The Stakeholders' Blueprint

for Long Term Care Redesign

The Wisconsin Long-Term Care Coalition believes that through collaboration it is possible to redesign Wisconsin's publicly-funded long term care system to satisfy both the aspirations of the Legislature and executive branch expressed in the 2015-2017 state budget, and those of the people who use the long term care system and their families. We are putting forward a Stakeholders' Blueprint for Long Term Care Redesign that fits within the decisions made by the Legislature to change the long term care system and capitalizes on the changes that have the potential to improve the long term care system.

Wisconsin Long-Term Care Coalition

To find an electronic version of this document, visit:
www.wilongtermcarecoalition.org/stakeholders-blueprint

February 2016

Introduction

There are many people and organizations that have a stake in ensuring that Wisconsin's publicly-funded long term care (LTC) system works well for the people who rely on it. These stakeholders include more than 60,000 people who are currently enrolled in Family Care, IRIS, Partnership, or other long term care programs and rely on the services these organizations provide to help them get out of bed, use the toilet, get a job, go to work, and otherwise assist them so that they can live successfully in the community. It also includes several hundred thousand family members of program participants; long term care workers who have longstanding relationships with these people; the provider agencies who employ these workers; managed care organizations that coordinate and contract for services; Aging and Disability Resource Centers (ADRCs); and the aging and disability advocacy agencies that represent consumers of long term care services.

The Stakeholders' Blueprint for Long Term Care Redesign was developed by the Wisconsin Long-Term Care Coalition, which includes representatives of all the stakeholders listed above as well as organizations with strong connections to the people who receive long term care services. It addresses all the major questions identified by the Wisconsin Department of Health Services (DHS) in its September and October 2015 hearings and additional important questions posed by the Long-Term Care Coalition.

We appreciated the opportunity to submit verbal and written testimony at the DHS hearings and during the comment period that ended October 30, 2015. But in keeping with the legislature's charge in Act 55 to consult with stakeholders, we see the hearings as only the beginning of the stakeholder input process. After the public comment period ended, we reviewed the major themes that were raised at these hearings and incorporated them into this single coherent Blueprint. The themes are reflected in the Key Elements in this Blueprint. We hope that the ideas in the Stakeholders' Blueprint will be considered by DHS and the Legislature in the next stage of the long term care redesign process.

The Purpose of Wisconsin's Long Term Care System

A sustainable long term care system is essential to meeting the needs of the large and growing number of Wisconsin's citizens, both people with disabilities and older adults, who need long term care. Cost-effective and quality care should serve as the cornerstone of the long term care system. To continue to receive high consumer satisfaction ratings and maintain its high national ranking, Wisconsin's long term care system must:

- Identify and build upon the personal strengths of every person receiving long term care services;
- Partner with participants to empower them to fulfill their employment and other potential, become as independent as possible, and meet their individual goals;
- Preserve the abilities and independence of every person, and prevent or delay further progression of disease or disability;
- Continue to promote the guiding principles of the original Family Care program: choice, access, quality, and cost-effectiveness;
- Create a sense of shared ownership and responsibility between the long term care system and long term care participants to jointly promote cost-effectiveness and service quality; and
- Support aging in place so that people can remain in their own homes and stay connected to their neighborhoods and communities.

Core Values of the Quality Long Term Care System Envisioned by the Stakeholders

1. Build on what is already working in Wisconsin's long term care system, which includes a regional structure that allows for adaptation to the unique features of each region; Wisconsin-based managed care organizations (MCOs) with proven records of successfully supporting people in the community; a variety of high-quality provider agencies; a robust self-directed services program; and nationally-recognized local Aging and Disability Resource Centers (ADRCs).

2. Make stakeholders equal partners in decision-making at all levels of the system, and in ensuring the long term sustainability of the system.

3. Implement major changes in the long term care system using a thoughtful, staged process that allows enough time to pilot the new model in some parts of the state, evaluate and refine it, and then systematically expand.

4. Prioritize community living and employment; create multiple mechanisms to prevent and reduce institutional care; and take the necessary measures to accommodate participants with complex health and/or behavioral health needs.

5. Use a variety of strategies to prevent, delay, and reduce the need for long term care services.

6. Ensure that the person drives the process, and that each individual care plan reflects the person's goals.

7. Incentivize innovation.

8. The focus of the long term care system should be on the needs of the whole person with coordination of care across the continuum to ensure that medical, behavioral, and non-medical long term care support needs are met.

9. Protect and empower consumers with unbiased, consumer-friendly information; strong rights protections; and an independent ombudsman system.

10. Ensure full access to services regardless of where people live.

11. Put people before profits — improving people's quality of life should take precedence over maximizing profits.

Key Elements of the Stakeholders Blueprint for Long Term Care Redesign

1. Build on Our Strengths
2. Base Quality on Clear Values
3. Preserve the Effectiveness of ADRCs and a Strong Prevention Focus
4. Enable Real Self-Direction
5. Make the Integrated Model Person-Centered
6. Do Behavioral Health Right
7. Make Cultural Competence a Priority
8. Safeguard People's Rights
9. Use an Innovative Approach to Fiscal Sustainability
10. Provide Adequate Funding to Do Long Term Care Right
11. Raise the Bar with Readiness Standards
12. Phase in Gradually
13. Sustain an Ongoing Dialogue

1. Build On Our Strengths

Instead of "building a new long term care system," which implies starting from scratch, improve on Wisconsin's current nationally-recognized long term care system by capitalizing on and retaining the strengths of our existing system.

Wisconsin's current long term care system was built on the principles of choice, access, quality and cost-effectiveness. By all accounts, Family Care and IRIS are meeting these goals. Over the last two decades, Family Care and IRIS have ended waiting lists for services, given participants a choice of where and how they live, achieved consumer satisfaction rates of over 90%, and spent 95% of tax dollars received on participant services.

In both the PowerPoint for the listening sessions and in the report for the Joint Finance Committee in December 2015, DHS assured stakeholders that they can expect the following from the redesigned long term care system:

- No changes in eligibility
- The current range of benefits is unchanged
- Participants will maintain the right to live independently, with dignity and respect
- Personal choice, self-determination, and person-centered care
- Provider choice in communities where the participants live
- The ability to self-direct all current IRIS services
- Focus on natural supports and connections to family, friends, and community
- Person-centered plans developed in the most cost-effective manner possible
- Appeal and grievance rights
- Ombudsman services for all program participants
- The right to receive independent and unbiased enrollment counseling

The Wisconsin Long-Term Care Coalition is encouraged by the Department's commitment to maintaining these elements in the redesigned long term care system. We believe that retaining these features will be necessary to ensure that the new system offers person-centered, sustainable care to all participants.

Many of the elements proposed by Act 55 already exist in our current long term care system. Managed long term care services, including a fully integrated benefit package, have been available through Wisconsin's Family Care program since the 1990s. Consumers have had access to a stand-alone self-direction program, IRIS, since 2008. County-based ADRCs have provided unbiased long term care options and enrollment counseling to Wisconsinites since 1998.

This system was built deliberately, through open discourse and thoughtful planning. To minimize disruption, Wisconsin must build on what is working in our current system.

Keep it Local

Wisconsin's nationally recognized and successful model of long term care is based on local relationships. Managed care organizations (MCOs) are rooted in the communities they serve. Local businesses provide services to members of their community. Independent, county-based Aging and Disability Resource Centers (ADRCs) work with individuals in need of long term care services to solve problems and find services that best meet their needs. Likewise, IRIS and Family Care participants select people they know and trust to work for them.

Our long term care system works best when it reflects local input and vision. Integrated Health Agencies (IHAs) and providers must be responsive to local needs and use community resources.

The long term care redesign should keep this successful infrastructure in place. This means:

- Maintaining Wisconsin's nationally recognized Aging and Disability Resource Center (ADRC) model;
- Continuing to use Wisconsin-based MCOs, which have decades of experience providing managed long term care services to Wisconsinites;
- Allowing everyone eligible for long term care to self-direct all services and have full budget and employer authority; and
- Maintaining and growing the current long term care provider network. The "any willing provider" requirement must continue indefinitely to ensure that small Wisconsin businesses are given the opportunity to compete and allow for consumer choice, and out-of-network providers should not be penalized by IHAs with dramatically lower rates than in-network providers.

Provide Services on a Regional Basis

The long term care redesign must continue Wisconsin's regional approach to providing long term care. IHAs must be required to serve an entire region and should not be allowed to self-select service areas based on ZIP code or other arbitrary factors.

The long term care redesign must continue Wisconsin's regional approach to providing long term care.

A regional model of providing services allows MCOs to collaborate with local providers, law enforcement, and counties, and to tailor services to the unique needs of each participant. Existing MCOs have built relationships, developed institutional knowledge, and gained expertise related to the counties in which they provide services. The long term care redesign needs to continue to leverage this local knowledge, presence, and accountability.

If DHS wishes to modify the current Geographic Service Regions (GSRs) in any way, special consideration should be given to allowing participants to maintain their current MCOs and providers to minimize disruptions in care. GSRs should not be created based on general population or arbitrary borders.

Special consideration should be given to the needs of each community across the state. For example, as the state has closed institutions and moved people into the community, some areas of the state, like Jefferson County, have a much higher percentage of people with developmental disabilities living in their communities than other areas of the state. DHS should also consider factors such as the availability of providers, minimizing participant disruptions and transitions, and leveraging existing systems and local relationships as they develop

new GSRs. For a full list of considerations for creating new GSRs, please refer to Appendix A.

Additionally, stakeholders, including existing MCOs, should be involved in any planning efforts to modify the current Geographic Service Regions and allowed to provide input on proposed GSR modifications.

Keep Homegrown MCOs

Wisconsin-based MCOs and their employees know the communities they serve because they live in the communities they serve. They are aware of the free transportation options provided by local churches, know about opportunities for family caregivers to receive respite, and have direct access to and relationships with local employers that facilitate community employment opportunities for people with disabilities. The long term care redesign should continue to emphasize community connections and collaboration.

The goal of any redesign should be improving care while creating the least amount of disruption for those served. Due to their experience and success in providing participant-centered, quality, and cost-effective long-term care, Wisconsin's homegrown MCOs can shepherd participants through the long term care redesign with minimal disruption to our current system. DHS should work to ensure that current MCOs are able to become licensed as IHAs. Efforts should also be made to retain local providers of long term care services.

Make Sure the Person Drives the Process

Wisconsin's redesigned long term care system needs to acknowledge that 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. Successful long term care systems recognize that the participants they serve are people first — each with their own unique needs, dreams and desires — and provide services and supports around this principle.

The focus of the long term care system should be on the needs of the whole person with coordination of care across the continuum to ensure that medical, behavioral, and non-medical long term care support needs are met. Care plans and services must be developed and delivered in a way that assesses and responds to the many important factors that affect long term care outcomes, such as a participant's gender, age, sexual preference, spiritual beliefs, socio-economic status, physical and mental capacities, and geographic location.

Participants in the long term care redesign must be able to make decisions about the full array of their medical and non-medical services and supports, including both services provided by the IHA and those provided by community entities. Care teams must include professionals and non-professionals chosen by the participant. Participants must have the ability to make decisions about their own lives and be afforded the dignity of risk. Decisions must be made quickly and must respond to specific situations and concerns.

Provide Services in Home- and Community-Based Settings

People with disabilities and older adults live full and meaningful lives connected to communities of their choice. Wisconsin's long term care system must continue to prioritize community living and ensure there is no financial incentive to place people in institutions.

The new system must maintain the current emphasis on facility and institutional downsizing. There should be no financial incentive for IHAs to place participants who require high-cost care, those with complex needs, or those with challenging behaviors in institutions, and the new system should prioritize serving people in the least restrictive setting possible. The long term care redesign capitated rate must continue to include both institutional and non-institutional services.

Participants should have access to a variety of community living options, such as homes, apartments, affordable housing, group homes, and adult family homes, and nursing homes when needed for rehabilitation.

Guarantee Everyone Has Access to the Services They Need

No matter where someone lives in the state, they should have access to the services they need and have a choice of provider.

Services should not be reduced, modified, or terminated without a documented change in the participant's needs or circumstances that can be independently reviewed and challenged by the participant with the assistance of an independent ombudsman.

DHS should establish standards for provider networks that ensure adequate provider capacity throughout the state. As we transition to the new long term care program, we should protect existing consumer-provider relationships, and ensure continuity and coordination of care. For standards related to provider networks and capacity, please refer to Appendix B.

Capitation rates paid to IHAs must be sufficient to address participants' needs and maintain quality provider networks.

Provide Cost-Effective, Quality Care

The Wisconsin Long-Term Care Coalition shares the Department's and Legislature's commitment to creating a sustainable long term care system that continues to provide cost-effective and quality care to Wisconsin residents. Family Care and IRIS have already produced significant cost savings to the state. Analysis done by the Department found that Medicaid spending on long term care decreased from 53% of total spending in 2002 to 43% in 2011. Annually, Family Care and IRIS save Wisconsin taxpayers approximately $400 million per year compared to the Waivers/Fee-for-Service Medicaid program.

Family Care currently controls medical costs by coordinating members' medical care. In a December 2013 report, the Department found that in 2010 the fee-for-service medical costs in Family Care was $282 per member per month; this cost decreased to $265 per member per month in 2012, an annual savings of $7.5 million per year. Moreover, IRIS participants return on average 17% of their individual budget allocations to the State.

The cost savings produced by Family Care and IRIS over the past 20 years have resulted in the increased sustainability of Wisconsin's long term care system. Additional savings and efficiencies can be achieved by embedding the successful elements of these models in the redesigned long term care system.

Promote Community Integration

True community integration is not only where a person lives, but also how a person lives. People using the long term care system must be able to participate fully in the community. In addition to providing competitive community employment opportunities and the support to maintain employment regardless of the severity of one's disability, the long term care system must provide access to a full array of services that enable long term care participants to live, work, and socialize in the community.

Older adults prefer to age in place. The Center for Disease Control defines aging in place as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level." The long term care system should include supports that enable long term care participants to age in place, such as access to transportation, housing, social and recreational activities, and health and wellness services.

Leverage Natural Supports and Family Caregivers

The new system must recognize the critical role played by family and other caregivers in meeting the needs of older adults and people with disabilities. The system should offer services such as caregiver training, adult daycare, and respite that "wrap around" the natural support network in order to keep it in place, thereby delaying or preventing the need for more expensive institutional care. Participants must continue to have the right to hire family members or independent caregivers who are not affiliated with a provider as paid caregivers, as long as the chosen caregiver is not a legal representative of the participant or has other conflicts of interest.

Wisconsin should continue to educate, engage, and support families as partners and allies in person-centered processes and self-direction. Effective family support strategies include training in best practices and support coordination, building family-to-family networks, and providing services specific to their caregiving role.

Prioritize People, Not Profit

The long term care system must focus on maximizing participant outcomes, not profit. It should protect consumers and taxpayers by capping IHA profits and administrative costs. While it is clear that IHAs will be licensed as insurance companies in the new system, safeguards must be in place to ensure that profit does not become the goal of the long term care system. On average, national, for-profit insurance companies expect a return on equity of 13%, which represents millions of dollars of profit. The redesigned long term care system should protect taxpayer funding while also guaranteeing quality services for participants. For detailed fiscal recommendations, see pages 23-25.

2. Base Quality on Clear Values

Promote quality long term care services and health care as defined by the Core Values described earlier, such as convenient access to a full range of health care and long term care services that increase community integration, individual choice, community living, integrated employment, recovery-based behavioral health services, and consumer-directed health care.

Use Quality Measures that Reflect Core Values
The Centers for Medicare and Medicaid Services (CMS) expects states to measure the quality of programs as it relates to providing supports that ensure quality of life for participants.[i] Specific and quantifiable metrics used to evaluate performance must be explicitly outlined in both the system design and in the state's final contracts with IHAs, along with incentives for good performance and consequences for poor or no performance.

Contracts need to hold IHAs accountable for producing outcomes that meet participants' goals and contribute to their overall health and quality of life. IHAs should be required by contract to publicly post quality measures and indicators on a real-time, consumer-friendly dashboard for public viewing. These indicators should include:

- Clinical quality indicators. DHS can choose measures that are relevant to the long term care population from the Core Set of Adult Health Care Quality measures for Medicaid (Adult Core Set).[ii]
- Non-clinical quality of life indicators from recognized sources like National Core Indicators, the Council on Quality and Leadership, and the Program Operations Manual System.
- Mental and behavioral health indicators.

DHS should require a remediation plan and withhold the final 5% performance payment from IHAs that fail to meet performance standards as quantified in contract language.

Preserve Quality Local Provider Networks and Provide Adequate Support for Providers to Ensure Provider Choice and High-Quality Supports for Participants
Preserving quality local provider networks keeps existing provider/participant relationships in place, boosts local economies, allows for quick turn-around responses, encourages and supports innovation, and improves accountability.

To ensure that only quality IHAs are selected, DHS should prohibit IHAs that have CMS sanctions from operating in Wisconsin. IHA contracts should include elements to ensure a robust, high-quality provider network, such as standardized and transparent rate-setting with incentives for quality, requiring new plans to honor current service levels, penalty clauses for IHAs that abruptly leave the program, and preservation of the "any willing provider" rule. For a full list of suggested contract elements, please refer to Appendix B.

Report IHA Information Publicly
IHAs need to report publicly so participants can choose the IHA that best fits their needs. Contract standards should require IHAs to publically report and annually update data associated with providing services and quality of care. This information should be made available to the public disaggregated by IHA, by region, and, where appropriate, by provider. IHA contracts must include benchmarks to ensure that the profit motive doesn't eclipse quality of care. For a list of these benchmarks, please refer to Appendix B.

DHS should monitor and publicly disclose the following information for each IHA:

- Contractually required quality reports and financial reports;
- Impact or effectiveness of incentive programs;
- Quality-focused audits;
- Remediation plans for low- or non-performing IHAs
- Quality-related technical assistance for providers;
- Confirmation that IHA corrective actions have been implemented;
- Quality findings and reports to assess quality trends and to identify areas for improvement;
- Performance improvement projects for managed long term services and supports;
- Participant feedback; and
- Critical incidents and sentinel events.

Address Participants' Non-Medical Quality Priorities Through Performance Standards

Contracts should require IHAs to demonstrate commitment to several priority areas by requiring them to meet performance standards related to these participant quality priorities:

- Assisting and supporting participants in seeking and maintaining a competitive or customized job in an integrated community setting for which the participant is compensated at or above minimum wage.
- Demonstrating a commitment to self-direction of services.
- Providing adequate clinical and non-clinical mental health services and supports by meeting performance standards related to these quality priorities.
- Providing access to transportation sufficient to access work, shopping, social events, and other common activities of community life.

For a full list of quality priority benchmarks related to employment, self-direction, mental and behavioral health, and transportation access that should be included in IHA contracts, please refer to Appendix B.

Incentivize the Least Restrictive Setting and Staying in the Community

The IHA contract should include incentives for keeping participants in the most integrated setting and disincentives for movement to more restrictive settings. IHA contracts should also include supports for assistive technology and home modifications to support participants' staying in their homes and community.

3. Preserve the Effectiveness of Aging and Disability Resource Centers and a Strong Prevention Focus

Retain the existing model in which locally-based Aging and Disability Resource Centers (ADRCs) with strong local networks and knowledge perform the full range of ADRC functions. Prevent, delay, and reduce the need for long term care services by: providing practical information to enable people to stay in their own homes; providing functional eligibility screening and enrollment counseling for individuals entering publicly-funded long term care programs; and making evidence-based prevention and health promotion programs widely available in order to prevent falls, enable people to self-manage their chronic diseases and medications, and improve nutrition, mental health, and physical activity.

Local ADRCs support people in maximizing the use of personal and community resources by helping people understand the various community long term care supports and services available to them, and assisting them in evaluating these options so they can make informed decisions about which services and supports best meet their needs. By providing options counseling services and assisting people in accessing needed services, including prevention and early intervention services, ADRCs can prevent or delay the need for publicly-funded long term care programs. Enhanced support and funding should be provided to continue ADRCs' involvement in health promotion and prevention activities, as the majority of people contacting the ADRCs (75-80%) are not accessing Medicaid funding or programs.

ADRCs have a unique opportunity to work with a population that has not yet spent their financial resources and/or does not yet have extensive long term care needs. The ability of ADRCs to successfully assist this population in planning and preparing for future needs, as well as addressing current needs, usually in the least invasive, least expensive way, has a positive impact on the current and future Medicaid budget. This benefit could be further magnified by supporting the delivery of evidence-based health promotion and prevention activities such as medication management, chronic disease and diabetes self-management, and falls prevention.

ADRCs often provide services in an individualized, non-linear fashion, and are part of a person-centered system. Respecting and responding to participants' needs and goals requires staff to be flexible and move between services and functions to best address individual needs. The ADRCs are an integral part of the system for both long term care program participants and for those who don't meet eligibility criteria for long term care programs. Therefore, the new long term care system should continue to partner with ADRCs. The following services should be retained, and in some cases retained and expanded.

One-Stop Shop

ADRCs provide their communities with a single entry point for all services for the aging and disability communities, helping citizens to find the best way to meet their individual needs. For many people, working with the ADRC prevents them from reaching a crisis stage where publicly-funded long term care becomes necessary. The ADRCs are able to work with people who are on a continuum of care and help them identify local services that meet their needs. ADRCs are distinct entities from IHAs, as ADRCs work with all people in their target groups of the elderly and people with disabilities, not just those enrolled in publicly-funded long

term care. As a resource that helps people meet their individual care needs, ADRCs provide a valuable community service that should be retained in the new long term care program.

Community-Based Support
ADRCs provide a central source of reliable and objective information about a broad spectrum of programs and services available locally. It is the local element that makes ADRCs strong and effective. People are given solid information about local agencies, rather than a national phone number. The need for a strong local presence with extensive local knowledge makes ADRCs indispensable, and they should be central to the new program.

Options Counseling
Options counseling typically includes a face-to-face interaction with staff about locally available long term care options, including services available for purchase through private payment, and may include referrals to not only long term care providers, but also to health care agencies and mental health providers. Options counseling looks at the needs of the whole person, not just their fit for a single program, and requires an intimate knowledge of the local long term care landscape. As long term care is integrated with primary and acute care, the role of ADRCs in options counseling should be expanded to include medical care providers and enrollment into IHAs. Options and enrollment counseling must continue be conducted by independent, conflict-free entities.

Access to Publicly-Funded Long Term Care Programs and Services
ADRCs ensure that customers who request access to publicly-funded long term care services and who are potentially eligible for these services are informed of and assisted in accessing these services. The ADRC determines functional eligibility by administering the initial Long Term Care Functional Screen. If a person is both functionally and financially eligible, the ADRC then provides enrollment counseling about the programs in its catchment area. These services of the ADRCs should be retained.

As long term care is integrated with primary and acute care, the role of ADRCs in options counseling should be expanded to include medical care providers and enrollment into IHAs.

Nursing Home Alternatives and Relocation
ADRCs help prevent nursing home admissions through a series of meetings with individuals and their families. ADRCs also assist in relocating residents out of nursing homes and back into their communities, saving taxpayer money. This work requires extensive knowledge of local services and outreach to local nursing homes and their staff, so this service of ADRCs should be retained.

Benefits Counseling
ADRCs provide benefit counseling by specialists, an important service that ADRCs should continue in the new system. Benefit specialists are experts in helping people with the extensive and complicated paperwork that is often required in obtaining benefits including Medicare, Social Security, private insurance, and other benefit programs. They also help people access local food programs, avoid evictions, locate prescription assistance, and find other basic necessities.

Caregiver Services
While the individual in need is the primary focus, assistance for caregivers is also a key function provided by ADRCs. Caregivers are at a much higher risk of illness due to chronic stress than the general public. ADRC staff identify support services like respite and personal care for caregivers. ADRCs should continue to provide caregiver services.

Transitional Services for Students and Youth
ADRCs play a critical role in helping families and young people with disabilities learn about their options once they are no longer in school. ADRC staff work closely with local school districts and vocational rehabilitation counselors to provide information and help with the transition to the adult long term care system. For many families, this information from ADRCs is the first time they hear about the possibility of community-based employment and what kinds of supports are available to attain it; therefore, ADRCs should continue to offer this service in the future.

Short-Term Service Coordination
ADRCs provide short-term service coordination for those who need help accessing and coordinating personalized services to address complex needs. The effectiveness and timeliness of this coordination can often make the decisive difference in averting a crisis or preventing an unnecessary institutional placement. These services should be retained and expanded under the new long term care program.

4. Enable Real Self-Direction

Ensure that a robust self-direction option is available to all long term care-eligible individuals in long term care, health care, and behavioral health, which includes full budget and employer authority.

All people eligible for long term care in Wisconsin, including those with behavioral health needs, have the right to elect a self-directed supports option, including budget and employer authority, and they must be objectively informed and educated about self-direction. Self-direction is recommended by CMS for states moving into integrated care and has been clearly endorsed by the Wisconsin legislature in Act 55. Self-direction is a cost-effective way for people to achieve their chosen long term care outcomes and it enhances quality and participant satisfaction. Consequently, it must be an integral part of Wisconsin's future long term care system.

The extent of a person's disability or his or her level of care should not dictate whether a person is deemed capable of self-direction. When determining the capacity of a participant to self-direct his or her care, the IHA should take into consideration his or her family and personal support network, as self-direction can include the option of shared or supported decision-making, in which a person's family or friends help the person make

good decisions, or share the decision-making authority with the person. If the capacity of the person and his or her circle of support is in question, then the IHA must take steps to work with the person to create or strengthen the supports the person will need to effectively self-direct.
Patients must be allowed to self-direct their acute and primary health care and behavioral health care along with their long term care.

Cost-containing measures must not undermine self-direction. The concept of self-direction is inherently cost-effective; IRIS participants return on

average 17% of their individual budget allocations. [iii] However, some cost-effectiveness strategies used in managed care, such as across-the-board provider rate cuts, can undermine self-direction. Allowing the person maximum control over his or her individual plan and budget creates the best opportunity for the person to incorporate natural supports into the plan, which increases cost-effectiveness. The new system must minimize the level of bureaucracy and red tape in self-direction to avoid costs resulting from unnecessary professional involvements and paid services not needed in self-direction. As demonstrated by the cost savings in IRIS, the current approach encourages, supports, incentivizes, and removes barriers to natural supports.

Allowing the person maximum control over his or her individual plan and budget creates the best opportunity for the person to incorporate natural supports into the plan, which increases cost-effectiveness.

Maintain Self-Directed Supports Consultant Services

In Act 55 and in their public comments, the Legislature clearly spelled out a "consumer directed option" in the new system that would contain all the features and services of the current IRIS program.

Therefore, DHS should continue to certify IRIS Consultant Agencies (ICAs) that will provide the current IRIS service of "IRIS Consultant Service" as one of the services in the IRIS Waiver on July 1, 2015 that is mandated to be included in the new system per Act 55. The certification process must ensure that only entities that are philosophically committed to self-direction and have a record of supporting self-direction can attain certification. The service would be retitled "self-direction consultant service" and the entities providing it would be called "self-direction consulting agencies" (SDCAs). The self-direction consultant will provide much-needed continuity for individuals who have chosen to self-direct their services in the new system. This will help mitigate other disruptive factors associated with the transition to the new system.

The support of a self-direction consultant must be available to the person on an ongoing basis (as it is in IRIS), not just at the initial individual planning period. There should also be a choice of at least two SDCAs operating in every service region of the state. When a participant chooses to self-direct their long term care services, they should be informed by the IHA about the choices of certified SDCAs operating in their county. The SDCA chosen by the person would provide all the support coordination the person needs to manage their long term care services, and the person's team within the IHA would coordinate the person's primary and acute health care. Both the IHAs and SDCAs would be contractually required to coordinate with each other.

In order to certify, support, and oversee a group of SDCAs in the future, it will also be important for DHS to continue to have a clearly identifiable "Self-Direction Team" inside DHS, which has the necessary expertise in self-direction to ensure quality and fidelity to the self-direction model.

Allow Self-Direction Participants to Set Their Own Goals and Maintain Budget and Employer Authority

Self-direction participants must set their own goals using a person-centered planning process, and they must have full budget authority and employer authority. [iv] People who want to self-direct are the experts on their own lives. They know what they want, what they need, and who they want to provide it in order to create a fulfilled, safe, and healthy life in the community. People

who set their own goals and create their own plan are more likely to take responsibility to achieve their goals and make their plan work. As stated in Act 55, all the services covered under IRIS as of July 1, 2015 must continue to be covered, including Self-Directed Personal Care (SDPC). Participants must be able to select any agency or person to provide services, provided the person is qualified and passes a background check.

Individual budgets must be set fairly and objectively before the person-centered planning process begins, and must be based on the participant's long term care needs and desired outcomes. The budget-setting methodology must address the person's physical caregiving needs, supervision and support needs related to behavioral challenges, emotional needs, and need for community integration. Individual budgets must be based on the actual cost of services, not artificially deflated rates.

Wisconsin has the benefit of several years of experience with individual budgeting within the IRIS program. DHS staff and others have invested substantial time and energy in developing and refining that process. A new mechanism for IRIS individual budgeting based exclusively on IRIS claims data is due to be implemented in early 2016. If this new individual budgeting mechanism is better than all previous versions, it should be incorporated into the self-direction option in the new system. For people transitioning from IRIS to the self-direction option inside the long term care redesign, the person's individual budget history should be given considerable weight in determining his or her new individual budget.

Individual budgeting must use the same process across all IHAs, and there must be safeguards to ensure such consistency. Because no computerized budget calculation system is perfect, the current DHS system in which participants can request budget adjustments when the initial budget is inadequate or when a participant has an exceptional one-time expense must be preserved. Participants must also have appeal rights (as in IRIS) so they can challenge their budget determination. The appeals should be handled by the Division of Hearing Appeals. In the new system, as in IRIS, the cost of the person's self-direction consultant and the Fiscal Employer Agent must not come out of the person's individual budget; otherwise a person would in effect be penalized for choosing to self-direct.

Protect Integrity of Self-Direction and Rights of Self-Directing

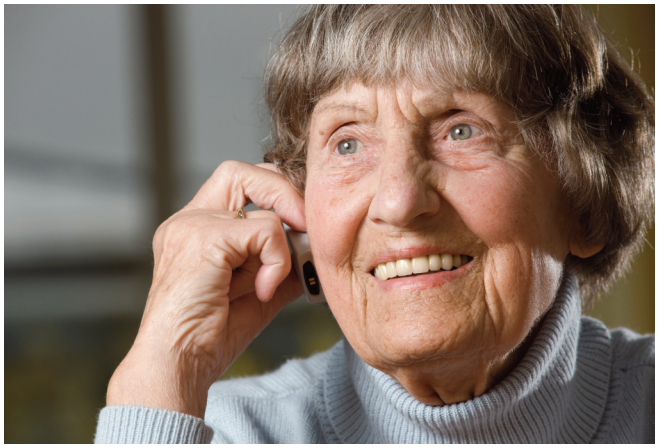
The new system must protect program integrity and participant rights in self-direction. This will require:

- Creating 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 self-direction;
- Using appropriate fraud prevention and protection measures that do not add unnecessary bureaucracy to self-direction;
- Providing adequate funding for ombudsman services that are independent of ADRCs, IHAs, SDCAs, and provider agencies;
- Developing specific safeguards to prevent unnecessary institution admissions; and
- Allowing participants placed in institutions for short-term stays (90 days or fewer with stays of up to 180 days allowable with DHS approval) to stay enrolled in the self-direction option and access services of their self-directed services consultant as they transition home.

5. Make the Integrated Model Person-Centered

Ensure that the principles of person-centered planning and consumer choice are preserved and strengthened in the integrated model in relation to long term care, health care, and behavioral health services, including offering the participant the choice to continue with current providers.

Act 55 requires that the new long term care system provide or coordinate integrated care, long term care, acute care, primary care, and behavioral health. In the existing model, a few MCOs coordinate and facilitate payments for participants using Medicare and Medicaid through the Partnership model, but most provide long term care services only. 80% of people currently in Wisconsin's long term care system are dual eligible, meaning they are eligible for Medicaid and are also Medicare beneficiaries. While some states have a form of integrated or managed care in their long term care system, no state has implemented a system similar to the one envisioned by the Joint Finance Committee. This section addresses both the challenges and the opportunities of restructuring the Wisconsin system as an integrated care model.



Prioritize Person-Centered Planning

The care plan and delivery system of the new system must be person-centered. The location of decision-making for all services should be as close to the person as possible with a quick turnaround in approval for decisions. This includes geographic closeness so that the participant can have face-to-face contact with their providers and people making decisions about their care. The redesigned long term care program should have clear processes to explain how a decision is made regarding any changes in care or services. If a participant chooses to appeal a decision, care and services should not be reduced during the appeals process.

Accommodate Dual Eligibles and Medicare Integration

We believe that Medicare beneficiaries cannot be required to give up traditional Medicare A and B or Medicare Advantage coverage as a condition of receiving Medicaid managed long term care. Waivers such as those available in the Medicaid program are not available in the Medicare system. The Joint Finance Committee recognized this in Act 55 by requiring the inclusion of Medicare-funded services to the extent allowable by CMS. Participation in integrated care should be an opt-in for dual eligible participants, not an opt-out, and no one should have to give up Medicare Part A, Medicare Part B, or Medicare Advantage to receive long term care services under the long term care redesign.

To accommodate dual eligibles, IHAs might have to continue providing managed long term care but receive additional compensation to coordinate medical appointments and set up and maintain an information-sharing and care coordination system for those who choose to continue traditional Medicare. One of the ways to expand the number of Medicare beneficiaries who opt into a fully integrated system is to expand the Partnership program state-wide, either as part of a staggered transition into the new model or as an

option an IHA can make available to participants. This would allow the participants to choose between an integrated system similar to Family Care, a self-directed integrated option, or Partnership.

Maintain Provider Choice and Current Local Connections

The new system must also allow provider choice as much as possible, including choice of providers for long term care, acute and primary care, and behavioral health and mental services, as well as the option to stay with current providers.

The new system must retain connections to local communities and providers. The program should also provide adequate supports for families and caregivers, and provide supports traditionally supplied through counties and nonprofit services.

6. Do Behavioral Health Right

Fulfill the state's aspiration to improve behavioral health services in the new long term care system by ensuring adequate screening for behavioral health issues, specialized supports for individuals with co-occurring conditions of intellectual disability and mental illness, access to a full range of trauma-informed and recovery-based behavioral health services available on a voluntary basis, and improved coordination with county mental health and crisis response services.

DHS has indicated that the new model for long term care will include integration of behavioral health services through regional IHAs. For the purposes of this document, behavioral health services includes both mental health and substance use services, and includes a continuum of prevention, intervention, treatment, and recovery support services.

About half of Family Care participants have identified mental health and/or substance use needs. These needs are often not fully addressed in the current long term care system, which has led to concerns about, among other things, overreliance on crisis and institutional services, access to qualified mental health professionals, and access to key mental health services.

Many participants in long term care have a dual diagnosis of a developmental disability and co-occurring mental health needs. This can include complex behavioral and mental health challenges. Support for these complex needs should also be addressed under the framework of behavioral health services.

Follow General Principles for Serving Participants with Behavioral Health Needs

- **Recovery-Based, Respectful Services.** Behavioral health services must be recovery-based, trauma-informed, culturally appropriate, and respectful of the person receiving services.
- **Least Restrictive Setting and Independent Living.** Participants with mental illness should live and receive services in the least restrictive setting appropriate to meet their needs and consistent with their choice. Community supports should focus on helping an individual to live as fully and independently as possible.
- **Flexible, Quality Services.** IHAs must ensure that a seamless array of flexible, quality services helps participants maintain homes, jobs, and family and community ties, and encourages participants to seek the assistance they need.
- **Participant Choice.** Participants must be given real choices about the services they receive and who delivers those services, along with flexible

budgets that put some of the resources in the hands of participants to spend on services they choose.

- **Wide Array of Interventions and Supports.** Forced mental health treatment is never appropriate, except when there are immediate and serious safety risks. For choice to be real, systems must offer a wide array of interventions and supports, and consumers must understand their benefits and risks.
- **Comprehensive Services and Supports.** Behavioral health services and supports included in the service array should be comprehensive and not limited to a medical model.
- **Access to All Medicaid Behavioral Health Benefits.** The new long term care model should ensure that participants have the option to access all Medicaid behavioral health benefits, including those services administered by Wisconsin counties; enrollment in long term care should not limit participants' access to Medicaid covered mental health and substance use disorder services.

Involve Stakeholders

Mental health and substance use stakeholders have generally had minimal involvement in forums that provide input regarding the long term care system. As part of the long term care redesign, DHS should develop a structure to ensure the substantive engagement of behavioral health consumers and providers, including counties, advocates, and family members, with policymakers and funders in the long term care system.

- **Advisory Council.** DHS should form an ongoing advisory council that is representative of the adult long term care stakeholder base, including at a minimum two consumers with mental health and/or substance use disorders.
- **Involvement in IHA Boards.** IHAs should be required to include behavioral health consumers and providers in their governing boards.
- **Contract and Readiness Standard Review.** Stakeholders should have the opportunity to review current contracts with IHAs to identify provisions that would be desirable in the redesigned system, especially those related to client rights, client safety, and collaboration with county agencies. Stakeholders should also be involved in identifying the requirements for these readiness reviews.

The new long term care model should ensure that participants have the option to access all Medicaid behavioral health benefits . . .

For additional requirements about the inclusion of stakeholders in the long term care system, please refer to section 13. Sustain an Ongoing Dialogue.

Coordinate with Counties

Wisconsin counties play a key role in delivery of mental health and substance use services. County human service staff and the Wisconsin County Human Service Association (WCHSA) should be among the stakeholders involved with the long term care redesign and integration of behavioral health services.

Each IHA should have a behavioral health liaison and should closely coordinate with county human services to provide care for participants who could be served by either or both of these systems. DHS should organize a separate workgroup with county stakeholders, advocate stakeholders, and IHA representatives to identify appropriate contract language around the range of coordination for these services.

Wisconsin counties must be required to provide access to county behavioral health services, such as certified Comprehensive Community Services (CCS) and the Community Support Program (CSP), to eligible long term care participants who choose to access these services.

Use Consumer-Driven Care Planning and Decision-Making

Behavioral and substance use services must be consumer-driven and promote consumer empowerment, choice, and participation. The program must affirm the participant's right to self-direct, provide alternatives to guardianship, ensure that decisions regarding medical necessity are guided by client choice, and promote independent living services. The program must also include care planning for all long term care-eligible people residing in nursing facilities and other institutions, and DHS should work with ADRCs, IHAs, and advocates to create a strategy and action plan to prioritize community relocations for people with mental illness residing in institutions who are eligible for long term care. For a list of suggested contract elements related to care planning and decision-making, please refer to Appendix B.

Include Mental Health and Substance Use in the Screening Process

ADRCs have the responsibility of screening for eligibility for long term care services. All ADRCs should have a certified screener available with education and expertise in mental health and substance use services. All staff should be required to have training on providing trauma-informed services.

A professional with expertise in mental health and substance use must be part of the evaluation process for all participants using behavioral health services, and a Recovery Plan must be put together with the participant to identify what services and supports are needed and desired.

Young adults who have been served by the children's mental health system, in addition to receiving other disability services, must receive appropriate assessment, appropriate screening, and needed mental health supports as they transition to the adult system.

Ensure Access to Services

IHAs should be required to develop adequate networks of behavioral health providers throughout the state, and participants should have the choice of continuing to be served by their current providers. Participants should have access to specialized services such as Certified Peer Specialists and Recovery Coaches and should be able to self-refer to Peer Run Respites. Participants should have access to behavioral health providers in specialty areas, such as cognitive behavioral therapy. Finally, the program's rate structure should provide adequate flexibility to serve participants with a higher level of need, including those with ongoing mental health and/or substance use needs and those with complex needs who require flexible, community-based behavioral supports. For a list of suggested contract elements related to behavioral health access, please refer to Appendix B.

Provide Substance Use Treatment Services

Participants should have access to a full range of substance use disorder treatment services. For a full list of included substance use disorder treatment services, please refer to Appendix B.

The importance of a gender-responsive approach to care is critical for a participant's success. Specialized programs and services that address the unique needs of women are needed to ensure that a trauma-sensitive approach to care is a standard of clinical practice.

Maintain Other Key Supports

IHAs must prioritize employment services and supports for participants with a mental health diagnosis who want to work, and to support them in securing the education and supports they need to find community employment at a competitive wage. IHAs must include coverage for Individual Placement and Support (IPS) supported employment programs, which help people with mental illnesses find competitive employment that fits their preferences and provide ongoing workplace support.

IHAs must ensure that participants can access common activities of community life as necessary, including work, shopping, medical appointments, and social activities. They must also ensure that participants can get a ride for activities on the following day from the most integrated service appropriate to their needs, including transit, paratransit, taxi, or specialized vehicle, and participants must be able to get next-day rides on nights, holidays, and weekends. The certainty and timeliness of these services must be comparable to bus or taxi services in the community or to NEMT if no public transit is available in the community.

DHS must explore policies that will enhance the behavioral health and substance use treatment workforce, such as continued support of the development of the peer workforce, policies that will promote better integration of mental health and primary care, and policies that will attract and retain qualified mental health professionals.

Commit to IHA and Provider Staff Competencies

Many people with a mental health diagnosis have experienced 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. There must be a commitment by all providers in the network to be responsive to health care concerns raised by participants and to guard against the potential barrier of disability-related discrimination.

- IHAs should have qualified mental health professionals who are available to meet regularly with teams and are available to offer consultation if a participant so requests or consents.
- The IHA behavioral health system must be trauma-informed, with all IHA staff and all service providers taking a trauma-informed care approach.
- Staff should be informed about the full range of mental health, alcoholism, and additional needs and services, and should receive training in motivational interviewing.
- Staff must address the specialized behavioral health needs of older adults and have expertise in supports for participants with dementia.

Establish Protocols for Crisis Care

Wisconsin counties have statutorily defined responsibilities for providing crisis care. IHAs must establish protocols with counties on how and when participant involved/centered Crisis Plans shall be developed, reviewed, and updated for participants with mental health and/or substance use disorder needs.

IHAs must collaborate with counties to address how follow-up supports and services will be provided after crisis contacts occur. IHAs should be required to work with counties to ensure capacity for comprehensive community crisis response, including mobile crisis response teams and access to a community consultation team with expertise in crisis intervention, as well as development of effective individualized crisis response plans. DHS should also review current access to Crisis Response Teams, and evaluate what is needed to develop ca-

pacity to ensure services are available twenty-four hours a day and seven days a week moving forward. For a list of suggested contract elements related to crisis care, please refer to Appendix B.

IHAs should share the cost for crisis services to ensure there is a strong financial incentive to provide ongoing high-quality community supports that will reduce the need for crisis services. In addition, IHAs and counties should share the responsibility for costs related to emergency detentions to prevent potential incentives for shifting costs and care of participants to counties.

Serve Participants with Complex Needs

Many participants in long term care have a dual diagnosis of a developmental disability and co-occurring mental health needs; these participants often have complex needs, including behavioral and mental health challenges. To successfully serve participants with complex needs, including challenging behaviors, IHAs need clear direction from the state on this issue, and frontline staff need knowledge and ongoing support to adequately meet their needs.

IHAs must provide education and support for direct support providers as key components to successful community life for people with challenging behaviors. Providing supports like these can create cost savings in the form of fewer days of institutional care. For a list of topics that should be included in this education and support, please refer to Appendix B.

The Department must issue clear direction that includes the following:

- Unequivocal lines of responsibility for managing and funding services that must be coordinated with counties, specifically CSPs and CCSs.
- Readily available access for care teams to mental health professionals who have expertise in serving people with developmental disabilities and behavioral needs.
- A preference for supported safe living situations in the community, as both a valued approach and a cost saving measure.
- Coordination with community resources with expertise serving persons with complex needs, such as the Waisman Center Community TIES, to create comprehensive approaches.
- Support for the development of such resources in communities where they do not exist.

Metrics for IHAs should provide incentives to invest in strong community services and Community Consultation Teams and limit the use of institutional placements in state centers or institutions for mental diseases (IMDs). When such placements do occur, they should be short-term placements with clear responsibilities for comprehensive discharge planning. We also recommend considering a policy that will ensure that a participant who has experienced a crisis and out-of-home placement does not lose their home as a result.

The new system should retain and expand the current Long Term Care Functional Screen to include planning for how to address challenging behaviors so that the data from this improved screen can be used to determine the capitated rate for higher needs people.

In addition, when treating participants with chronic health conditions and co-occurring mental health disorders, IHAs should develop a plan for providing integrated primary and behavioral health care for participants if they do not currently have such a practice in place.

7. Make Cultural Competence a Priority

Ensure that IHAs, ADRCs, and providers have culturally competent staff and services that consistently meet the long term care, health care, and behavioral health needs of people of diverse identities, including people of various races, cultural and ethnic heritages, genders, gender identities and expressions, sexual orientations, ages, and religions. Staff must also provide services in the language appropriate to the participant.

People of different cultural backgrounds sometimes:

- Have different views of disability and illness;
- Have different views of the appropriate role of families and other natural supports in a person's care;
- Have different ways of connecting with, and participating in community life;
- Require culturally-specific approaches for outreach, encouragement to participate in prevention programs, and convincing people to accept long term care services; and
- Take longer to develop trust with the long term care system and the people working in it.

In Wisconsin's long term care system, real cultural competence will require a commitment from DHS, ADRCs, IHAs and ICAs, and provider agencies. This commitment must include several important dimensions:

- A strong commitment to the importance of cultural competence and to the goal that every person receiving long term care services, regardless of their background, is equally deserving of a high-quality experience;
- A deep resolve to recruit, hire, and support staff who reflect the demographics of the population served in terms of race, ethnicity, language, and sexual orientation (these demographics vary depending on the region of the state);

- An initial staff orientation and ongoing staff training with a strong cultural competence component provided by expert cultural competence trainers;
- Pro-active supervision by supervisors and managers who are truly committed to achieving the day-to-day reality of providing culturally competent services;
- Agency policies that clearly lay out the cultural competence expectations for staff and the agency commitment to quality for every service recipient regardless of their background; and
- A clear line of accountability from direct service staff to the highest level of DHS to ensure that Wisconsin' s long term care system provides culturally competent services.

8. Safeguard People's Rights

Include contractual, monitoring, grievance process and ombudsman safeguards in the redesign to ensure that all relevant rights of participants (as defined in state and federal law) are protected, including the right to be free from unnecessary institutionalization and from forced treatment except when there are immediate and serious safety risks.

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).

Create a Robust Grievance System

The plan must have a robust set of grievance and appeal mechanisms, including:

- Compliance with all relevant Federal regulatory grievance and appeal requirements;
- A timely grievance and appeals process;
- Continuation of benefits during the appeals process, as long as the appeal is submitted prior to the effective date of termination of services (even if services were authorized for a specified period of time);
- An opportunity for participants to use the internal appeal or grievance mechanism while simultaneously pursuing a state fair hearing;
- Prominent, adequate notice of all appeal rights and how they can be accessed, provided at enrollment, periodically thereafter, and whenever an action occurs that affects eligibility or services; and
- Merger of the Medicare and Medicaid appeal systems for all dual eligible participants, incorporating the most participant-friendly parts of each system and creating a new hybrid system.

Offer an Independent Ombudsman Program

There must be an adequately-funded, independent ombudsman program available to all participants, which includes:

- The ability to advocate in relation to long term care, behavioral health care, acute health care, and primary health care;
- A mandatory ratio of one ombudsman per 2,500 participants;
- The right to represent consumers at state fair hearings;
- Retention of an attorney component and an expansion of attorney authority to allow the attorney to petition circuit court under Chapter 227 for review of negative fair hearing decisions;
- Continuation of the current system of having one ombudsman program for people under age 60 and one for people 60 and older; and
- Expansion of ombudsman services to include persons age 60 and older who choose to self-direct.

Comply with the ADA and Wisconsin Law

In order to comply with the Americans with Disabilities Act and Wisconsin law, the redesign must include incentives to move people out of institutions and prevent inappropriate institution admissions. Nursing facility services, intellectual and developmental disability (IDD) facility services, and inpatient psychiatric hospital services should be included in the IHA benefit plan with no carve-out. This will deter institutionalizations that occur when the cost of care in the community is perceived to be "too high," even when the institution cost is much higher.

DHS must also ensure care planning for Family Care-eligible persons residing in nursing facilities and other institutions, including IMDs. This must include a needs assessment conducted at least semi-

annually, enrollment for non-enrolled persons, and discharge planning unless the participant rejects care planning. The facility closing process should continue to require a planning and oversight role of the state-convened closing team to ensure that the rights and choices of residents are protected.

The system must include protections for high-cost participants. Cost must not be a reason to deny a person access to care and treatment in the least restrictive environment and most integrated setting. DHS should preserve the current acuity-based rate-setting methodology. Pay-for-performance incentives should be used to encourage IHAs and providers to support people in the most integrated setting. IHAs should be reimbursed the actual cost of caring for people leaving institutions during the period before their costs are factored into the capitated rate calculation.

Include Enrollment Protections

The long term care redesign should include certain protections related to the enrollment process, and current participants in Family Care, Partnership and IRIS must be given adequate notice and adequate time to choose between IHAs.

- There should be no defined, proscriptive open enrollment period. Participants should be able to enroll, disenroll, and switch between IHAs at will at any time, any number of times, and for any reason; robust competition between IHAs is one way to ensure quality.
- Medicare beneficiaries must not be required to surrender their Medicare benefits as a condition of receiving long term care services and supports.
- There must be no auto-enrollment of Medicare beneficiaries into IHAs.
- IHAs should be required to offer two plans, one that incorporates a person's Medicare benefits and one that does not, which supports the person's right to self-direct their acute and primary care services. These plans should have different capitated rates.
- DHS must ensure that there is no lapse in acute or primary care services if a person chooses to disenroll and is in Medicare.
- To avoid an inadvertent interruption in service, if a current participant does nothing in response to the invitation to choose an IHA in the new system, he or she should be auto-enrolled with an option to opt-out.
- IHAs must be subject to the same marketing restrictions that currently apply to MCOs, including the prohibition on directly marketing to individuals.

9. Use an Innovative Approach to Fiscal Sustainability

Achieve cost-effectiveness by using approaches that maximize quality at reasonable cost and limit administrative costs and profits, not by cutting costs or maximizing profits at the expense of quality.

Cost-effectiveness must continue to be a core value of Wisconsin's long term care system. This doesn't mean providing the participant with the least expensive services or reducing services that support participant outcomes, but rather providing the participant with services and supports that result in the most efficient and cost-effective care over time. Providing long term care services in home- and community- based settings is proven to reduce long term care costs. Under the current long term care system, annual Medicaid nursing home days dropped from 8.8 million in 2002 to 5.7 million in 2012—a 35% reduction saving taxpayers over $300 million per year. Long term care supports that promote independence and community connections, such as integrated employment and community living, keep participants healthy and delay or prevent the need for acute care services, such as emergency

room visits or institutional placements. By reducing participants' reliance on publically funded benefits, these services have the added benefit of containing Medicaid costs.

The long term care redesign should adopt a pay-for-performance policy that rewards IHAs for home- and community-based outcomes, such as the number of participants working and living in the community. Likewise, the pay-for-performance rewards should extend to service providers based on outcomes and good performance.

In addition, the long term care redesign should continue to allow IHAs to provide the most cost-effective and flexible services even if they are not explicitly listed as part of the state plan. Current MCOs provide cost-effective and innovative services to achieve better outcomes for participants with unique needs. Some examples include electronic or video monitoring instead of in-home night staff, Weight Watchers instead of a nutritionist, and exercise classes instead of physical therapy.

The use of innovative technologies such as mobile devices, including tablets, should also be encouraged by the long term care redesign.

10. Provide Adequate Funding to Do Long Term Care Right

Ensure adequate funding to realistically enable IHAs and providers to provide services of sufficient quantity and quality that allow people to achieve their own long term care, behavioral health, and health care goals.

Reflect the Integrated Benefit in the Capitated Rate

The rate-setting process for the long term care redesign must be transparent and predictable. Capitation rates must be set in a way that ensures program participants have access to the services they need and that IHAs can attract and retain quality providers.

As the state incorporates medical services into the long term care benefit packages, measures need to be taken to ensure that the capitated rate paid to IHAs accurately reflects the cost of providing a fully integrated benefit. The costs of providing acute, primary, behavioral, and long term care services should be considered separately when setting the capitated rate paid to IHAs. The costs for each service area should be considered independently from each other, and the final capitated rate should include the cumulative costs of all service areas combined to ensure that medical care does not dominate the model. In addition, the inflation trend used to establish future capitation rates must be sufficient to include future cost increases and to give IHAs the flexibility to meet unanticipated changes in participants' acuity and case mix.

Special consideration needs to be given to the integration of Medicare benefits. The capitation rate-setting process used for the long term care redesign needs to include a separate rate-setting process for Medicaid-only participants. Currently, the Medicaid portion of the capitation rate in Partnership is the same for participants who are eligible for both Medicaid and Medicare as it is for Medicaid-only participants. Thus, Medicaid is underfunding the acute and primary portion of care, as participants who are only Medicaid eligible do not have Medicare funding or an increased Medicaid rate. This makes it incredibly difficult to meet the needs of Medicaid-only participants. Capitation rates in the long term care redesign should accurately reflect the cost of providing care to Medicaid-only participants.

Support Wisconsin-Based Businesses

Because Wisconsin-based MCOs do most of their contracting with local small businesses and any Medicaid money spent has remained within Wis-

consin's borders, these contracts have created jobs in the state and benefited the Wisconsin economy. Supporting and retaining current long term care providers is critical to ensuring that people with disabilities and older adults are able to continue receiving services in their own homes or the community. Small providers, such as "mom and pop" adult family homes, are much more prevalent in rural areas, but are not traditionally included in the provider networks of large insurance companies. If there are not enough providers serving rural areas, participants will not be able to access services. Maintaining a robust provider network also controls cost and increases quality through participant choice and competition. The current "any willing provider" provision must continue indefinitely.

In the new long term care system, current rates must serve as the "floor" to ensure that Wisconsin long term care providers can continue providing services. In addition, safeguards need to be put in place to guarantee that IHAs pay providers in a timely and efficient manner, as failing to ensure current and timely payment rates will destabilize established provider networks and further limit participant options and choice. The long term care redesign must also contain safeguards to ensure that program participants can access out-of-network providers, and IHAs should be required to pay out-of-network providers sufficient rates.

Address the Workforce Crisis

Careful and thoughtful consideration needs to be given to the direct care workforce crisis currently impacting almost all providers of long term care services. The vast majority of direct care provider agencies report difficulty filling open positions and high turnover rates, with one organization reporting a turnover rate as high as 67%. The demand for personal care services is set to increase dramatically over the coming decade, which will only exacerbate this problem. Our new long term care system must address this workforce crisis so that people with disabilities and the elderly can continue receiving services in the most cost-effective setting: their own homes and communities. DHS and IHAs should work together to ensure that contracted providers receive rate increases necessary for them to remain solvent and to attract and retain quality employees. As the state invests in a redesign long term care system, it must also ensure that there are enough caregivers available to make the system work.

Protect Taxpayer Dollars

Profit has never been the goal of long term care in Wisconsin. Current MCOs keep surpluses below 2% and administrative costs below 5%. This model maximizes what is spent on participants and protects Wisconsin taxpayers. In an attempt to address the challenges experienced by other states, the CMS recently proposed a minimum medical loss ratio of 85% for Medicaid managed care plans. This would require potential IHAs to spend a minimum of 85% of dollars received on services provided to participants and allow IHAs to have administrative costs of up to 15%.

As DHS works to develop the redesigned long term care system, special consideration should be given to the proposed federal medical loss ratio standards and whether a higher medical loss ratio could feasibly be set. Current Family Care MCOs have an average administrative cost of roughly 5%, and Partnership MCOs have administrative costs of roughly 6%. This means that the average medical loss ratio of current Family Care and Partnership MCOs are approximately 95% and 94%, respectively.

To further protect taxpayer dollars and control the growth of the state's Medicaid budget, any surpluses produced by IHAs should stay in Wisconsin, and any significant cost savings produced by IHAs should be re-invested in the long term care system to improve the program and maintain providers. The state should set clear and transparent repay-

ment obligations in its contract with IHAs that cap profits at a certain percentage mark and require that any earnings over the profit cap be returned to the state. Money returned to the state by IHAs should be used for program improvement initiatives. Any repayment obligations should be applied consistently and clearly articulated in DHS-IHA contracts.

11. Raise the Bar with Readiness Standards

Establish rigorous readiness standards as part of the initial IHA certification process, and develop and enforce performance standards to measure the ongoing performance of IHAs over time.

Establish Rigorous IHA Readiness Standards

The State must ensure that risk-based, integrated care organizations demonstrate that they are able to provide the full range of services — primary, acute, behavioral, and long term services and supports — that is required by the enrolled population before they are permitted to enroll participants. The State should also ensure that plans demonstrate the ability to provide high-quality care and care coordination services. Well-defined care coordination must be integrated into health care for older adults, people with physical disabilities, people with developmental disabilities, and people with co-occurring mental health and substance needs. Tools for care coordination should include health information technology, integrated health care teams, and Internet-based resources. Explicit elements of care coordination must be included in the delivery system design and training, and resources must be provided for care coordination.

DHS should develop a robust plan-readiness review process, and contracts should undergo an independent assessment to determine whether IHAs in the capitation model are prepared to provide all contracted services in a safe, efficient, and effective manner. In addition, DHS should certify health plans that meet plan readiness criteria before awarding the IHA providing the plan a contract for services. Performance measures should be tied to the requirements of plan readiness certification, which should include, for example, a proven track record of high performance, providing budget and employment authority for self-directed care, plans and providers that offer person- and family-focused care, and offering services in a culturally and linguistically competent manner. For a full list of recommended readiness requirements, please refer to Appendix C.

DHS should allow IHAs that have met plan readiness certification requirements to bid or compete to provide contracted services. In awarding contracts, DHS should consider the quality of care provided and the capacity of the organization to provide services as well as the cost of the contract.

Create a High-Quality Contract

The quality standards for the redesign and contract should provide for the implementation of the new system. DHS should require an independent assessment of IHA regions and contracts and build capacity in underserved areas based on findings from the independent assessment. Elements that should be included in IHA contracts to ensure a robust, high-quality enforceable contract include, for example, standardized rate-setting with incentives for quality, ensuring continuity of care, and requiring new plans to honor current service levels. For a full list of suggested contract elements, please refer to Appendix B.

12. Phase in Gradually

Roll out the new system in regional stages to avoid simultaneous statewide implementation of a model with start-up flaws, and to create a learn-as-you-go process in which lessons from early regions can be incorporated into the start-up process for later regions.

During the implementation of the new model, a safety net needs to remain in place so that the disruption to participants' lives can be minimized. We recommend keeping parts of the old system in place during a limited rollout of the new IHAs.

Stagger the IHA Rollout

IHAs should be rolled out using a multiyear plan with a strong safety net system and parts of the old system remaining in place as an option for participants during the initial phases. Several regions must have successful rollouts before the program goes statewide. Structuring the process in this manner will ensure stability, help avoid mistakes that have been made in other states, and ensure that participants have a safety net and a choice in every region.

The rollout should have pilot projects so that various proposed structures and models of care delivery can be tested and consumers can have more options. Self-direction can be piloted to include primary, acute, and behavioral services, if the participant so chooses. DHS should consider using a pilot region to demo self-direction of acute and primary care, and using a special request for proposals to solicit IHAs for the pilot regions and models.

Because it is the only current system that integrates Medicare, Medicaid, and long term care services, the current Partnership model should be expanded to all counties as part of the services offered by the IHA, the current MCOs, or as a standalone option. The Partnership model can serve as a bridge or an available option during the implementation phase.

Use Steps to Ensure a Smooth Rollout

After receiving the program waiver and before implementing the new system, DHS should complete the following steps to ensure a smooth rollout of the new system:

1. **Identify possible regions and IHAs.** These two are linked together because the readiness review of any organization wishing to become an IHA is tied to their ability to pass the readiness review to serve a given region. Readiness reviews evaluate the capacity of the organization to perform services. Passing a readiness review allows the organization to be considered for a contract to become an IHA. An independent provider assessment should be required by DHS before IHA regions are drawn or the IHA request for proposals goes out. DHS should develop a plan to build capacity in under-served areas based on findings from the independent assessment.
2. **Identify potential pilot projects or pilot regions for staggered rollout.** In creating regions for managed long term care, DHS should consider:
   - Existing regional structures for primary and acute care;
   - Existing regional structures for behavioral health; and
   - The number of counties included in the region with which the IHA would have to subcontract and the number of providers in the region. Regions should be small enough that it is feasible to monitor care quality and manage the number of agreements in the region.
3. **Identify the regional safety net.** For every region identified to have one or more IHAs that have passed a readiness review, DHS must determine the nature of the safety net in case of IHA failure.

4. **Solicit interested parties and create contracts.** Responses to the request for proposals must be evaluated against both the quality standards in the contract and the readiness standards. Failure to meet either quality or readiness standards should eliminate the organization from contract consideration. The contract must include enforceable quality standards and data reporting requirements, as reflected in Appendix B. Failure to agree to the standards will eliminate an organization from contract consideration.
5. **Select IHAs for pilot.** DHS will choose from among the available options that meet the readiness standards and create a three-to-five-year implementation plan, which includes regular evaluations of new programs, the successes of the pilots, and the strength of the safety net programs.

13. Sustain an Ongoing Dialogue

Create an open culture of ongoing dialogue in Wisconsin's long term care system, so that all the stakeholders have an opportunity at any time to give feedback to DHS and the Legislature, and to suggest new ideas to improve quality and cost-effectiveness.

No one knows the strengths and weaknesses of the long term care system better than the people who use the programs. DHS must build the new long term care system in collaboration with long term care program participants, their family members and caregivers, providers, advocates, managed care organizations, community-based organizations involved in providing long term care services, counties, and other long term care stakeholders. This collaboration must take place at the beginning of any redesign process and provide ongoing opportunities for stakeholder input.

To comply with CMS guidance [v], Wisconsin must establish a formal long term care redesign advisory committee, comprised of the long term care stakeholders described above. Advisory committee members should come from a variety of racial, ethnic, and socio-economic backgrounds.

Once the advisory committee is established, DHS must consult with the committee about key decisions that will impact the provision of long term care services. When making programmatic changes, DHS should be required to show how stakeholder input is incorporated into the changes. If stakeholder input is not incorporated, DHS must provide an explanation of why stakeholder recommendations were not used.

DHS should work with the advisory committee to develop a communications plan to notify participants how and when programs may change before any planning takes place, and clearly state how participants can provide feedback on changes before they are made. In accordance with CMS guidance, DHS should work with the advisory committee to develop stakeholder education and outreach plans as part of the waiver development process.[vi]

After the long term care redesign is implemented, DHS should continue to consult the stakeholder advisory committee, using the current IRIS Advisory Committee as a model.

Committee members must include a cross-section of long term care redesign participants, health care advocacy organizations, disability and aging advocates, and Aging and Disability Resource Center representatives. Moreover, DHS must ensure that people with developmental disabilities, physical disabilities, and frail elderly from a variety of socio-economic, spiritual, racial, and ethnic backgrounds are represented on the committee. The Committee shall provide input, guidance, and community feedback to DHS and develop continued improvements to the redesigned long term care program.

The Committee shall advise DHS on matters that directly concern the redesigned long term care program. The specific purposes of the Committee should include advice on the following:

- Program operations, areas for improvement, and timely input on program processes and procedures;
- Community acceptance and understanding of the redesigned long term care programs from a community perspective;
- Approaches to help participants to have the most efficient and effective plans to meet their long term care outcomes and overcome barriers;
- Participants' perspectives of the quality of services and supports received and advice on possible redesigned long term care program changes to improve quality;
- Preservation and maximization of self-determination principles within the redesigned long term care programs;
- The sustainability and cost-effectiveness of the program; and
- Relevant topics that may affect participants in the redesigned long term care programs.

In addition, DHS must require IHAs to include a diverse representation of long term care stakeholders on their governing boards. Current MCO-DHS contracts state "at least one-fourth of the members of the board of a managed care organization shall be representative of the target group or groups whom the managed care organization is contracted to serve or those participants' family members, guardians, or other advocates." These requirements should continue, and IHAs must be required to hold meetings of their governing boards in local and accessible locations.

Conclusion

The Stakeholders' Blueprint for Long Term Care Redesign represents the best ideas from Wisconsin stakeholders at this time. We hope it will stimulate an important dialogue around the future of long term care in our state. But there are many innovative consumers, families, providers, advocates, and others who will continue to generate new ideas between now and when DHS submits its plan to the Joint Committee on Finance, while DHS is developing its waiver proposal for CMS, during the implementation phase of the new system, and beyond that time.

Many other states are redesigning their long term care and related systems, and Wisconsin should also be receptive to the best ideas that are being tried elsewhere. However, the new long term care system the Legislature and the Department of Health Services ultimately creates should be uniquely Wisconsin. There is no one-size-fits-all model for managed long term care. The Legislature, DHS, and long term care stakeholders must jointly determine the values and goals of Wisconsin's long term care system and build the new program around those objectives.

We urge DHS and the Legislature to create an ongoing open and transparent culture of dialogue and encouragement of new ideas as a permanent feature of Wisconsin's long term care system. This was the hallmark of the public process that led to the creation of Family Care, Partnership, and IRIS, and one of the main reasons that Wisconsin currently has a long term care system that many other states have tried to emulate. We believe this is the only way to create a lasting self-improvement engine within the long term care system that will lead to continuing self-examination and innovation.

Methodology

This Blueprint is the work product of the Wisconsin Long-Term Care Coalition. The Coalition solicited interest from members in participating in a group process to respond to the changes in the long term care system set forth in Act 55. Many groups and individuals responded, including representatives from aging and disability advocacy organizations, ADRCs, managed care organizations, IRIS support organizations, the long term care workforce, county departments, providers, and many individuals who are part of or who work with the long term care system. Sixty-five of those who responded agreed to serve on the following eight work groups: Core Values, Building on Existing Strengths, Self-Direction, Fiscal Sustainability, Quality, Participants' Rights, Integration Model, and ADRCs. These work groups drafted suggestions for the long term care system redesign that were referred to the group as a whole for discussion and refinement. After three summit meetings, the larger group reached consensus on the values, principles, and suggestions included in the Blueprint. A Writing Committee combined the work of all the groups into a single document that was reviewed and approved by the group as a whole.

Appendix A: Recommendations for Defining Service Regions

- Regional boundaries should not be established solely by population or by arbitrarily defined, equally-sized districts.
- Regional boundaries should consider differing cultures, races, economic and social circumstances, geographies, preferences, and perspectives.
- Regional boundaries should be established in a way that reduces the number of transitions necessary for participants (such as changes in IHAs or providers, etc.).
- IHAs should serve the entirety of the regions they contract within, not just select ZIP codes or areas of population density.
- Regional boundary delineation should consider the distribution of acute, primary, and long term care providers to ensure access to high-quality services within reasonable times and distances.
- Acute and primary services are generally provided by a few large regional providers; long term care supports are generally provided by many small local providers. This difference should be accounted for in the long term care redesign.
- There should be a strong focus on substance abuse, mental and behavioral health needs, and complex medical supports.
- Regional boundaries should be established in ways to leverage local knowledge of resources, connections to communities, existing service systems, and informal supports.
- The new system needs to continue to leverage the local knowledge, presence, and accountability that existing MCOs have built in the counties in which they provide supports.
- Establishment of regional boundaries should focus attention on the opportunity to grow local small businesses and the impact they have on local economies.
- Long term care supports should be a primary focus of model development; acute and primary care should not drive the model.
- Regional boundaries should be created in consideration of existing regional structures for primary and acute care and existing regional structures for behavioral health.
- The number of counties included in the region with which the IHA would have to subcontract and the number of providers in the region should be considered. Regions should be small enough that it is feasible to monitor the quality of care and manage the number of agreements in the region.

Appendix B: Quality Standards for Program Design and Contracts

Elements that should be included in IHA contracts to ensure a robust, high-quality provider network include:

Care and Benefits

- Require new plans to honor current service levels.
- Include penalty clauses in contract language for IHAs that abruptly leave the program.
- Incorporate quality standards.
- Create data collection and transparency requirements.
- Ensure continuity of care so that program participants have a right to maintain existing quality providers for up to 18 months after enrollment with an IHA. DHS must have a plan to ensure continuity of care with no interruptions if an IHA abruptly leaves the program.
- Clearly articulate circumstances under which IHA will be required to pay for out-of-network providers.
- Provide a technical assistance process to providers for understanding managed care contracting and billing.
- Include a process for ensuring the most integrated setting is preserved.
- Use pay-for-performance incentives to encourage IHAs and providers to support people in the most integrated setting.
- Collect data on time and distance standards.
- Preserve the "any willing provider" rule so that it would continue after the three year minimum indefinitely unless these conditions are met:
  - The provider agrees to be reimbursed at the IHA's contract rate negotiated with similar providers for the same care, services, and supplies.
  - The provider agrees to quality of care standards, utilization, and other criteria applicable to facilities or organizations under contract for the same care, services, and supplies by the IHA.
  - If the IHA declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.
  - In establishing provider and management subcontracts, the IHA shall seek to maximize the use of available resources and to control costs.
  - Maintain continuity of care with access to specialists who consumers identify as best qualified to meet their needs.

Rates

- Set adequate rates for participants' episodic and extraordinary needs.
- Have a standardized and transparent rate-setting process with incentives for quality (withhold final 5% payment until delivery and quality have been assured).
- Ensure provider access to rate appeal process.
- Ensure no provider rate reductions for first 18 months after go-live date of managed care implementation.
- Pay interest on late payments to providers.
- The program's rate structure should provide adequate flexibility to serve participants with a higher level of need, including those with ongoing mental health and/or substance use needs and those with complex needs who require behavioral supports.

Quality Assurance

- IHAs must set performance benchmarks for providers with an option to terminate for low or non-performance.
- Require measurement from IHAs for preventing restrictive settings.
- Develop specifically articulated remedies for provider network inadequacy.
- Include penalty clauses in contract language for IHAs that abruptly leave the program.
- Develop a three-year prohibition on re-entry for IHAs after abruptly leaving the program.
- Prohibit IHAs with CMS sanctions from operating in Wisconsin.
- Loss ratios should be high enough that the profit is no greater than the administrative costs allowable under the current system.
- Include incentives for quality (e.g., withholding final 5% based on performance).
- IHAs must explain how excess savings beyond 3% overall profit will be re-invested into programming.
- All IHA savings beyond 3% profit must be re-invested in direct supports.

Required Reporting by IHAs

- Require IHAs to report:
  - Number of people self-directing all services.
  - Number of people self-directing some services.
  - Key health indicators (diabetes control, obesity, cardiovascular disease) by mental health status (e.g., those with and without identified mental health needs). IHAs must address discrepancies in outcomes.
  - Use of emergency services and inpatient hospitalization for psychiatric conditions.
  - Comparison of congregate living between those with and without mental health disorders. IHAs should be required to address any disparities.
  - Employment pre-vocational service and day systems data.
  - Integrated employment data.
  - Residential systems data.
  - Suicides among long term care participants with mental health diagnoses.
  - Community integrated employment data and outcomes.

Community Integrated Employment Support

- Service definitions in an outcome-based reimbursement approach that will provide accountability as well as monetary incentives for completed steps on the path to community employment.
- Services are exclusively focused on obtaining and/or maintaining a competitive or customized job, or self-employment, in an integrated community setting for which the participant is compensated at or above minimum wage.
- Employment support includes an introduction to benefits planning and the variety of work incentives available to participants receiving SSI, SSDI, Medicaid, and/or Medicare.
- 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.
- Require a pay-for-performance billing strategy for supported employment services, [vii] currently implemented by one Wisconsin MCO, for all Family Care IHAs.
- Require integrated employment outcomes, performance metrics for employment services, specific data collection and reporting requirements, and tie employment outcomes to performance incentives.
- Require IHAs to implement policies that place employment as the central element around which to build a person-centered plan of supports and services, with the expectation that a person's week will include some hours of community-integrated employment and wrapping supports will be integrated into the person's week around their community involvement. Policies should also 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.
- Require IHAs to post community integrated employment outcomes data on a publically accessible, searchable website such that long term care participants can compare individual employment providers and IHAs when deciding which option to choose.
- Require IHAs to prioritize community employment services and supports for participants 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. [viii]

Transportation Requirements

- IHAs must ensure that participants can get a ride for activities on the following day by the most integrated service appropriate to their needs (transit, paratransit, taxi, or specialized vehicle) including on nights, holidays, and weekends.
- The IHA ensures that pick-up performance with respect to certainty and timeliness is comparable to bus or taxi service in the community, if any, when a ride is scheduled. If no public (fixed route or demand responsive) transit is available in the community, performance should be comparable to NEMT service. This standard would not apply when no advance scheduling is necessary.

Behavioral Health and Substance Use Treatment Requirements

Care Requirements:

- For participants who elect full self-direction, the requirement to go through the full IHA interdisciplinary team should be waived so participants can directly access mental health services.
- IHAs should be required to provide alternatives to guardianship such as supported decision-making to ensure that participants maintain autonomy and choice in making decisions about their lives and care plans.
- Decisions regarding medical necessity for mental health and substance use services should be guided by client choice and the recommendation of the mental health professional and/or substance use professional on the participants' team.
- DHS must ensure care planning for all Family Care-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.
- IHAs should provide and actively encourage participants' plans to include independent living services that promote independence and limit use of rep payees to where this level of oversight is clearly justified.
- DHS should work with ADRCs, IHAs, and advocates to create a strategy and action plan to prioritize community relocations for people with mental illnesses residing in institutions 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.

Stakeholder Requirements:

- IHAs should be required to include behavioral health consumers and providers in their governing boards.
- Each IHA should have a behavioral health liaison and should closely coordinate with county human services to provide care for participants who could be served by either or both systems.

Access Requirements:

- IHAs should have qualified mental health professionals who are available to meet regularly with teams and are available to offer consultation if a participant so requests or consents.
- Participants should have access to a full range of substance use disorder treatment services available on a continuum including: 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).
- IHAs must develop adequate networks of behavioral health providers throughout the state, including staff with the needed competencies defined in this document, as well as other specific behavioral health specialty areas such as cognitive behavioral therapy. IHAs should be required to provide access to these specialties or therapies, regardless of whether a specific provider is in the network.
- Behavioral health services should be available within 30 minutes or 15 miles of the residences or workplaces of 90% of participants, or within 60 minutes or 30 miles of the residences or workplaces of 90% of participants in a region designated by the DHS as rural.
- Participants should have the choice of continuing to be served by their current psychiatrists, therapists, or other behavioral health service provider with whom they have a long-standing relationship, and IHAs should be required to provide a Provider Specialty Exemption which would allow participants to go out of network to access psychiatrists or therapists.
- Participants should have access to specific behavioral health specialists and services, including:
  - Specialty areas such as cognitive behavioral therapy.
  - Certified Peer Specialists (CPSs) and Recovery Coaches. Participants should have the choice to have their Peer Specialist or Recovery Coach participate as a participant of the interdisciplinary team. Employers of CPSs and Recovery Coaches should be required to undergo training to help them

understand how to best utilize these providers within the scope of their practice.
  - Self-referral to Peer Run Respites for participants in long term care who experience emotional distress, a non-medical, short-term residential crisis alternative open and free to any adult in Wisconsin regardless of Medicaid eligibility.
- IHAs should offer coverage for Individual Placement and Support (IPS) Supported Employment programs, which help people with mental illnesses find competitive employment that fits their preferences and provide ongoing workplace support.

Crisis Services Requirements:

- IHAs must establish protocols with counties on how and when participant involved/centered Crisis Plans shall be developed, reviewed, and updated for participants with mental health and/or substance use disorder needs.
- Each IHA must assure access to community-based crisis and institutional diversion services, including crisis resource centers and mobile crisis team.
- 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 a developmental disability and complex needs, including dementia-informed mobile crisis.
- IHAs must have financial responsibility for hospitalization and institutional care to minimize institutional care and ensure engagement in discharge planning when a participant is hospitalized or in a care institution.
- 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 that will reduce the need for crisis services.

Support for Direct Care Providers:

- Education and training of IHA staff, as well as direct care staff, on best practices for successfully supporting community life for people with challenging behaviors.
- Care teams need regular access to mental health professionals (as needed) so they can carefully consider how to respond appropriately to and adequately support the mental health and behavioral needs of participants they are serving. If these resources are not available internally, teams need a community resource to access them.
- Development of community consultation teams, which can be a resource to IHAs, as well as frontline staff who provide ongoing support to participants 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.
- A requirement for continued outreach to support relocation of individuals with complex needs from institutional to community-based settings, and financial incentives to encourage deinstitution-alization.
- Develop capacity for comprehensive community crisis response. This should include access to a Community Consultation Team with expertise in crisis intervention, as well as development of effective individualized crisis response plans. It will also be important to clearly define the role of county mental health staff and crisis response teams and jointly fund these services. In some areas, there may be a need to develop regional mobile crisis teams.

Appendix C: IHA Readiness Standards

- Network adequacy including the ability to pay contracted providers within a reasonable amount of time as well as an adequate provider network of acute, primary, behavioral and long term care providers.
- A proven track record of high performance and/or the ability to provide high-quality care coordination services. Organizations with CMS sanctions from other states should not be granted contracts.
- The ability to offer participant-directed long term services and supports (LTSS) including, but not limited to, counseling and financial management services.
- Demonstrated financial stability in the plan and adequate protections against insolvency.
- The ability to generate required data and reports for governmental entities and public reporting.
- Providing budgetary and employment authority for self-directed care.
- Adequate capacity to respond to participant grievances and appeals.
- 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.
- Plans and providers demonstrating that they offer person- and family-focused care and honor the participant's preferences and values by supporting the desire of the participant or their representative to self-direct, and by recognizing and supporting the family caregiver's willingness and capacity to provide care.
- Ensuring that services are offered in a culturally and linguistically competent manner.
- Having a built-in quality assurance and improvement plan that includes participants and community-based relationships or provider relationships, with a preference for local presence.
- Providing prevocational and vocational employment plans, along with measurement for continued stakeholder and participant involvement in plan design and implementation.
- Demonstrating the capacity to work with the disability community, specifically with adults with physical disabilities, adults with developmental disabilities, and with youth in transition.
- Demonstrating the capacity to work with individuals with dementia and as a Dementia Capable organization.
- Demonstrating knowledge of and capacity to work with local county human service systems such as corporation counsel, adult protective services, crisis, aging units, and public health departments.
- Experience with assistive technology and home modifications.
- Experience addressing known health disparities in specific populations (people with developmental disabilities, people with physical disabilities, older adults, people of different cultural backgrounds, etc.).

Endnotes

[i] From the CMS Guidance to States bulletin on long term care: "States, contractors and/or MCOs must measure key experience and quality of life indicators for managed long term services and supports (MLTSS) participants. The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g., phone or in-person as opposed to mail). Results of the surveys must be maintained by the state and CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results for the state. The state must analyze the results, make them available to its stakeholder advisory groups for discussion, publicly post the results on its website, and provide the results in print upon request for individuals without access to a computer...Personal level encounter data is critical." (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf)

[ii] www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf

[iii] Wisconsin Legislative Fiscal Bureau Budget Paper #356, Long Term Care Changes, May 27, 2015.

[iv] "Budget authority" means decision-making authority over how the Medicaid funding in your individual budget is spent. "Employer authority" means decision-making authority over who provides your services and how the services are provided.

[v] In a recent publication entitled "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Care Services and Supports Programs" CMS says that they "expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contracts to do the same." As part of this process, CMS requires states to establish a formal long term care stakeholder advisory council.

[vi] CMS requires states to develop stakeholder "education and outreach plans" as part of the waiver development process. CMS provides the following guidance: "These education and outreach plans must include information about how individuals may provide input as part of the state's stakeholder engagement strategy."

[vii] 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 long term care participant, encourages finding a good job match that minimizes the need for support, and rewards reducing job coaching over time because the agency is still paid for the hours a person works regardless of services delivered.

[viii] 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.

About the Wisconsin Long-Term Care Coalition

The Wisconsin Long-Term Care Coalition is made up of aging and disability advocates, managed care organizations, Aging and Disability Resource Centers, county government, and long term care providers.