes.
- Establishes a tiered benefit structure based on the needs of the individual, and orients the benefit structure and aligned financial incentives to focus on integrated employment and independent community living. Each benefit package will have an individual cost limit.
- All participants will have the option for self-direction, including full budget authority

Recommendations: Integrated employment

1. **DHS's Family Care Waiver should include the policies and service definitions related to integrated employment and pre-vocational services found in Tennessee's Employment and Community First CHOICES integrated managed long term care demonstration waiver**[8].

2. **DHS's Family Care contract should require "Pay for performance" billing strategy for supported employment services**[9] —currently implemented by at least one Wisconsin MCO—for all Family Care IHAs.

3. **DHS's Family Care contract should contain specific language requiring integrated employment outcomes, performance metrics for employment services, specific data collection and reporting requirements, and tie employment outcomes to performance incentives** (See Quality Outcomes and Measurements section and Appendix A).

4. **DHS's Family Care contract should require IHAs to implement policies that mirror Dane County's practices**[10], and include a presumption of integrated employment for youth exiting school and a non-funding policy for facility-based services that do not support an integrated employment goal.

5. **DHS's Family Care contract should require IHAs to post community integrated employment outcomes data** (see Quality Outcomes and Measurements section) on a publically accessible, searchable website such that LTC participants can compare individual employment providers and IHAs when deciding which option to choose.

6. **DHS's Family Care contract should require IHAs to prioritize community employment services and supports for individuals with a mental health diagnosis who want to work.** The waiver should enable IHAs to provide coverage for Individual Placement and Support (IPS) Supported Employment programs[11].

[8] http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf

[9] Service codes in long-term care can be changed to pay for hours an individual works, rather than hours of service provided. This incentivizes obtaining more hours of employment for a LTC participant, finding a good job match that minimizes the need for support, and rewards fading of job coaching over time because the agency is still paid for the hours a person works regardless of services delivered.

[10] Dane County's approach places employment as the central element to build a person centered plan of supports and services around. The expectation is that a person's week will be filled with some hours of community integrated employment. Wrapping supports (transportation, volunteer opportunities, classes, health and fitness activities, etc.) to maintain integration in the rest of the person's week is easier when the person has developed community relationships and interests. Dane County has established a Partners in Business program, has successfully used this approach for 25 years, and has a 75% integrated employment rate.

[11] This is the evidence-based model for rapid employment to help people with mental illness find competitive employment that fits their preferences. Once a person has found a job, IPS programs provide ongoing workplace support.

Transportation

Transportation is consistently identified as the number one challenge impacting employment options and independent living by people with disabilities[12]. When rides don't come or are late, it can cause other disruptions in an individual's life, and a ripple effect that touches families, employers, in-home care providers, and medical professionals.

Improving both long term care and non-emergency medical transportation options is critical for an integrated system. Successfully supporting people with disabilities and older adults to live independently in their homes, obtain and maintain employment, access community businesses and accomplish daily living tasks, be meaningfully integrated and engaged in the community, and maintain health is dependent on transportation.

Recommendations: Transportation

1. **DHS should modify its NEMT broker contract and implement "Pay for Performance" billing for all NEMT rides.** Currently the broker is paid for all rides, regardless of whether the ride shows up or gets a rider to their destination late. Survival Coalition recommends no payment be made if a ride does not show, and a sliding scale penalty be imposed that reduces payment the later the ride is, with no payment due if the ride results in a patient missing a scheduled appointment.

2. **DHS's IHA contract should allow IHAs to have health care facilities in their acute and primary care network coordinate and schedule their own NEMT rides** in conjunction with the medical and other treatment appointments they schedule. With the implementation of an integrated system, IHAs will be responsible for transportation to primary, acute, and behavioral services in addition to long-term care transportation needed for employment and community integration.

3. **DHS should modify its NEMT broker contract and include in its Family Care Contract the ability for the IHA to assess and recover costs from the NEMT broker associated with missed appointments.** Survival Coalition assumes there are costs to medical and treatment facilities when a professional's time is not used, and a cost to other patients who could have been scheduled in place of a no-show. Since NEMT is billed on a per ride basis, any rides that do not show or arrive late causing patients to miss appointments cause additional billed rides and additional scheduling of a professional's billable hours to be needed.

4. **DHS's Family Care contract should require IHAs to coordinate with County Coordination Councils and County Mobility Managers**, and whenever possible maximize dormant transportation equipment—owned by a variety of entities, education, one stops, hospitals, community transportation—to leverage share transportation coverage areas and conjoin

12 Lack of transportation directly impacts the ability of people with disabilities to participate in the workforce. Even people with disabilities living within major metropolitan areas and employment centers may have restricted or no access to places relatively close to their front doors because flexible and reliable transportation options do not exist. In suburban and rural areas, reliably getting from one town to another and/or crossing county lines can be an insurmountable barrier for those who do not drive.

service delivery for LTC participants. **DHS should include reimbursement rates and requirements for IHAs to reimburse counties for actual transportation costs associated with LTC participants.**

5. **DHS's Family Care Waiver should include purchase of public transit system fare cards as a Medicaid reimbursable service.** Public transit systems are generally a lower-cost alternative than other Medicaid funded single-ride/single-purpose programs. For individuals with access to accessible public transportation, fare cards may offer individuals the ability to determine and stick to their own schedule.

6. **DHS's Family Care Waiver should identify Uber/Lyft and other shared ride drivers, or costs associated with volunteer drivers (gas, milage) Medicaid reimbursable services that can be utilized by LTC participants.**

7. **DHS should use a 1915 (b)(4) waiver to establish statewide managed care for Medicaid transportation that can also be utilized for broader transportation supports (braided support programs)**[13]. The 1915 (b)(4) can be used to establish managed care for transportation, and can be blended with 5311(b)(3) Rural Transit Assistance Program funds. Flexible community funding from sources such as employers, hospitals, chambers of commerce, etc. can be used to fund the RTAP state match.

[13] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Managed-Care-1915-b-Waivers.html

IHA Innovation, use of new technology, & leveraging local resources

Learning and innovation are the cornerstones of continuous improvement, and lead to enhancements in program delivery over time.

Use of innovative technologies (Ipads, various applications) integrated with personal care coordination can lead to more independence more supported decision-making and giving participants more flexibility to take care of needs on their terms and on their schedule, and helping to create better outcomes. Appropriate use of remote technology has helped reduce labor costs associated with paid services.

Recommendations: Use of Innovative Technologies and leverage of local resources

1. **DHS's Family Care contract should create flexibilities for IHAs to innovate, pilot new ideas, and continuously improve the program.** Innovative ideas should be piloted, monitored, and evaluated prior to broad implementation.

2. **DHS's Family Care contract should contain incentives for program innovations that support identified areas of interest or needed improvement.**

3. **DHS should include in the Family Care waiver instruction in the use and maintenance of the additional assistive specific technology, equipment, and supplies added as a service category.** Consider requiring a six month or at least annual review of the successful use of the assistive technology, equipment, or supply to make sure it is working properly and is a benefit to the individual.

4. **DHS's Family Care waiver should require training on Supported decision making[14] with the expectation that this support is available to all Family Care participants and is used in all person centered planning processes.** Supported decision-making can further goals outlined in Medicaid[15] and other federal policies like ABLE Act accounts[16], and be applied to youth in transition[17].

5. **DHS's Family Care waiver allow training services for unpaid caregivers.** Data shows that the highest-quality care with the best outcomes is provided by family members. Self-Direction must support caregivers, not just the individual participant.

[14] Supported decision making (National Resource Center for Supportive Decision Making, http://supporteddecisionmaking.org/education#ed_sdm) is an approach that allows people to use trusted friends, family members, and professionals to help them understand the situations and choices they face. People are supported in making daily life choices about where they live and who they interact with, their finances, and their health care—people are enabled to make their own decisions as often as possible. These decisions are not made for the person. Supported decision making is a recognized alternative to guardianship.

[15] Participant decision making on health and long term care services leads to better outcomes, and helps states achieve better outcomes. http://supporteddecisionmaking.org/events/supported-decision-making-and-medicaid-home-and-community-based-services-settings-final-rule

[16] Fully implementing Congress's intent to further independence and employment for people with disabilities who create ABLE act accounts relies on people with disabilities making decisions on spending of funds and earning their own money to contribute into accounts. http://supporteddecisionmaking.org/events/supported-decision-making-and-able-act-achieving-better-life-experience

[17] Students who have self -determination skills are more likely to successfully make the transition to adulthood, including improved education, employment and independent living outcomes. http://supporteddecisionmaking.org/events/supported-decision-making-and-youth-transition

Provider and Network Capacity

No matter where a LTC participant lives in the state, they should have access to the services they need and have a choice of quality providers (See also Quality Outcomes and Measurements section). Survival Coalition has consistently commented on the current long term care system's inadequate number of providers (residential, employment, transportation, day service), especially in rural and/or underserved areas, and has expressed concerns about provider quality standards.

In the context of the CMS Home and Community Based Services (HCBS) administrative rule, families across the state consistently report that most of the current options in many communities for HCBS funded employment, day services, and residential services have segregating and isolating qualities despite families and individuals indicating they want community based options[18]. Integrated services are not available statewide, and wait lists exist in many areas for integrated options. The new Family Care system must develop integrated community based settings and services capacity as long term strategy to provide improved quality for participants while containing costs.

Community living and integrated community employment has already been proven to be cost-effective strategies, and a new generation of LTC participants wants and expects these services. Investment in authentic community based services that maximize independence, self-determination, and self-sufficiency will result in individuals having an overall reduction on the reliance of publically funded supports. As the system prepares to serve more people, improvements in provider quality and capacity can continue to bend the cost curve down.

The addition of primary and acute health care services and behavioral health services greatly expands the need for a diverse and robust workforce of professionals with the skills and expertise to serve the LTC population. Historically, access to health care, dental, and mental health and substance abuse services has been difficult as many providers do not accept Medicaid patients/rates. Few professionals have received specific training on working with people with disabilities and Intellectual/Developmental Disabilities; a limited number of specialists are available for LTC participants with specific disabilities. There are currently significant shortages in the workforce. IHAs will need to develop capacity throughout the state to build a large enough pool of professionals that LTC participants can choose from and access in their communities.

Network capacity is part of long-term fiscal and program sustainability. A larger network of smaller providers that are more deeply connected to community is equally cost effective and gives better quality outcomes, while offering LTC participants more options and flexibility for participants, especially in rural and/or underserved areas. Emphasis on individualized services leads to deeper connections to local networks of unpaid services.

[18] Survival Coalition indicated in previous comments on the HCBS rule that DHS—in addition to ensuring that all setting options receiving HCBS funds must meet integrated settings requirements—1) at least one of the settings offered is always a non-disability-specific setting; 2) existing providers transition to a different business model, if necessary; 3) Community capacity is assessed and developed to increase integrated setting options. These changes are important to ensure Wisconsin is in compliance with the Olmstead decision, and so future generations of LTC participants are able to become/remain as independent as possible using cost-effective community based supports.

Recommendations: Provider and network capacity

1. **DHS should contract with a non-provider independent quality reviewer[19] to assess and report on primary, acute, behavioral, and LTC (transportation, employment, residential, workforce) capacity in all areas of the state.** This assessment will give DHS important information about the type and number of choices available by location, and geographic information may reveal areas of the state with few or no choices in certain provider capacity.

2. **An Independent quality reviewer should be required** to 1) have the capacity to do statewide comprehensive evaluation 2) be independent from providers that provide LTC services or receive Medicaid funds for primary, acute or behavioral health services 3) is experienced with comprehensive quality review of Long Term Care programs.

3. **Any entity the Department contracts with for independent quality assessment and evaluation purposes should**: 1) Have no contracts with the Department or with regulated providers that may give the perception of a conflict of interest or jeopardize the independence/objectivity of the final assessment. 2) Is not a recipient of Medicaid reimbursements for direct services, and has no potential for direct or indirect financial gain from the outcome of provider capacity assessment.

4. **Network Adequacy Standards should be developed using data elements outlined in Appendix B and the independent assessment of Provider Network Adequacy should include analysis of that data.**

5. **DHS should establish in its Family Care waiver and Contract specific minimum standards and measures of travel time and distance to determine whether the networks of their contracted plans are adequate.** IHAs must demonstrate they can meet geographic access, provider-patient ratios, and timely access to care for all services offered. (See Appendix B).

6. **DHS's Family Care contract should specify required data elements that must be collected and reported to quantify the accessibility and adequacy of the network on at least an annual basis** (see Quality Outcomes and Metrics section and Appendix B).

7. **DHS's Family Care contract should include provisions to specify IHA obligations when no primary/acute/behavioral health provider is available within the network that meets the time and distance standard or quality standards.** This provision will ensure care for the LTC participant and hold IHAs accountable for gaps in provider capacity. Survival Coalition suggests IHAs be required to either arrange for care to be provided by a geographically proximate provider who is out-of-network, arrange for a provider to travel to the enrollee or

[19] DHS has successfully used independent contractors in the past to conduct statewide quality reviews of statewide programs. A task of this scope and statewide scale—evaluation of provider capacity across primary, acute, behavioral, and LTC services—is worthy of issuing a comprehensive Request For Proposal (RFP) for one entity to do all assessments, on-site visits, participant interviews, analysis, recommendations, and reporting back to DHS. Independent assessments will continue to be an ongoing need after transition to the new LTC system, and should routinely be conducted on an ongoing and cyclical basis.

a designated location that is geographically proximate to the enrollee's home or workplace, or provide telemedicine. (See Appendix B).

8. **DHS's Family Care contract should itemize specific primary medical/behavioral/dental specialties, therapeutic service categories specific to certain conditions or disabilities, or formulaic medications where the number of qualified specialists or providers is limited statewide.** IHAs should be required to provide access to these specialties or therapies regardless of whether a specific provider is in the IHA network. (See Appendix B).

9. **DHS's Family Care contract should include network adequacy standards for LTC services, in addition to time and distance standards, including standards that apply to situations where the LTC participant travels to the provider, as well as standards for situations where an LTC provider travels to the beneficiary in a home or community setting.** Survival Coalition suggests contract provisions include mechanisms to measure and enforce timeliness and reliability standards for such providers (See Appendix B).

10. **DHS's Family Care Contract should include a process and mitigation plan to maintain LTC participant's access to services in the event an IHA ceases to be a contracting entity with DHS.** (See Administrative and General Contract Provision recommendations).

11. **LTC participants should be allowed to keep their existing medical, behavioral, and LTC service providers** to ensure continuity and coordination of care.

12. To ensure continuity of care, **all approved Prior Authorizations should transition with the individual** when their LTC services are transferred to an IHA.

13. **DHS's Family Care contract should restore the "any willing provider" focus for IHAs to create as many provider options as possible from which participants can choose.** A larger network of smaller providers that are more deeply connected to the community is equally cost-effective and has better quality outcomes. An emphasis on individualized services leads to deeper connections to local networks of unpaid services. Local choices and many choices lead to better competition and outcomes.

Program Integration

Prevention of over-medicalization of the LTC model

Long term care is not health care. The new system proposes to add three additional complex and broad areas—primary care, acute care, and behavioral health—that are not part of managed long term care in the current system. Survival Coalition in concerned IHAs may disproportionately emphasize the medical elements of the integrated system at the expense of long-term care services. Medicaid managed care in other states has often focused on management of primary and acute care; potential IHAs that operate in other states may not have the experience with management and delivery of long term care services.

Long term care services—residential, community employment, personal care, transportation, etc.—support a person in all aspects of their life. Long-term care—the right amount of support at the right time—is the difference between independence and dependence; between community and isolation; between working and unemployment.

Staying healthy is important, but the long term care system should not privilege or strive to equally balance the four distinct elements that will be a part of the integrated long-term care system. Long term care services are routine parts of people's daily lives and touch them across multiple areas of their life. Primary, acute, and behavioral services focus on one part of the person; adding these services should be done in a manner than enhances and compliments the existing community-based long term care supports.

People who need long-term care supports are not always sick and do not always have major medical needs. Long-term care should continue to be about people living quality lives in the community, including being healthy. Care coordination for a person must ensure their medical, mental health and non-medical long term care support needs are met.

Tennessee's statutes acknowledge that "services delivered in home and community-based settings are not primarily medical in nature, but rather, support services that will provide needed assistance with activities of daily living and that will allow persons to remain in their homes and communities." Wisconsin's long term care system should be based on the same principle.

Recommendations: Prevention of over-medicalization of the LTC model

1. **DHS's Family Care Contract should include an integrated rate setting process that considers each separate LTC system component** (primary, acute, behavioral, LTC services, administrative) **independently, sets a capitated rate for each component, and combines all components as equal contributors to the overall capitated rate.** Costs for each service area should be considered independently from each other, and the eventual capitated rate should include the cumulative costs of all service areas combined. No one service area spending should be at the expense of fully funding the needs of another service area.

Independent readiness assessment, staged transition.

The State must ensure that risk-based, integrated care plans demonstrate that they are equally able to provide the full range of services – primary, acute, behavioral, and LTC services– that is required by the enrolled population before they are permitted to enroll participants. The addition of primary and acute health care and behavioral health services—three diverse and complex elements that are not currently part of the LTC system—makes it likely that few IHA applicants will be equally experienced and talented in operating all four elements included in the new LTC system. Some potential IHAs may have primary/acute care managed care, others may have focused exclusively on the diverse elements of community based long term care. Managed behavioral health services may be new territory for most IHA applicants.

In addition to the Independent assessment of provider networks and demonstration by the IHA that they can meet time and distance and other standards as recommended in the Provider and Network Capacity section, the state should conduct an independent assessment to evaluate readiness to transition from the current to the new long-term care system.

Recommendations: Independent readiness assessment, staged transition

1. **The State should develop a robust plan-readiness review process that includes stakeholder input to determine whether health plans in the capitation model are prepared to provide all contracted services in a safe, efficient, and effective manner.** Plan readiness includes, at a minimum:

a) *Network adequacy (including the ability to pay contracted providers within a reasonable amount of time, and analysis of data elements outlined in Appendix B),*

b) *A proven track record of high performance and/or the ability to provide high quality care coordination services*

c) *The ability to offer participant-directed LTSS including, but not limited to, counseling and financial management services*

d) *Demonstrated financial stability in the plan and adequate protections against insolvency*

e) *The ability to generate required data and reports for governmental entities and public reporting*

f) *Providing budgetary and employment authority for self-directed care*

g) *Adequate capacity to respond to enrollee grievances and appeals*

h) *Health plan provider networks that include a sufficient number of health and LTSS providers in both rural and urban areas that are willing and qualified to serve the unique needs of plan participants*

i) *Plans and providers demonstrating that they offer person- and family-focused care by honoring the individual's preferences and values by supporting the desire of the individual or*

their representative to self-direct, and by recognizing and supporting the family caregiver's willingness and capacity to provide care

j) Ensuring that services are offered in a culturally and linguistically competent manner

k) Having a built-in quality assurance and improvement plan that includes members and community-based relationships or provider relationships, with a preference for local presence

l) Providing prevocational/vocational employment plans and measurement for continued stakeholder and participant involvement in plan design and implementation

m) Demonstrating the capacity to work with the disability community and with youth in transition

2. **Stakeholders and the public should have the opportunity to provide feedback and public comment on the results of the readiness assessment** in a timely manner so that DHS can make adjustments to its transition plan as necessary.

3. When it is determined that the state is ready to transition from the current system to the new system, **IHAs should be rolled out over a multiyear transition plan in defined regional areas, with quality metrics and reporting requirements build in to evaluate the new system and make adjustments as necessary.** Success transition and demonstrable quality outcomes in several regions must be obtained before going statewide.

Behavioral Health

Survival Coalition has consistently identified a lack of access to qualified mental health professionals and key mental health services, lack of recovery oriented care and in some areas of the state, and overreliance on congregate care living arrangements for members with mental illnesses in Family Care as problematic. The lack of effective community based services has contributed to overreliance on crisis and institutional services, including emergency detentions of individuals in Family Care.

More than 50% long term care participants have mental health or substance abuse needs. Many long term care participants have a dual diagnosis of developmental disability and co-occurring mental health needs which may contribute to complex or challenging behaviors. The 2011 Family Care audit found that "better coordination of behavioral health needs could achieve cost-savings in long-term care."

Improving Wisconsin's approach to Behavioral Health Services is necessary, and to do so successfully requires that the new long-term care system must be recovery-based, trauma-informed, culturally appropriate, and empower members to have an authentic decision-making role to have real choices over the services they receive and who delivers those services. Forced mental health treatment is never appropriate, except when there are immediate and serious safety risks. Even then, listening to members and respecting their choices is essential to designing service plans that succeed. For choice to be real, systems must offer a wide array of interventions and supports, and consumers must understand their benefits and risks.

LTC participants with mental illness should live and receive services in the least restrictive setting possible, and community supports should be focused on supporting the individual to live as independently as possible. IHAs must assure that a seamless array of flexible, quality services is available on a voluntary basis that helps members maintain homes, jobs, and family and community ties and encourages members to seek the assistance they need.

Recommendations: Behavioral Health

1. **The Behavioral health services definition should include both mental health and substance use services, and include a continuum of prevention, intervention, treatment, and recovery support services.**

2. **Participants should have access to a full range of substance use disorder treatment services available on a continuum** to include: detoxification services; medically monitored residential; transitional residential; day treatment; outpatient; intensive outpatient; narcotic treatment service programs; continuing care and relapse prevention groups; recovery support services; and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

3. The new long-term care system should **reduce the current overreliance on CBRFs and other congregate settings** for Family Care members with mental illness, and provide support for more independent living.

4. **DHS should establish an MOU with county departments establishing the right for LTC participants to choose county mental health and substance abuse services** including the full range Comprehensive Community Services (CCS), Community Support Program (CSP) services, peer support through certified peer specialists, recovery coaches, and other appropriate services.

5. **DHS should include reimbursement rates and requirements for IHAs to reimburse counties for rendered behavioral health services within the IHA Contract.**

6. **DHS's IHA contract should include requirements to have a designated liaison to coordinate with County human services departments** that administer mental health and substance abuse programs. Some clients could be served by either the county, LTC, or both systems.

7. **DHS's IHA contract must establish IHA/county protocols on** how and when LTC participant involved/centered **Crisis Plans** shall be developed, reviewed, and updated for members with mental health and/or substance abuse needs. IHA/county collaboration protocols on how follow-up supports and services are provided after crisis contacts have occurred should also be included in the contract.

8. **Each IHA must assure access to community based crisis and institutional diversion services, including peer run respite.** Each IHA must have financial responsibility for hospitalization and institutional care to minimize institutional care and ensure engagement in discharge planning when a member is hospitalized or otherwise in a care institution.

9. **The cost for crisis services should be shared by the IHA to ensure there is a strong financial incentive to provide ongoing high quality community supports which will reduce the need for crisis services.**

10. **The responsibility for costs related to emergency detentions should be shared by IHAs and counties** to guard against potential incentives for shifting costs and care of clients to counties.

11. **Crisis services must be developed to meet the needs of key groups served by long term care including individuals with Alzheimer's or other dementias, as well as individuals with members with a developmental disability and complex needs.**

12. **DHS must ensure care planning for all FC-eligible persons residing in nursing facilities and other institutions, including IMDs.** Unless rejected by the institutionalized person, this must include at least semi-annual needs assessment, enrollment for non-enrolled persons and discharge planning.

13. **DHS should work with ADRCs, IHAs and advocates to a strategy and action plan to prioritize community relocations[20] for people with mental illnesses residing in institutions**

20 Madison's Community TIES program provides behavioral supports to people with developmental disabilities who live in the community. They tracked a number of their participants and found significant cost savings in the form of far fewer days in institutional settings, which were

who are eligible for Family Care. The facility closing process should continue to require protection of the state convened closing team to ensure that the rights and choices of residents are protected.

14. **DHS's contract should require IHAs to work with counties to ensure capacity for comprehensive *community* crisis response, including mobile crisis teams.** This should also include access to a Community Consultation Team[21]. with expertise in crisis intervention, as well as development of effective individualized crisis response plans.

15. **DHS's contract should require IHAs to partner with experts in serving for serving people with developmental disabilities who also have mental health and/or behavioral needs** such as Wisconsin's Waisman Center for Excellence in Developmental Disabilities and community consultation teams

16. Metrics for IHAs (see Quality Outcomes and Measurement Section) should **provide incentives to invest in strong community services and Community Consultation Teams**[22] and limit the use of institutional placements in state centers or IMDs.

17. **DHS should establish policies to ensure that LTC participants who have experienced a crisis and out of home placement does not lose their home as a result.**

18. **The long term care functional screening tool used by ADRCs must be updated to reflect the inclusion of behavioral health services**, and to ensure that mental health and substance abuse needs are accurately identified, evaluated, and an appropriate recovery plan of services and supports can be developed.

19. The **Functional Screen should include specifics regarding challenging behaviors**, and this data should be used to determine the capitated rate for higher needs people.

20. **ADRC screeners, IHA staff, Family Care members, care teams, and direct care staff must be trained** on the full range of mental health, alcoholism and addiction needs and services, including recovery values, trauma–informed care, strength based services, cultural intelligence, and peer-to-peer services, motivational interviewing, and how people's lived experience is important to recovery.

---

roughly twice the cost of supporting even people with very complex behavioral needs in the community. This model could be a promising resource for IHAs to consider.

21 Development of community consultation teams can be a resource to IHAs as well frontline staff to provide ongoing support to members to support a successful community placement. The team can provide assistance with crisis intervention and stabilization. Milwaukee County has developed such a team as a resource to help support residents with complex needs who have relocated from an institution to the community.

[22] The community consultation experts can be a resource for development of behavioral support plans as well as development of environmental accommodations to living spaces that assure safety and promotes continued participation in community life. Community consultation can also provide care teams with regular and real-time access to mental health professionals so they can respond appropriately and adequately respond to the mental health and behavioral needs of LTC participants.

21. **A professional with expertise in mental health and substance use must be part of the evaluation process** to ensure mental and behavior health needs are identified and recognized.

22. **DHS's contract should require IHAs to develop adequate networks of behavioral health providers, throughout the state, as a prerequisite to offering services**[23].

23. **LTC participants** that have a psychiatrist, therapist or other behavioral health service provider with whom they have a long-standing relationship **should be able to keep their current providers.** This relationship is often the essential to good outcomes for the client and to supporting recovery.

24. **Decisions regarding medical necessity for mental health and substance use services should be guided by client choice**, and by the recommendation of the mental health professional and/or substance use professional on the members' team.

25. **Primary and acute health care providers must be trained to be responsive to health care concerns voiced by LTC participants with a mental health diagnosis**[24].

26. **IHAs should be required to have mental health professionals that meet regularly with care teams, and are available to offer consultation.** Their role should be to support the needs of members who are experiencing mental health or substance abuse needs.

27. If the LTC participant agrees, **there should be the option to include a mental health professional (as defined in HFS 36.03 (16)) on the team assigned to a member who has been diagnosed with a major mental illness** who need specialized services due to their mental illness.

28. If the LTC participant agrees, **there should be the option to include their Peer Specialist or Recovery Coach as a member of the interdisciplinary team.**

29. **DHS's contract should include a structure to ensure IHAs have substantive engagement with behavioral health consumers, providers, advocates, county human service staff**, and such representation should be required on IHAs governing boards (see Ongoing Participant and Advocate Engagement Section).

30. **Stakeholders should have the opportunity to review current contracts with MCOs** to identify provisions that would be desirable in the redesigned system, especially those related to client rights and safety and collaboration with county agencies.

---

23 Access to mental health and substance abuse providers, especially prescribers, can be very difficult for individuals covered by Medicaid as many providers do not accept Medicaid, and there are significant work force shortages; for example, some counties have no psychiatrists. Developing network capacity and expertise in behavioral supports for LTC participants with dementia is a critical component of overall network needs.

[24] Many people with a mental health diagnosis have experienced disability related discrimination from health care providers who may be dismissive of their health care concerns and inappropriately ascribe these physical concerns to mental illness or addiction.

Quality Outcomes and Measurements

It is critical that the foundation of the new system be rooted in measurable outcomes that go beyond medical measures, and that strong accountability mechanisms are built into the system as well as incentives to reward outstanding performance. Performance based payments or penalties should be used to hold health plans and providers accountable.

Requirement to collect and report specific data will give the state an accurate picture of the effectiveness of its investment of public dollars in improving employability, independence, and reducing overall reliance on public benefit programs and services. Measurable outcomes that go beyond medical measurements must include data elements that inform the state about the quality of LTC participant's lives. Where are participants working and how much do they work? Can they get where they need to go? Are people's choices honored? Do they feel safe?

Community integrated employment efforts and measurable outcomes both need to be tied to performance incentives that are spelled out in all managed care contracts. Tying expectations and outcomes to specific contract language is critical (See Appendix A and B).

Recommendations: Quality Outcomes and Measurements

1. **DHS's Family Care contract should require data collection and reporting of key non-clinical quality of life indicators and participant experiences**[25]

2. **DHS's Family Care contract should require data collection and reporting of key clinical indicators.**[26]

3. **DHS's Family Care contract should require data collection and reporting of metrics that can be derived from claims data**—such as nursing home and other institution transition rates, integrated employment outcomes (See Appendix A), the number of people in self-directed services etc.

4. **DHS's Family Care contract should require** measures of timely and geographically accessible access to care (See Appendix B).

5. **DHS's Family Care contract should require specific data collection and reporting of metrics by mental health status** on

[25] Non-clinical quality of life indicators must be included, using recognized sources like National Core Indicators, Council on Quality and Leadership indicators, and Program Operations Manual System measurements. CMS expects states to measure the quality of programs as it relates to providing supports that ensure quality of life for participants. CMS Guidance to States bulletin on long-term care: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf): http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

[26] The Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) provides a vast array of from which to select clinical quality measures. These measures are stewarded by organizations who have rigorously tested the measures. Specific consideration and priority should be given to those measures that are relevant to the long term care population. (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf)

a) *Key health indicators (diabetes control, obesity, cardiovascular disease) by mental health status (e.g., those with/without identified MH needs). Address discrepancies in outcomes.*

b) *Use of emergency services/inpatient hospitalization for psychiatric conditions*

c) *Comparison of congregate living between those with and without mental health disorders. Address disparities.*

d) *Report on suicides among LTC participants with mental health diagnosis.*

6. **DHS's Family Care contract should require quarterly submission of all data elements from each IHA.**

7. **A publically accessible web based data dashboard should be available so that LTC participants can transparently compare** quality of life outcomes. Data should be able to be disaggregated by IHA, Region and, where appropriate, provider; aggregate, annual, and quarterly data reports should be available.

Recommendations: Administrative & general contract provisions

In addition to the specific Contract requirement recommendations contained in all sections, Appendix A, and Appendix B, Survival Coalition recommends the following elements be included in DHS's Family Care contract:

1. **DHS's Family Care contract should include caps on administrative costs and profits**; the current limits should remain (5% admin, 2% profit). **Alternatively, DHS could establish a minimum requirement that 93% of Medicaid dollars received must be spent on services**, thereby incentivizing reduction of administrative costs as a mechanism to boost profits.

2. **DHS's Family Care Contract should include a process and a mitigation plan to maintain LTC participant's access to services in the event an IHA ceases to be a contracting entity with DHS**.

3. **DHS's Family Care contract should include provisions that require an IHA exiting their LTC contract for a region(s) to remain in operation until a contract with a replacement IHA that has demonstrated its capacity to serve the region is in place** and members have transitioned to a new IHA.

4. **Penalty provisions should be included in DHS's Family Care contract such that the departing IHA does not incur the profits** allowable under the contract, the **admin costs are reimbursed to the state**, and the **state collects a penalty to offset DHS administrative costs** associated with evaluating and contracting with a new IHA and LTC participant transition costs.

5. **DHS's Family Care contract should include provisions that prohibit IHAs that leave** within a contract **period from applying for additional Family Care contracts** for at least two contract cycles.

6. **DHS's Family Care contract cycle should be at least three years.**

7. **DHS's Family Care contract should allow LTC participants to open enroll into an IHA at any time** (like the current system) to quality service innovations and improvements and competition among IHAs.

8. **DHS's Family Care contract should include "Pay for Performance billing strategies" to incentivize quality outcomes and provide accountability**

    a) *See NEMT pay for performance recommendation in Transportation section*

    b) *See Appendix B for Time, Distance, and Timely Access requirements. These metrics could provide data to drive Pay for Performance formulas on different aspects of primary, acute, behavioral, and LTC service delivery.*

c) *Community integrated employment (CIE): Earn annual performance based payment if, among working-age members (16-60) not engaged in CIE, the number with a goal in their Plan of Care/ISP to obtain CIE for at least 15 hours a week increases by 5% or more.*

d) *Community integrated employment (CIE): Earn annual performance based payment if percentage of working-age members (16-60) engaged in at least 15 hours/week of CIE increases by 5% or more.*

e) *Community integrated employment (CIE): Earn annual performance based payment if at least 5% of members in CIE (at beginning of year) advanced in career during the year (defined as achieving increased hours; additional part-time job; promotion with higher pay)*

9. **DHS's Family Care contract should include penalties in billing structure to incentivize quality outcomes and provide accountability**. DHS should reserve the right to reduce or stop Medicaid payments or rescind Medicaid payments for administrative costs for services that fail to arrive, arrive late, results in missed appointments or late arrival at employment, provide training where the individual does not progress towards the outcome of the training within a reasonable period of time, etc.

10. **DHS's Family Care contract should reserve the right for the Department to withhold 5% of allotted payments** if IHAs do not meet performance measures.

11. DHS's Family Care contract should establish a **standardized billing and processes** consistent across IHAs

12. DHS's Family Care contract should establish a **transparent and standardized rate setting process** (see also Prevention of Over Medicalization section recommendation)

Participant protections and rights

Wisconsin's new long-term care system must be rooted in values that recognize people with disabilities and older adults have the same values and rights as able-bodied people. Living, working, learning, and socializing in the community are fundamental rights, and are directly correlated to better health outcomes and higher quality of life measures.

Long-term care services impact the most intimate aspects of people's lives. When the system and individuals within the system works well, people live full lives in the communities. When it doesn't, they suffer in isolation, and may become victims of abuse and/or neglect.

Recommendations: Participant protections and rights

1. **The Family Care waiver and Contract should specifically ensure all individuals, including high-cost individuals, have the right to live in the community, and that services are delivered in the least restrictive setting possible.**

    a) *Cost must not be a reason to deny a person access to care and treatment in the least restrictive environment and most integrated setting*

    b) *The current acuity based rate-setting methodology should be preserved*

    c) *Pay for performance initiatives should be included within DHS's Family Care contract to encourage and facilitate people accessing the least restrictive environment*

    d) *IHAs should be paid the actual cost of caring for people leaving institutions during the period before their costs will be factored into the capitated rate calculation.*

2. **IHA contracts must include all patient, resident, recipient, and ward rights in Wis. Stats. Chapters 50, 51, and 54 and Wis. Admin. Code Chapters** DHS 10 (Family Care), 36 (CCS), 63 (CSP), 82 (1-2 bed AFH), 83 (CBRF), 88 (3-4 bed AFH), 89 (RCAC), 94 (Client Rights), 104 (Medicaid), 131 (hospice), 132 (SNF), 133 (HHA) and 134(FDD).

3. **At a minimum, grievance and appeal mechanisms must comply with all relevant Federal regulatory requirements, and maintain the notice and appeal rights** in DHS 10.51, 10.52, 10.55, and 10.56. **IHAs should also be required to cooperate with advocates as is required under DHS 10.57**.

4. **DHS' Family Care contract should continue benefits during the appeals process**, as long as appeal is submitted prior to the effective date of termination of services even if services were authorized for a specified period of time

5. **The DHS Family Care Contract should require the first step of any appeal or grievance process to be conducted outside of the IHA**.

6. **There should only be one appeal process and it should incorporate the DHS the most consumer-friendly elements of the Medicare and Medicaid appeal systems for all dual eligible and create a hybrid system.**

7. **The DHS Family Care Contract should require prominent, adequate notice** in accessible consumer-friendly format **of all appeal rights and how they can be accessed**. These should be provided at enrollment, periodically thereafter on a routine schedule, and whenever an action occurs that affects eligibility or services.

8. In order to maintain continuity of care, **participants must be permitted to continue to use the providers in their Family Care plans** for an 18 month transition period regardless of whether a current provider is in the participant's IHA's network.

9. **Medicare beneficiaries must not be required to surrender their Medicare benefits as a condition of receiving LTC services and supports; there must be no auto-enrollment of Medicare beneficiaries into IHAs**; IHAs should be required to offer two plans (one which incorporates a person's Medicare benefits and one that does not—this supports the person's right to self-direct their acute and primary care services); those plans would have different capitated rates

10. **An independent Ombudsman must be in place, and the Ombudsman must have the ability to advocate for all LTC, behavioral health, acute and primary health care aspects of the Family Care program**.

11. **The Ombudsman must continue to have the right to represent consumers at state fair hearings**. The attorney component must be retained and attorney authority expanded to allow attorney to petition circuit court under Ch. 227 for review of negative fair hearing decisions.

12. **DHS's Family Care waiver should mandate a ratio of 1 Ombudsman per 2500 Family Care enrollees.**

13. **The DHS Family Care program should continue the current system of having one Ombudsman program for people under age 60 and one for people 60 and over.** The Family Care program should ensure Ombudsman services are available to people who are over age 60 that are choosing self-directed services.

14. **Options and enrollment counseling must be conducted by an independent, conflict-free entity.**

15. **IHAs must be subject to the same marketing restrictions that currently apply to MCOs-meaning there can be no direct marketing to individuals**

Ongoing participant and advocate engagement

The National Council on Disability (NCD) has the following guidance to states implementing Medicaid Managed care regarding stakeholder involvement:

> *"States must ensure that key disability stakeholders—including people with disabilities, family members, support agency representatives, and advocates—are fully engaged in designing, implementing, and monitoring the outcomes and effectiveness of Medicaid managed care services and service delivery systems.*
>
> *Active, open, and continuous dialogue with all affected parties offers the best prospects for creating and maintaining a service delivery system that meets the needs of people with disabilities. All participants must be confident that the transition to a managed care system will yield better outcomes for people with disabilities."*

Survival Coalition reiterates the importance of meaningful participation and inclusion of the disability advocate community and long term care participants in the development of a new integrated system, continued involvement throughout transition and full implementation of the new integrated primary/acute and long term care model, and a permanent role in evaluating and evolving the new system.

The new integrated care model will include many elements that are not part of the current LTC system. Each IHA will benefit from having a governing board that includes participant, advocate, and stakeholder representation. Likewise, a state level committee that includes participant, advocate, and stakeholder representation to advise DHS on the entire system will be necessary.

Recommendations: Ongoing Participant and advocate engagement

1. Consistent with current requirements**, DHS's Family Care contract should require each IHA to have a governing board** that is at least one-fourth comprised of older adults, people with physical disabilities, people with behavioral health needs, people with intellectual/developmental disabilities, family members, or other advocates[27].

2. **DHS should establish a state level Family Care committee** with representation from advocates, LTC participants and family members, and Family Care providers to provide a forum for continuous improvement of the integrated Family Care system[28].

[27] The forthcoming CMS rule on Medicaid managed care will require MCOs to have an advisory board, and will add a new standard to requiring each MCO, PIHP and PAHP to solicit input from consumers. The proposed rule would require MCOs to maintain a member advisory committee, which must include "at least reasonably representative sample of the LTSS populations covered under the contract with the MCO, PIHP and PAHP."

[28] Survival Coalition recommends the membership composition of the state level Family Care committee be as follows: a representative from the state-designated Protection and Advocacy agency; a representative from the state Developmental Disability Board; a representative from the Independent Living Centers; a representative from the Aging Advocacy community; a representative of Aging and Disability Resource Centers; a representative of behavioral and mental health advocates; a representative of County Human Service agencies; a representative for direct care service workers; a representative for workforce incentive benefit counselors and competitive integrated employment; two IHA representatives, with at least one serving a rural or underserved population region; three representatives—family member or self-advocate—currently participating in self-direction option; three representatives—caregiver or self-advocate—current participating in the Family Care program; a long term care participant with a mental health diagnosis; a representative of Children's Services. LTC participants should be representative of older adults, people with physical disabilities, and people with developmental disabilities.

3. **DHS should develop required information and communication strategies to conduct outreach to participants**. A pro-active communications strategy is essential to minimize LTC participant confusion and misinformation, and maintain transparent communications about Family Care changes and the transition process. LTC participants may be non-readers, non-verbal, use adaptive or responsive technology (including touchpads), have large print needs, may not have access to the internet, etc. DHS and IHA communications strategies should be able to be implemented across responsive technologies and multiple communications mediums. Clear communication strategies that can be understood by all LTC participants are important.

Local communities, local relationships

Provision of services on a regional basis

Wisconsin's national leadership and success in managed long term care has been based on local relationships. Managed Care Organizations (MCOs) rooted in the communities they serve, local businesses providing services to local people, and independent Aging and Disability Resource Centers (ADRCs) that have personal relationships with LTC participants work together to problem-solve and provide the right supports at the right time. Likewise, IRIS and Family Care participants can select people they know and trust to work for them. A regional approach allows for quick turn-around responses, encourages and supports innovation including how local nonpaid community resources can be leveraged to provide additional supports, and improves accountability because people know each other.

Recommendations: Provision of services on a regional basis

1. **DHS's Family Care Contract should establish no less than seven regions**, the boundaries of which are established on the basis of geography, differing culture/perspectives, provider network primary/acute/behavioral/LTC adequacy and distribution, time and distance standards evaluating access to all services, and population density and numbers served. Region boundaries should not be established solely by population or by arbitrarily defined equally-sized districts.

2. **Additional factors that determine region boundaries should include** reduction of the number of transitions necessary for members (i.e. changes in IHAs, providers, etc.), leveraging local knowledge of resources, connections to communities, and informal supports.

3. **DHS's Family Care contract should include criteria to identify and designate a region as serving rural or underserved populations**.

4. **DHS's Family Care contract should require IHAs to serve the entirety of the regions they contract within**, not just select zip codes or areas of population density.

5. **DHS's Family Care contract and waiver should establish specific minimum standards and measures of travel time and distance** to determine whether the provider networks of their contracted plans are adequate (See Appendix B).

6. **DHS's contract should require IHAs to demonstrate they can meet geographic access, provider-patient ratios, and timely access to care for all services offered and have a robust provider network that can provide participants with multiple service choices before DHS can award a contract to provide services for a region.** This litmus test should be a requirement for each region the IHA applies to serve; IHAs applying to operate in more than one or all regions must pass this evaluation in each region before being awarded a contract to operate or expand into another region.

7. **DHS's Family Care contract should require IHAs applying to operate in more than two regions to operate in at least one region designated as serving rural or underserved populations such that a 2:1 ratio is maintained.**

8. **DHS's Family Care contract should include rate incentives for IHAs to serve rural and underserved regions**, and the ranking system developed to award contracts should give IHAs planning to focus solely on rural or underserved regions bonus points in the application process.

9. **DHS's Family Care contract should award at least three contracts to IHAs in each region**, and should include provisions to ensure that there is no period of time when LTC participants may not have a choice of IHAs.

10. **DHS's Family Care contract should continue the ability to provide community based services that are not itemized as reimbursable on the state plan/waiver**, but are flexible, no more costly, and offer innovative approaches to meet better outcomes on an individual basis ("in lieu of services" clause).

ADRC's role in fiscal sustainability of the LTC system

The work of local ADRCs supports people in maximizing the use of personal and community resources by helping people understand all of the various community long term care supports and services available to them and assisting them to evaluate these options in order to make informed decisions regarding which services and supports best meet their needs. By providing this options counseling service and assisting people in accessing needed services, including prevention and early-intervention services, ADRCs help to prevent or delay their need for publicly funded long-term care programs.

ADRC's ability to determine what individuals needs are, and their ability to provide folks with more affordable community based options to meet those needs, can prevent/reduce the number of people in publically funded programs reducing LTC costs overall). ADRCs can act as a mechanism for moving people from most expensive to less expensive alternatives within LTC, resulting in a delay in accessing or avoidance of publically funded LTC entirely.

Recommendations: ADRC's role in fiscal sustainability of the LTC system

1. **DHS should continue to contract with ADRCs to administer the LTC functional screen, conduct options counseling, benefits counseling, caregiver services, prevention of nursing home admissions, facilitating nursing home relocations back into the community, transition services for students and youth, and short-term service coordination.**

2. **DHS's ADRC contract should include and provide funding for a greater role for ADRCs reevaluating people currently in LTC and moving people from nursing homes into the community.**

3. **DHS' should include prevention/health promotion activities (and funding) in the ADRC contracts**– since preventing and delaying folks from needing LTC is a way to address MA budget concerns much further up stream (medication management, falls prevention, chronic disease management, etc.).

Self-Direction under managed care

Currently, all LTC-eligible people in Wisconsin have the right to elect a fully or partially self-direct supports option. The extent of a person's disability or his/her level of care needs should not dictate whether a person is deemed capable of SD. Every person has the right to be empowered, to realize their human potential, and be treated with dignity. SD also creates an excellent opportunity for true person-centered planning. CMS policy places no limits on who can elect and benefit from SD.

Self-direction is also a strategy to spend less per capita. SD is recommended by CMS; it is a cost effective way for people to achieve their chosen LTC outcomes; and it enhances quality. Individual budgets must be set fairly and objectively before the person-centered planning process begins, and must be based on the individual's long term care needs and desired outcomes.

The concept of SD is inherently cost effective, as evidenced by the fact that IRIS participants give back 17% of their individual budget allocations. But some cost effectiveness strategies used in managed care, e.g. across-the-board provider rate cuts, can undermine SD and the cost effectiveness potential of SD. Allowing the person maximum control over his/her individual plan creates the best opportunity for the person to incorporate natural supports into the plan (which increases cost effectiveness).

Recommendations: Self-Direction under managed care

1. **DHS's Family Care contract should include a definition of Self Direction** as: 1) The most control possible over the best possible life. 2) You have decision-making authority over your funding and services, and you take direct responsibility to manage your long term care (LTC) services (with the assistance of a set of available supports) in order to meet your functional, vocational and social needs.

2. **Anyone eligible for the program should have the opportunity to self-direct their any and all services and supports**.

3. **IHAs should encourage support for alternatives to guardianship such as supported decision making**, to ensure that members maintain autonomy and choice in making decisions about their lives and care plan.

4. **IHAs should provide support for independent living services that encourage independence such as money management and budgeting, and limit use of rep payees to where this level of oversight is clearly justified.**

5. **The model must have full budget and hiring authority[29].** LTC participants should have the ability to spend their budgets as they see fit and hire the people they want to provide supports. Should also include a robust budget amendment process.

[29] Budget authority" = decision-making authority over how the Medicaid funding in your individual budget is spent. "Employer authority" = decision-making authority re who provides your services and how the services are provided. You get to recruit, hire, train, supervise, and fire the people who provide your services, including parents, spouses, and relatives.

6. **1915j Self Directed Personal Assistance Services (PAS) must be available to everyone who elects the SD option.** Participants must be able to select any agency/person to provide services, provided the person passes a background check.

7. **Self-Direction must assure payments to family members who provide supports**.

8. **All LTC-eligible people in Wisconsin must be objectively informed and educated about self-direction as an option by an entity that is not an IHA**—such as an ADRC.

9. **The waiver must include safeguards inside IHAs to ensure that managed care is not promoted above self-direction**, and that people can make a truly informed choice between managed care and SD.

10. **The self-direction option must allow participants to set their own goals.** People who set their own goals, create their own plan, and define "what's possible" for themselves are more likely to take responsibility to achieve their goals and make their plan work. SD includes a person-centered planning process.

11. **The budget-setting methodology must address the person's physical caregiving needs, supervision/support needs related to behavioral challenges, emotional needs, and need for community integration** (this will require an improvement over the current functional screen).

12. **Individual budgets must be based on the <u>actual</u> cost of services** (not artificially deflated rates).

13. **Individual budgets should not penalize people for having built a good natural support system**. The Family Care waiver should encourage, support, and remove barriers to natural supports.

14. **SD consultants and a financial services agency must be available to everyone who elects SD.** Managing the delivery of services includes fulfilling the responsibility of being an employer and complying with all the rules in the waiver. People's circumstances change and people can experience crises—support to adjust a person's plan is crucial at those times.

15. **Minimize the level of bureaucracy and red tape associated with self-direction to avoid unnecessary costs resulting from professional involvements that are not needed**.

16. **Waive the requirement to consult with and/or seek approval of the interdisciplinary team for people who elect SD**.

17. **The Waiver must ensure that people only receive services they want and need (not services someone else thinks they need).**

18. **Integrated employment should be a priority** within self-directed services.

19. **The DHS Family Care Contract should include a data collection and reporting requirement on the number of people self-directing all services, and the number of people self-directing some services with the ability to delineate which service types are being self-directed.**

Appendix A: Quality metrics for community integrated employment

Survival Coalition recommends collection and reporting of the following data elements be required as part of the Family Care contract. Consistent with other recommendations, collected data should be posted on a publically accessible website so that LTC participants can assess individual provider choices and overall IHA performance.

1. Number/percentage of working-age members (16-60) with disabilities working in Competitive Integrated Employment (CIE) at least 15 hours per week

2. Among working-age members (16-60) not engaged in CIE, the number/percentage with a goal in their Plan of Care/ISP to obtain CIE for at least 15 hours a week

3. Among working-age members (16-60) not engaged in CIE, the number/percentage receiving services to obtain CIE of at least 15 hours a week through the MCO or another recognized funding source

4. For those members working in CIE:

e) Average gross wages adjusted for length of time on job

f) Number/percentage with some level of health care coverage through employer

g) Number/percentage with paid time off

h) Number/percentage who advanced in career during prior year (defined as achieving increased hours; additional part-time job; promotion with higher pay)

5. Average overall Medicaid spending on individuals receiving competitive integrated employment services and/or participating in CIE as compared to those not receiving CIE services and/or not participating in CIE

6. Average overall Medicaid spending for individuals working in CIE as compared to average annual spending in two years prior to entering CIE and two years prior to starting services to obtain CIE

Appendix B: Time and Distance & Network Adequacy Standards

Survival Coalition recommends DHS the following time and distance and network adequacy standards are included in the Family Care waiver and contract. Consistent with previous recommendations, these network standards should only be considered met if the individual provider has met the quality criteria necessary for an IHA to demonstrate they provide quality community based supports to be included in the provider network.

1. **Provider-specific network adequacy-standards.** IHAs should be required by contract to meet or exceed the following:

    a) *Primary care and acute care, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural..*

b) *Women's health care services, which may be provided by OB/GYNs, Family Practitioners, Nurse Midwives, Nurse Practitioners, Physician Assistants, and other providers, are available within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees.*

c) *Behavioral health services, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural..*

d) *Specialist, is available within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees.*

e) *Hospital, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural.*

f) *Pharmacy, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees.*

g) *Birth center, is available within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees.*

h) *Dental, including dental sealants and fluoride varnish for enrollees under age 21, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural..*

i) *Indian Health Care Providers, as defined in § 438.14(a), are available within 60 minutes or 30 miles of the residences or workplaces of 90% of Indian enrollees, as defined in § 438.14(a).*

j) *Community Integrated employment services is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees.*

k) Transportation, NEMT and LTC transportation, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural.

l) Personal Care and Home Health nurse services, is available within 30 minutes or 15 miles of the residences or workplaces of 90% of enrollees, or within 60 minutes or 30 miles of the residences or workplaces of 90% of enrollees in a region designated by the DHS as rural.

m) Additional provider types when it promotes the objectives of the Family Care program, as determined by DHS.

n) DHS may establish network adequacy standards other than time or distance standards for LTC service provider types that travel to the enrollee to deliver services.

2. **Whenever medically necessary care is not available within the state's standard for travel time or distance**, the IHA shall arrange for the enrollee to receive medically necessary care by:

    a) Arranging for the enrollee to see an out-of-network provider;

    b) Providing transportation, including the costs of food, lodging, and attended, when necessary, to a contracted provider to whom travel exceeds the standard;

    c) Arranging for a provider to travel to the enrollee or a designated location that is within the state's standard for travel time and distance; or

    d) Where medically appropriate, arranging for telemedicine

3. **Timely access.** Require IHAs to meet and require its network providers to meet the following standards for timely access to care and services, taking into account the urgency of the need for services:

    a) Urgent care appointments for medical or dental services shall be available within 48 hours of the request for appointment, except as provided in (f);

b) Non-urgent appointments for primary and specialty care shall be available within 15 business days of the request for appointment, except as provided in (f) and (g);

c) Non-urgent appointments with a non-physician mental health care provider shall be available within 10 business days of the request for appointment, except as provided in (f) and (g);

d) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within 15 business days of the request for appointment, except as provided in (f) and (g);

e) Non-urgent dental appointments shall be offered within 30 business days of the request for appointment, except as provided in (f);

f) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

g) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly.

h) Each IHA shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone.

i) Each IHA shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

j) A IHA may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services; telephone medical advice services; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

k) For routine, preventive, and non-urgent appointments, the in-office waiting time for waiting time in the provider's office from the time of a scheduled appointment shall not exceed 30 minutes in length; if the wait time must be prolonged do to exigent circumstances, the provider's office staff shall provide the enrollee with an explanation for the delay and make an offer to reschedule the appointment;

l) The state shall require that for each IHA, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative who is knowledgeable about and competent to respond to an enrollee's questions and concerns shall not exceed ten minutes.

4. **Development of network adequacy standards.** Network adequacy standards should consider, at a minimum, the following elements:

a) The anticipated Family Care enrollment.

b) The expected utilization of primary, acute, behavioral, and LTC services.

c) The characteristics and health care needs and the characteristics and long-term care needs of specific Medicaid populations covered in the Family Care contract.

d) *The numbers and types (in terms of training, experience, and specialization) of network health care professionals, behavioral health service professionals, and Long-term care service professional (including residential, community integrated employment, personal care and home health care, and transportation workers) required to furnish the contracted Medicaid services.* ***At a minimum, the State shall ensure that each IHA contracts with one adult primary care provider for each 1200 adult enrollees.***

e) The numbers of network health care professionals who are not accepting new Medicaid patients.

f) *The geographic location of health care professionals behavioral health service professionals, and Long-term care service professional (including residential, community integrated employment, personal care and home health care, and transportation workers) and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees.* ***If the majority of Medicaid enrollees in the service area of an IHA use public transportation, the travel times and distances must be calculated based on public transportation schedules and routes. Similarly, if roads are frequently closed in the region due to weather, the travel times and distances must account for potential road closures.***