



Legislative Fiscal Bureau

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May 26, 2016

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Family Care/IRIS 2.0 Concept Paper

On April 1, 2016, the Department of Health Services (DHS) submitted to the Joint Committee on Finance a Family Care/IRIS 2.0 Concept Paper summarizing the Department's proposed changes to the Family Care and IRIS (Include, Respect, I Self-Direct) programs, as required under provisions enacted in 2015 Wisconsin Act 55 (the 2015-17 biennial budget act).

The Department seeks the Committee's approval of the Concept Paper. With the Committee's approval, DHS would be authorized to develop and submit to the federal Centers for Medicare and Medicaid Services (CMS) proposed revisions to the federal medical assistance (MA, or Medicaid) waiver agreements under which Family Care and IRIS operate. Act 55 lists required features of the waiver amendments, and authorizes DHS to administer the revised programs in accordance with the amended waiver agreements, notwithstanding current statutes and rules relating to these programs, if the revised waiver agreements are "substantially similar" to the requested amendments and the Concept Plan approved by the Committee. Act 55 prohibits DHS from submitting any proposed changes to the program unless the Committee approves the Department's Concept Paper.

BACKGROUND

Dual Eligibles and Medicaid-Funded Long-Term Care Programs

DHS offers Medicaid-funded long-term care services through several home and community-based programs, including Family Care, IRIS, Family Care Partnership, and PACE (Program of All-inclusive Care for the Elderly). Most individuals that participate in these programs are enrolled in both Medicaid and Medicare. For these individuals ("dual eligibles"), Medicare provides coverage for most primary and acute care services (including physician, inpatient and outpatient hospital services, and prescription drugs) and certain behavioral health (mental health and substance abuse) services. Medicaid-eligible services not covered by

Medicare, such as long-term care services and certain primary, acute and behavioral health services and cost-sharing required of Medicare enrollees, are funded by the state's Medicaid program. Dual eligibles may receive Medicare-funded services on a fee-for-service basis, through managed care organizations (MCOs) that offer Medicare Part C (Medicare Advantage) plans, and MCOs that offer the Family Care Partnership and PACE programs.

A brief summary of the state's Medicaid funded long-term care programs addressed in the Concept Paper is presented below.

Family Care. Family Care is a managed care program that provides long-term care services to qualifying low-income individuals who are elderly, physically disabled, or developmentally disabled. DHS pays each participating MCO monthly capitation payments to provide services to enrollees who reside in the geographic service regions (GSRs) served by the MCO. Capitation payments are funded from state general purpose revenue (GPR), county contributions, and federal MA matching funds. MCOs are not required to be licensed health maintenance organizations.

DHS contracts with an actuary (currently, Milliman, Inc.) to assist in the development of capitation rates, based on actual encounter data from a recent year, with adjustments to reflect projected changes in provider payment levels, service utilization, member acuity, and differences in regional labor costs. The capitation rates must be "actuarially sound" to comply with federal Medicaid requirements.

To qualify for Family Care and IRIS, individuals must meet financial and functional eligibility standards. Enrollees must meet the income and asset limits applicable to elderly, blind, and disabled (EBD) Medicaid recipients that qualify for long-term care services, which vary depending on the individual's circumstances, as the state's spousal impoverishment protections and required member contributions toward the cost of care apply to these programs. Further, individuals who have divested themselves of financial resources within five years before applying for Family Care may not receive Family Care benefits during any divestment penalty period. DHS pursues recovery of MA expenditures for long-term care services from the estates of members ages 55 or older who were enrolled in a MA-funded long-term care program, and from the estates of members of any age who resided in an institution. DHS recovers the full Medicaid capitation payment for individuals previously enrolled in the PACE and Family Care Partnership programs.

An individual meets the functional eligibility criteria if the person's functional capacity requires a nursing home level of care, which is defined as a long-term or irreversible condition expected to last at least 90 days or result in death within one year of the date of application that requires ongoing care, assistance, or supervision, or the person's functional capacity is at the non-nursing home level, which is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others. To determine functional eligibility, applicants must submit to a functional screen conducted by aging and disability resource centers (ADRCs). These screens assess an individual's ability to complete activities of daily living and instrumental activities of daily living. Experienced professionals, usually social workers or registered nurses who have taken an on-line training course and passed a

certification examination, administer the screen.

Attachment 1 lists the range of services that MCOs may provide to enrollees, as identified in the 2016 state contract with the MCOs. The contract provides detailed explanations of these services, including service limitations. These services include both specialized long-term care services that are only available to individuals who participate in the Medicaid long-term care waiver programs ("waiver services") and certain services available to all MA recipients under the state's MA plan ("state plan services"). The MCOs may contract with providers or provide the services directly to Family Care members.

The services each enrollee receives are based on the initial development and updates of the enrollee's member-centered plan (MCP). MCOs must ensure that the member, the member's authorized representative and any other persons identified by the member are included in the care management processes of assessment, member outcomes identification, MCP development, and reassessment. Each enrollee is assigned an interdisciplinary team (IDT) that must include the member, other people specified by the member, and IDT staff that includes a social service coordinator and a registered nurse.

Under the current Family Care MCO contracts, IDT staff must routinely reassess and, as appropriate, update all of the sections in the member's comprehensive assessment and MCP as the member's long-term care outcomes change. At a minimum, the reassessment and MCP review must take place by the end of the sixth month after the month in which the previous comprehensive assessment was completed. The entire IDT must participate in an annual reassessment. At a minimum, IDT staff must conduct a face-to-face meeting with the member during each quarter of the calendar year, although this requirement may be waived if certain conditions are met.

Individuals enrolled in Family Care MCOs have the option to self-direct all their long-term care services, except residential care and care management, if they are identified by the IDT as consistent with the member's outcomes. A detailed discussion of the current self-direction option in Family Care is presented later in this paper.

The program is currently offered in 64 of the state's 72 counties. Under 2015 Wisconsin Act 127, the program will be expanded to Rock County by July 1, 2016. Following this expansion, the program will be available in all counties other than Adams, Dane, Florence, Forest, Oneida, Taylor, and Vilas Counties.

Seven MCOs currently offer Family Care services in 12 GSRs: (a) Care Wisconsin; (b) Community Care, Inc.; (c) Community Care Connections of Wisconsin; (d) ContinuUs; (e) Lakeland Care District; (f) My Choice Family Care; and (g) Western Wisconsin Cares. The Office of Commissioner of Insurance monitors the financial condition of Family Care MCOs to ensure that they meet financial solvency requirements established by rule (INS 57). Attachment 2 shows the twelve current regions served by each MCO.

As of March 1, 2016, there were 42,451 individuals enrolled in Family Care, including 17,831 individuals with developmental or intellectual disabilities, 13,098 individuals with physical

disabilities, and 11,522 frail elders. Of these individuals, 18,832 were age 65 or older.

IRIS. The IRIS program provides a self-directed alternative to Family Care. Individuals enrolled in IRIS are not enrolled in Family Care MCOs. Instead, they are informed of their "monthly budget estimate" during enrollment counseling, which is based on their assessed care needs, as determined by the functional screen. If, after receiving the monthly budget estimate, an individual chooses to enroll in IRIS, an IRIS consultant agency (ICA) assists the enrollee in developing a service plan, with IRIS members determining who will provide services specified under the care plan and the amount they will pay to service providers. The ICA approves the support and service plan. Individuals have access to a wide range of services, including a service option called "customized goods and services," which is intended to provide flexibility in designing service plans to permit these plans to include services not explicitly included under other defined service categories, but are directly related to the enrollee's goals and needs and meet other criteria. Individuals may apply to DHS for adjustments to their budget if they are not able to develop a cost effective support and service plan within the initial budget estimate. IRIS budgets are reviewed at least once per year.

An individual eligible to receive personal care services may choose whether to self-direct these services or use their Medicaid card to access personal care services through an agency. If an individual chooses to self-direct their personal care services, a personal care screening tool is used to develop a budget exclusively for those services, in addition to the IRIS budget.

An individual may select all of their long-term care services and supports, and may select their own workers, such as family, friends and neighbors who meet qualification requirements, including passing background checks and attending any required training.

There are currently two ICAs -- The Management Group, which serves IRIS enrollees in all counties, and Connections (operated by Lutheran Social Services), which offers services to IRIS enrollees in nine counties in eastern Wisconsin. A fiscal employer agent (FEA), iLIFE, assists all IRIS enrollees in carrying out the financial aspects of the plan, such as payroll for self-directed service providers. IRIS is available in all counties served by Family Care MCOs.

As of March 1, 2016, there were 13,080 individuals enrolled in the IRIS program, including 6,482 individuals with physical disabilities, 5,004 individuals with developmental or intellectual disabilities, and 1,594 frail elders.

PACE and Family Care Partnership. Under PACE and the Family Care Partnership Program, MA recipients may receive both long-term care services and acute care services (including services covered by Medicare) from an MCO that is licensed as an HMO. Under these programs, Wisconsin currently provides integration of long-term care and acute care services, including outpatient prescription drugs, through managed care entities. DHS makes capitation payments to participating MCOs to pay for enrollees' Medicaid-supported services, and CMS makes capitation payments to MCOs to fund enrollees' Medicare-funded services.

PACE serves elderly individuals who regularly attend a day health center operated by the

PACE MCO. Enrollees' primary care physicians are staff members of, or under contract with, the PACE organization. In contrast, the Family Care Partnership MCOs offer services to both elderly individuals and adults of any age with disabilities that require long-term care services. Individuals enrolled in Family Care Partnership may retain their own primary care physician if the physician is part of the MCO's network, and are not required to regularly attend a day health center.

Under both programs, individuals are limited to a network of providers from which they may obtain their primary and acute care services. Individuals enrolled in both programs receive assistance in developing service plans from interdisciplinary teams, which include health professionals, and other professionals, family members and others chosen by the member. Individuals enrolled in PACE and the Family Care Partnership program may self-direct certain care services and employ family members, friends, neighbors, provider agencies, and community volunteer organizations to meet their long-term care needs.

Care Wisconsin, Inc. offers the PACE program in two counties. Three MCOs offer services under the Family Care Partnership program -- Care Wisconsin Health Plan, Community Care Health Plan-Partnership and Independent Care (I-Care) in a total of 14 counties. Attachment 3 shows the counties where PACE and Family Care Partnership services are currently available.

As of March 1, 2016, there were 640 individuals enrolled in the PACE program, including 356 frail elders, 235 individuals with physical disabilities, and 49 individuals with developmental or intellectual disabilities. As of that date, there were 2,963 individuals enrolled in the Family Care Partnership programs, including 1,686 individuals with physical disabilities, 761 frail elders, and 516 individuals with developmental or intellectual disabilities.

Legacy Waiver Programs. Qualifying individuals in the eight counties where Family Care and IRIS services are not currently offered may receive MA-funded long-term care waiver services through the legacy home and community-based waiver programs, including the GPR-funded (non-waiver) community options program, the MA-funded community options waiver program, and the community integration programs. The legacy waiver programs are supported from a combination of GPR, county funding, and federal MA matching funds. Counties may limit enrollment in legacy waiver programs to ensure that program costs do not exceed annual sum certain funding allocations they receive from DHS. For this reason, counties that administer these programs manage waitlists for legacy waiver services.

Approximately 3,600 individuals were enrolled in the legacy waiver programs as of December, 2015 and approximately 1,500 individuals were on waitlists to receive services.

Program Budgeting. Funding for services provided to individuals enrolled in Family Care, IRIS, Family Care Partnership, PACE, and the legacy waiver programs is provided as part of the total state Medicaid budget. The amounts budgeted for these programs reflect estimates of the amount of funding needed to support capitation payments, waiver services and county contracts, based on caseload projections, utilization trends, policy changes, and other factors.

Table 1 identifies the amounts budgeted in Act 55 for the Medicaid-funded long-term care

programs that are referenced in this paper. Several points should be made regarding the table. First, the GPR funding shown for Family Care capitation payments is offset by estimated county contributions totaling approximately \$43.1 million in 2015-16 and \$42.7 million in 2016-17. Second, the amounts in the table do not include federal Medicaid matching funds for county-funded waiver slots under the legacy waiver programs, and state plan services not funded by capitation payments. As such, the table does not reflect the full costs of providing MA-funded long-term care services, nor does it include estimates of funding for state plan services provided on a fee-for-service basis, including nursing home care, personal care, home health, and private duty nursing services.

TABLE 1

**Act 55 Amounts Budgeted for Selected Medicaid-Funded Long-Term Care Programs
(Capitation Payments and Waiver Services Only)**

(\$ in Millions)

<u>Program</u>	<u>2015-16</u>			<u>2016-17</u>		
	<u>GPR</u>	<u>FED</u>	<u>Total</u>	<u>GPR</u>	<u>FED</u>	<u>Total</u>
Family Care	\$599.4	\$836.0	\$1,435.4	\$633.6	\$880.7	\$1,514.3
MCO Supplements	3.4	4.7	8.1	3.4	4.8	8.2
IRIS	168.1	234.4	402.4	187.6	253.9	441.5
Partnership and PACE	63.1	88.0	151.1	68.0	94.5	162.5
Legacy Waiver Programs	<u>30.4</u>	<u>54.0</u>	<u>84.4</u>	<u>29.7</u>	<u>53.1</u>	<u>82.8</u>
Total	\$864.4	\$1,217.1	\$2,081.5	\$922.3	\$1,287.0	\$2,209.3

Table 2 shows the current percentage of individuals in the state's MA-funded long-term care programs who are dually eligible for Medicare and Medicaid.

TABLE 2

**Current Percentages of Medicaid-Only and
Dually Eligible Members, By Program**

<u>Program</u>	<u>MA-Only</u>	<u>Dual Eligibles</u>
Family Care	17%	83%
IRIS	38	62
Family Care Partnership/PACE	19	81

ACT 55 PROVISIONS RELATING TO LONG-TERM CARE PROGRAMS

Provisions in 2015 Wisconsin Act 55 directed DHS to make several changes to the state's long-term care programs.

Statewide Expansion of Family Care and IRIS. Under Act 55, DHS is required to request approval from the U.S. Department of Health and Human Services (HHS) to administer the Family Care program in every county in the state. If HHS does not disapprove the request, DHS must ensure that the Family Care program is available to eligible residents of every county in the state by January 1, 2017, or a date specified by DHS, whichever is later. If HHS does not disapprove its request, DHS is not required to seek additional approval from the Joint Committee on Finance to offer the program in the remaining counties under the current statutory approval process.

Concept Plan and Waiver Request. In addition to the statewide expansion of Family Care and IRIS, Act 55 establishes a process for DHS to seek changes to the waivers under which the Family Care and IRIS programs operate. The Act requires DHS to include the following components in its waiver request:

- a. providing primary, acute, and long-term care services through integrated health agencies (IHAs) to Medicaid-funded long-term care consumers and including, to the extent allowable by HHS, long-term care consumers who are eligible for both Medicaid and Medicare;
- b. increasing the size of regions currently served by the Family Care managed care organizations so that each region has sufficient population to allow for adequate risk management by IHAs;
- c. specifying that each of the regions be served by multiple IHAs;
- d. requiring IHAs to make available a consumer-directed option, in which IHAs would assist individuals in developing individualized support and service plans, ensure that all services are paid according to the plan, and assist enrollees in managing all fiscal requirements, including the ability to select, direct and employ persons offering any of the services currently available under IRIS, and the ability to manage, using the services of the IHA serving as a fiscal intermediary, an individual home and community-based budget allowance based on a functional assessment performed by a qualified entity and the availability of family and other caregivers who can provide needed support;
- e. modifying the state's long-term care programs, including allowing for audits of providers, to improve accountability in the provision of services;
- f. establishing an open enrollment period for the state's long-term care program; and
- g. preserving, for a minimum of three years in each region after the date of implementation of the waiver in that region, the requirement that an IHA contract for long-term care services with any long-term care provider that agrees to accept the reimbursement rate that the

IHA pays to similar providers for the same services and satisfies any quality of care, utilization, or other criteria that the IHA requires of other providers with which it contracts to provide the same long-term care services.

Consultation with Stakeholders, Public Hearings and Status Reports. The Act requires DHS, in developing its waiver or state plan amendment, to consult with stakeholders, submit as a part of its quarterly Medicaid reports to the Joint Committee on Finance, reports regarding its progress in developing the waiver, hold public hearings, and develop the waiver in accordance with the principles determined by CMS to be essential elements of managed long-term services and support programs.

Joint Committee on Finance Action on Concept Plan. Under the Act, before DHS submits any waiver application proposing such changes to HHS, the Department must submit a summary of the concept plan for the waiver amendment to the Committee no later than April 1, 2016, for the Committee's approval or disapproval. Act 55 prohibits the Committee from modifying the summary of the proposed concept plan, specifies that the procedures under s. 13.10 of the statutes do not apply to the Committee's action on the plan, and prohibits DHS from submitting any proposed changes to the waiver or a state plan amendment to HHS unless the concept plan is approved by the Committee.

If the Committee approves the plan, DHS is required to submit a waiver request to HHS for approval. If HHS approves the changes to the waiver and the waiver is substantially similar to the concept plan approved by the Committee, DHS may implement any changes to the Family Care and IRIS programs in accordance with the waiver agreement, notwithstanding the current statutory provisions relating to these programs. No further action would be required by the Committee. DHS would be required to include in its 2017-19 biennial budget request any proposed statutory changes necessary to conform the statutes to the approved waiver. Act 55 does not specify a date by which DHS must implement the changes to the program specified in the waiver request.

Funding Reduction to Reflect Projected Savings. Act 55 reduced funding to the state's MA-supported long-term care programs by \$6 million GPR and approximately \$8.3 million FED in 2016-17 to reflect anticipated savings associated with the proposed changes to the long-term care system. The Department of Administration (DOA) indicated that this estimate was based on the assumption that there would be approximately 1% savings to current expenditures for Family Care, PACE, Partnership, and IRIS services associated with the program changes. However, none of the proposed changes to Family Care and IRIS, if approved, are expected to occur in the 2015-17 biennium.

SUMMARY OF CONCEPT PAPER

The Department submitted a Concept Paper outlining proposed changes to the state's long-term care programs to the Committee on April 1, 2016. The Concept Paper describes: (a) the Department's efforts to solicit stakeholder input in developing the Concept Paper and how stakeholders would remain engaged in the new program following implementation; (b) the principles and concepts that guided DHS in the development of the new program; (c) program

design, including how members would self-direct long-term care services; (d) the extent to which members could choose IHAs and providers; (e) the future of the Family Care Partnership program; (f) the selection and functions of IHAs; (g) the establishment of procurement and rate setting zones; (h) network adequacy standards; (i) IHA enrollment policies; (j) the role of ADRCs; (k) payments to IHAs; (l) quality measures; (m) requirements relating to contracting with any willing and qualified providers; and (n) considerations for tribes and tribal members.

In summary, the Concept Paper describes program revisions that would consolidate MA-funded long-term care services currently available through Family Care MCOs, the IRIS program, and the legacy waiver programs with Medicaid-funded primary, acute and behavioral health services that would be provided through a new type of managed care entity, an IHA. All Medicaid recipients (both Medicaid-only recipients and dual eligibles) who are currently enrolled in Family Care MCOs and IRIS would be required to enroll in an IHA to receive MA-funded long-term care waiver services.

There would be no changes to the programs' functional and financial eligibility requirements, and no change in the scope of benefits that would be available to enrollees.

Medicaid-only recipients would be required to receive Medicaid-funded primary, acute, and behavioral health services from the IHA. Dual eligibles would receive all of their Medicaid-funded long-term care services through the IHA, while maintaining the choice to receive their Medicare-funded services on a fee-for-service basis or from a Medicare Advantage plan, including a Medicare Advantage plan offered by the individual's IHA, if one is available. DHS would maintain the Family Care Partnership program in the counties where these services are available, providing another possible option for the current Family Care and IRIS enrollees. The Concept Paper indicates that DHS might expand these programs to additional counties in the future.

Table 3 summarizes the scope of services that IHAs could offer to Medicaid recipients who qualify for long-term care services. DHS has indicated that this table reflects the Department's current understanding of the services IHAs may provide, but that the categories may be subject to change as DHS works toward implementing the proposal.

TABLE 3

Services Potentially Available through IHAs

<u>Service</u>	<u>Dual Eligibles</u>	<u>MA-Only Recipients</u>
MA-Funded Services		
Long-term care waiver services	Yes	Yes
Acute and primary care services	Only services not covered by Medicare.	Yes
Behavioral health services	Only services not covered by Medicare.	Yes
Outpatient drugs	No. Drugs not covered under a Part D plan would continue to be provided on a fee-for-service basis.	No. Drugs would continue to be provided on a fee-for-service basis.
Medicare-Funded Services		
Long-term care services	The member may choose to receive Medicare-eligible long-term care services through the IHA.*	Not eligible for service
Acute and primary care services	The member may choose to enroll in a Medicare Advantage Plan offered by the IHA.*	Not eligible for service
Behavioral health services	The member may choose to receive Medicare-eligible behavioral health services through the IHA.*	Not eligible for service
Outpatient Drugs	The member may choose to enroll in a Medicare Part D plan offered by the IHA.*	Not eligible for service

*If an IHA chooses to offer these services.

The Concept Paper indicates that there would be three zones in the state with three IHAs operating in each zone. Since one IHA could serve all three zones, DHS could contract with as few as three but as many as nine IHAs. The Department would contract with these IHAs through a competitive procurement process. DHS would reimburse IHAs on a risk-based capitated basis, and implement quality measures relating to consumer outcomes and satisfaction, and ensure IHA compliance with contract provisions.

ADRCs would continue to provide independent enrollment counseling to assist individuals in selecting an IHA. An individual who receives initial screening and enrollment counseling from an ADRC could enroll at any time (commonly referred to as "continuous open enrollment") in any of the IHAs that serve the zone where the individual resides, and could disenroll and transfer to another IHA serving the zone at any time.

Table 4 compares several features of the current long-term care programs with the program described in the Concept Paper, including some clarifications provided by DHS after the Concept Paper was submitted.

TABLE 4

Comparison of Current Law/Policy/Contracts and Concept Paper

Current Law/Policy

Family Care/IRIS 2.0

Program Phase-In and Entitlement Status

Family Care was piloted in five counties before it became available in additional counties through a series of program expansions approved by the Joint Committee on Finance and Legislature.

When the program expands to additional counties, there is a 36-month phase-in period, after which all individuals who meet the program's eligibility requirements are entitled to receive services. There is a continuous open enrollment period.

Service Regions (Zones)

There are currently seven Family Care MCOs serving 12 geographic service regions, with one to four MCOs serving each region. Family Care and IRIS services are not available in seven counties, which are not included in the current regions.

Services

Enrollees receive long-term care services through Family Care MCOs, through IRIS, PACE/Family Care Partnership, or under the counties' legacy waiver programs that are identified in care plans. All Medicaid-funded primary and acute care services are provided on a fee-for-service basis. Behavioral health services are primarily provided through county-based programs. Dual eligibles enrolled in Family Care and IRIS do not receive any Medicare funded services through the MCO or IRIS.

MA recipients who qualify for long-term care services may choose to receive only "state plan" benefits, such as nursing home care, on a fee-for-service basis -- they are not required to enroll in Family Care or IRIS.

Self-Direction

Members can self-direct some long-term care services under Family Care, or all long-term care services under IRIS. Family Care enrollees work with the MCO to self-direct certain services, while IRIS enrollees work with an external ICA and FEA to create a person-centered service plan, choose employees, and pay for services. Under IRIS, members have full budget and employer authority, receive

There would be a phased enrollment of members in IHAs and a phased approach to implementing Family Care/IRIS 2.0, one zone at a time over several months.

DHS indicates that the 36-month period before all qualifying individuals would be entitled to services would be maintained. There would be a continuous open enrollment period.

There would be three zones, which would be created by combining current Family Care regions. DHS would include a mix of urban and rural areas in each zone. Three IHAs would serve each zone. An IHA could serve more than one zone.

Medicaid-only members would receive Medicaid-funded primary care services (except outpatient prescription drugs), acute, long-term care, and behavioral health services through their IHA. Alternatively, if they choose not to receive MA waiver services, they could receive all Medicaid "state plan" benefits, such as nursing home care, on a fee-for-service basis.

Dual eligibles would receive all Medicaid-funded acute care, long-term care, and behavioral health services from an IHA, and could choose to receive Medicare-funded services from fee-for-service Medicare, or a Medicare Advantage plan (regardless of whether the IHA has a relationship with the Medicare Advantage Plan). Prescription outpatient drugs would continue to be provided through a Medicare Part D plan.

Members would be able to self-direct some or all of the current self-directed services under the IHA, but not acute, primary, or behavioral health services. IHAs would be required to fulfill the duties of the current ICA and FEA, and to contract with an external ICA and FEA for members to use if they wish. Budget amounts would be set after the IHA conducts an assessment and creates a member-

Current Law/Policy

initial service budget estimates (based on the results of the functional screen), then receive a final budget based on the services included in the member's plan of care. Members can appeal budget amounts to DHS, and may request one-time and ongoing increases in budget allocations.

Selection of MCOs/IHAs

DHS uses a competitive procurement process (request for proposals, or RFP) to contract with MCOs. DHS currently has a five-year purchasing authority for Family Care, with MCO contracts renewed annually, so that MCO contracts must be procured at least every five years.

Any Willing Provider Requirements

MCOs are required to include in their long-term care service networks any provider that is willing to accept the MCO's payment rates and that meets quality specifications of the MCO ("any willing provider").

Capitation Rates

Annually, DHS uses its contracted actuary to develop capitation rates, which are based on historical cost trends, the care needs of the population served (member acuity), and adjusted to reflect wage rates in the service regions. Rates must meet federal "actuarially sound" requirements.

Family Care/IRIS 2.0

centered plan with the enrollee, with the budget amount based on the services the member chooses to self-direct. Members would not receive an initial service budget estimate, based on the results of the functional screen. Members could appeal service budget decisions to DHS.

DHS would use an RFP to contract with IHAs. The Concept Paper does not indicate how entities that wish to serve as IHAs in the future could compete with the IHAs that receive the initial contracts. DHS has not determined what purchasing authority it will pursue, or how often the IHA contracts will be renewed.

DHS would maintain the "any willing provider" requirement for long-term care services for a minimum of three years, and would assess the need to extend the requirement beyond the initial three-year period after Family Care/IRIS 2.0 has been fully implemented and operational in all zones for at least two years. The "any willing provider" requirement would not apply to primary, acute, and behavioral health services.

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 must seek to maximize the use of available resources and to control costs.

DHS has indicated that, during the initial years of the program, it will gain experience regarding the impact of the requirement, and would be responsive to additional legislative guidance in regard to this requirement.

Annually, DHS would use its contracted actuary to analyze program costs for prior years, and establish capitation rates that would meet all federal requirements relative to actuarial soundness.

Independent Consulting Agencies and Fiscal Employment Agency Services

The Department contracts with ICAs and FEAs to provide care management and fiscal services to IRIS participants.

Performance Incentives

Under the current Family Care contracts, MCOs must implement performance improvement projects to improve outcomes for the MCO membership overall or a group of members who have similar care and service needs. DHS does not initially withhold part of the capitation payment, and then releases it after DHS determines that the MCO has met specified performance standards (pay for performance).

The current MCO contracts specify sanction procedures for violations, breach and non-performance of the contract provisions, which may include civil monetary penalties, temporary management, intensive oversight, suspension of new enrollment, Department-initiated enrollment reductions, withholding of capitation payments and orders to provide services.

Quality Measures

The MCO contract outlines quality management procedures and grievances and appeals processes for Family Care MCOs. The MCO's governing board must annually approve a written quality management plan outlining the goals, objectives, timelines and responsible person for the workplan. MCOs must also maintain documentation of the quality of assessments and member-centered plans, completeness and accuracy of functional screens, member satisfaction surveys, provider surveys, incident management systems, appeals and grievances that were resolved as requested by members, performance improvement projects (PIPs), and the quality of sub-contractor services, information that must be provided to DHS upon request. DHS contracts with an external quality review organization (MetaStar) to conduct an external quality review.

ICAs and FEAs are subject to similar quality standards, including implementing a quality management plan, submitting quarterly updates to the quality management plan, and meeting with the Department regarding the plan. In addition, the Department conducts annual IRIS participant satisfaction surveys.

All long-term care enrollees have access to independent

IHAs would be required to offer IRIS specialist services (currently provided by an ICA) and fiscal employment services. The IHA would provide members the choice of at least two IRIS specialists, one of which must be external to the IHA. Members could choose if they want to work with an external IRIS self-direction specialist or work the IHA's designated staff to develop a member-centered plan.

DHS would apply pay-for-performance requirements to IHAs. If an IHA fails to meet contract standards and performance requirements, DHS could assess fines and liquidated damages to ensure compliance.

The IHA contracts would contain provisions that are identical or similar to the current MCO contracts regarding violations, breach and non-performance of the contract provisions.

DHS would measure consumer outcomes, satisfaction, and contract compliance. Consumer outcomes would be measured through required reporting on: (a) a variety of health care performance measures, including prevention and treatment using the healthcare effectiveness data and information set (HEDIS); (b) national core indicators to assess outcomes of services provided to individuals addressing key areas of concern, including employment, rights, service planning, community inclusion, choice, and health and safety; (c) institutional admissions and relocations; (d) settings in which program participants are living, and changes in the types of settings; (e) potential preventable medical services resulting from the quality of long-term care services. Consumer satisfaction would be measured by: (a) independent evaluations to assess consumer feedback; (b) mechanisms for members to file, and for DHS to review, appeals and grievances; (c) publicly available scorecards; and (d) providing members with access to independent external ombudsman services to assist all members with all services. Contract compliance measures would include: (a) DHS oversight of IHAs; (b) annual quality and care management reviews conducted by external quality review organizations; (c) OCI regulation of the IHAs; (d) required reporting of any serious incidents,

ombudsman services, and a grievance and appeals process, under which a member must first try to resolve the grievance directly with the MCO, which would be reviewed by the Department. A member may appeal that decision through a state fair hearing process, which is the Department's final decision-making process. Benefits are continued through any appeals process if the member makes a timely request.

members changing programs and IHAs; (e) DHS audits of direct service providers; (f) ongoing fiscal oversight; (g) an accreditation incentive program that may include substitution of accreditation for certain contract requirements, financial incentives, or consideration during the procurement process; and (h) DHS authority to terminate contracts if financial penalties are insufficient.

MCO Governance

The current Family Care MCOs include Wisconsin-based not-for-profit organizations, entities organized as long-term care districts and one county government (Milwaukee County).

Either for-profit or nonprofit licensed insurers could compete for the IHA contracts.

ANALYSIS

This section discusses the following issues raised by legislators and stakeholders, including current members and their advocates, service providers, and Family Care MCOs, regarding the Family Care/IRIS 2.0 proposal: (a) enrollees' transition to the new program; (b) areas served by the IHAs (zones), the process DHS would use to select IHAs, and the continued participation of the Family Care MCOs; (c) self-directed services; (d) provider networks; (e) stakeholder input; and (f) the future of the Family Care Partnership program.

Transition. Several stakeholders have expressed concern over the process DHS would use to transition current enrollees to the new program, including possible disruptions of services, and whether the current Family Care MCOs could maintain staff and the quality of the services they provide during the transition period. This issue would be especially relevant for an MCO that does not compete for the RFP, and whose ownership and staff knew that the MCO as presently constituted would not participate in the new program. In its guidance to states that seek Medicaid waivers for managed long-term care services, CMS notes that adequate planning is necessary, including allowing sufficient time in advance of configuration to allow for thoughtful planning and design and implementation of safeguards to ensure a smooth transition. In addition, CMS indicates that states should outline outreach efforts and plans for transitioning participants and providers to managed long-term services and supports.

The Concept Paper indicates that DHS will conduct "readiness reviews" to ensure that each IHA is prepared to serve its enrolled members, and has: (a) an adequate provider network for long-term care, primary, acute and behavioral health services throughout the zone; (b) adequate staffing levels and training, including 24-hours a day, seven days a week on-call support, with competence in areas such as behavioral health, integrated employment and member rights; (c) appropriate systems capacity for member and provider enrollment, functional assessments, service authorizations, quality monitoring, financial tracking, analytics and claims processing; (d) appropriate procedures and staffing to support members who self-direct long-term care waiver

services; and (e) culturally competent staff that meet the needs of people of diverse identities.

After the release of the Concept Paper, DHS provided additional information on its transition plans. DHS indicated its commitment to work to facilitate collaborations between IHAs, MCOs, ADRCs and other stakeholder entities, by specifying that: (a) counties and current MCOs would continue to serve current members during the transition; (b) DHS would host meetings with MCOs, IHAs, county agencies, and ADRCs to discuss roles and responsibilities; (c) counties and current MCOs would provide IHAs with a list of providers currently serving their members; (d) counties and current MCOs would update functional screens for members and work with ADRCs and income maintenance agencies to ensure that every participant has uninterrupted functional and financial eligibility during the transition period; (e) DHS would mail transition information to all members; (f) upon enrollment in an IHA, counties and current MCOs would provide applicable member records to the IHA that detail the member's care plan, providers, risk indicators, court orders, protective placements, natural supports, self-directed services, restrictive measures and crisis plans; (g) the IHA interdisciplinary teams would contact each new member, in person or by phone, within three calendar days of enrollment and meet with the member in-person within ten calendar days of enrollment to complete an initial assessment and answer the member's questions; (h) IHAs would continue each member's existing care plan until new member-centered plans can be established in collaboration with members; (i) new IHAs would be expected to use existing supports to minimize disruption of services to members until the IHA works with the members to establish new member-centered plans; (j) counties and current MCOs would identify participants with high-risk care needs and work closely with the IHAs on transitioning those individuals; (k) counties and MCOs would establish agreements with the IHA to clarify roles and responsibilities related to crisis collaboration; and (l) DHS would facilitate IHAs to develop memoranda of understanding with crisis planning and other coordination of services.

Number of Service Zones, IHA Procurement and Potential Participation by Family Care MCOs. Under current policy, Family Care and IRIS are available in 64 of the state's 72 counties, with expansion to Rock County planned by July 1, 2016. Of those counties, five initially piloted the program, and the program has been incrementally expanded to the remainder of the Family Care counties since 2005. As the program has expanded, geographic service regions (GSRs) have developed based on natural divisions in service areas and MCOs' abilities to serve particular regions.

Number of Service Zones. As passed by the Legislature, the 2015-17 biennial budget bill would have directed DHS to propose no fewer than five service regions. This provision suggested that the Legislature wanted to maintain the local component of service delivery under the current program and to increase the likelihood that the current MCOs could successfully compete for the IHA contracts. The Governor vetoed the requirement that there be no fewer than five regions, noting in his veto message that the Department should have the flexibility to determine the number of regions that would best serve consumer needs.

The Concept Paper indicates that there would be three zones, with three IHAs offering services in each zone. DHS would use a competitive request for proposals (RFP) process to select three IHAs in each zone. An IHA could provide service in more than one zone. DHS has

indicated that each zone would include a mix of urban and rural areas to ensure access to services, limit disruption to existing services, and provide incentives for IHAs to seek to operate in the zone. Current Family Care GSRs would not be divided in order to minimize disruption to provider networks and facilitate member transitions. No county would be split between zones, and each IHA would be required to serve all counties within their zones.

DHS has not determined the boundaries of the three zones. However, in response to a request from Senator Darling, DHS developed several maps that it may consider. Due to the current distribution of the state's Family Care and IRIS members, the three zones would likely have unequal geographic areas, although the differences in zone sizes could be reduced if DHS chose to establish zones that included noncontiguous counties. These potential maps are shown in Attachment 4.

DHS selected three zones for several reasons. First, DHS wanted to ensure that there would be a sufficient number of enrollees for each IHA in each zone to reduce risk of potential excessive losses and net revenue (profits) for the IHAs and the state. The Department's contracted actuary, Milliman, conducted an analysis that showed the random cost variations associated with increasing group sizes by target group for the Family Care program. Based on this analysis, DHS determined that the baseline level of risk should be set to ensure that, based on normal cost variations, there would be an 85 percent chance that any IHA's annual service costs would be within 2.5% of the actual capitation rates the state would establish (for a total range of 5%). By establishing three zones, DHS could meet this risk threshold.

Milliman's methodology can be summarized as follows. First, it is assumed that, by 2020 when the program is fully implemented, approximately 69,300 individuals would be enrolled in the IHAs, including 28,400 individuals with developmental disabilities; 23,900 individuals with physical disabilities, and 17,000 frail elders. These estimates were then reduced by 25% to reflect the probability that not all IHAs in a zone will have the same number of enrollees -- this adjustment increases the likelihood that an IHA that enrolls less than one-third of the total number of enrollees in a zone would be financially viable. The resulting populations of each target group were compared with the actuary's estimates of the cost variability tables that reflect the rate band selected by DHS (+ or -2.5%), to determine the minimum number of individuals in each target group that would be enrolled in each zone if three IHAs were serving each zone. A limiting factor the Department considered in determining the number of regions was that approximately 40% of individuals with physical disabilities who qualify for the Medicaid funded long-term care programs reside in Milwaukee County, with the remainder residing in the rest of the state.

Second, the Department wanted to have three IHAs serving each zone to maintain choice for enrollees if one IHA discontinued providing services in an area. DHS notes that, since Family Care was created in 1990, two Family Care MCOs became insolvent and discontinued services, which required DHS to withdraw funds from a risk-sharing solvency fund the agency maintains for the program, resulting in additional costs to the state to replenish the fund.

DHS is confident that least three IHAs will bid to provide services in each zone. However, the decision to apply as an IHA, and continue to provide services in subsequent years, would be

determined by the IHA itself. DHS cannot guarantee continued participation of any IHA.

Procurement -- Selection of IHAs and Contract Length. DHS indicates that all companies would have the opportunity to compete for the IHA contracts, and would select IHAs best positioned to provide high quality services and fulfill all contractual obligations.

DHS would not select IHAs based on the lowest contract rates bid by IHAs responding to the Department's request for proposal (RFP). Instead, DHS would consider each applicant's quality, capacity, financial stability and experience. Applicants would need to demonstrate capacity to provide care management, long-term care acute, primary, and behavioral health services to elders and people with disabilities. Applicants would also need to demonstrate that they have adequate provider networks, expertise at care plan development and monitoring quality controls, fiscal and administrative capacity, and ability to comply with state and federal requirements. Past experience in these areas would likely be a way to demonstrate such abilities and expertise.

DHS would score and rank all responses to the RFP that meet the minimum mandatory requirements, and enter into contract negotiations with the top three scorers for each IHA zone. Should the contract negotiations be unsuccessful with one of the top three respondents, DHS may enter into contract negotiations with the respondent with the next highest score.

Currently, DHS procures the Family Care MCO contracts every five years, and renews the MCO contracts annually. DHS has not decided how frequently the IHA contracts will be procured, or how often IHA contracts will be renewed.

Participation by Current Family Care MCOs. The Department's decision to propose three service zones that are significantly larger than the current Family Care GSRs could affect the current Family Care MCOs' ability to compete for the IHA contracts for several reasons. First, it is uncertain whether some of the current Family Care MCOs could meet capital, compulsory and security surplus requirements that apply to HMOs, as specified by rule (INS 51). Further, current MCOs would need to expand their provider networks to include providers in areas not currently served by the MCOs in order to assure access to enrollees. In addition, it has been argued that the large region comprising each zone could potentially compromise the "local component" of the current system.

The Wisconsin Family Care Association (WFCA) indicates that all of the current Wisconsin-based MCOs wish to become IHAs. However, WFCA believes that the large, three-region model proposed by DHS requires risk reserves that will effectively preclude most, if not all Wisconsin-based MCOs from receiving IHA certification. Since no formal definition of an "IHA" exists, it is unclear what other contracting requirements DHS would include in the RFP that could result in additional obstacles that prevent Wisconsin-based MCO participation in Family Care and IRIS 2.0. It is unknown at this time if bidders would be required to meet all certification requirements before they could submit a response to the RFP, or if they would have time to meet requirements after the contracts are awarded. Moreover, five of the current MCOs would be required to become licensed as HMOs before they could bid on any future IHA contract. The timeframe for becoming an HMO would take several months. Depending on the timing of the RFP,

the timeline for HMO licensure itself may be an additional barrier to submitting a competitive RFP response and securing an award to operate as an IHA.

As previously indicated, one factor DHS will consider in awarding the IHA contracts will be an applicant's past experience in providing care management, long-term care, acute care, primary and behavioral health services to elders and people with disabilities. It is not clear how some of the current Family Care MCOs, including Community Care Connections, ContinuUs, the Lakeland Care District, MyChoice Family Care, and Western Wisconsin Cares could demonstrate past experience in providing acute care, primary and behavioral health services. Three current MCOs, Care Wisconsin, Community Care, Inc., and iCare (which offers services under the Family Care Partnership Program), are licensed as HMOs. Similarly, some current HMOs that do not currently provide MA-supported community-based long-term care services may be unable to demonstrate experience providing these services in Wisconsin, although some entities that respond to the RFP may be able to demonstrate their experience offering integrated managed long-term care services in other states.

DHS has identified several ways in which the current Family Care MCOs could potentially continue to participate in Family Care/IRIS 2.0, including: (a) creating an insurance company and transferring business and assets of the MCO to the insurer through merger or some other mechanism; (b) buying a license through the acquisition of an already licensed insurer, although this option would require that OCI approve the acquisition and that the entity meet OCI's capital and surplus requirements; and (c) contracting with a current licensed insurer under a service agreement approved by OCI, with the insurer providing capital and surplus to the MCO to meet OCI's financial solvency requirements. In addition, a Family Care MCO could be acquired by a for-profit insurer holding company that would provide the necessary capital for the entity to become a licensed insurer.

If a current Family Care MCO is not selected as one of three IHAs serving a region, DHS suggests that it could still participate by entering into a sub-contracting agreement with an IHA to deliver long-term care services within a zone, if an IHA chose to enter into such an agreement. DHS notes that several BadgerCare Plus HMOs currently subcontract with other entities to provide all behavioral health services to a regional service provider.

Although DHS has identified various ways in which the current Family Care MCOs could continue to participate in the new program, it is possible that none would successfully compete for the contracts. The successful respondents could then choose whether or not to contract for long-term care services with the current Family Care MCOs.

Self-Directed Services. Under current policy, an individual who is determined to be eligible for Medicaid-supported long-term care service, based on the results of the long-term care functional screen, receives enrollment counseling at an ADRC to determine what long-term care service delivery model would best suit the individual's needs. During enrollment counseling, the ADRC explains the Medicaid-supported long-term care programs available to the individual, including Family Care and IRIS.

Current Practice -- IRIS. The ADRC also provides the individual with a preliminary estimate of a budget for long-term care services that the individual might receive if he or she chose to enroll in IRIS. This preliminary budget is calculated in two steps. First, the historical average cost to serve people with similar long-term care needs is calculated. This calculation uses an acuity-based algorithm similar to the algorithm used to set the Family Care capitation rates. Second, the initial acuity-based rate is grouped into one of three rate bands -- high, medium, and low. This rate is then adjusted using a formula designed to ensure that the preliminary budget amount would be expected to fund at least 80% of costs for 80% of members within an assigned rate band. However, the preliminary budget model is not intended to reflect any member's specific care needs. Instead, it provides an estimate of the individual's IRIS budget prior to the development of the IRIS service plan.

If the individual chooses to enroll in IRIS, he or she may have an option of which ICA to select, depending on his or her county of residence.

Following selection of an ICA, the individual is contacted by the ICA to develop a person-centered care plan. In developing the care plan, the individual determines what outcomes he or she wishes to achieve, and what types of supports would assist the individual in achieving those outcomes. The ICA assists the individual in determining who provides supports and whether and how much that individual is paid for providing supports, creating the individual's plan and self-directed services budget. Individuals may also choose to self-direct their personal care services, which occurs outside of the self-directed services budget. Approximately 40% of IRIS enrollees choose to self-direct their personal care services. The fiscal employer agent (FEA) then coordinates payroll on behalf of the enrollee. While the FEA coordinates payment for services, the IRIS enrollee maintains employer and budget authority, meaning that the individual is responsible for determining who provides services (including hiring and firing decisions), how much employees are paid within guidelines issued by DHS, and more broadly, how to allocate his or her budget to achieve the outcomes outlined in his or her person-centered plan.

The initial amount that individuals receive based on the results of the functional screen and an adjustment for the individual's acuity level can be considered a "soft cap," under which an individual creates his or her person-centered plan. However, the actual service budget an IRIS enrollee receives is based on the services outlined under the plan, and could be lower than the amount generated by the screen, or potentially higher if the individual requests and receives additional funding. In calendar year 2015, the average IRIS per member, per month spending, excluding employer taxes, was \$1,479 for all services except self-directed personal care, and \$1,981 for all services including self-directed personal care.

Current Practice -- Family Care Self-Direction. Individuals may also choose to self-direct all services except residential care and care management under the Family Care program. To determine budgets for self-directed services in Family Care, MCOs estimate what it would cost the MCO to fund the self-directed portion of the care plan if the member was not self-directing care. That cost is the basis for the self-directed budget. Usually, this involves determining what the same authorized level of services and supports would cost if the MCO purchased them for this person or for another person with similar characteristics who was not self-directing. For some members who

would be likely to move into community residential care with a daily rate, or whose care would be otherwise paid at a daily rate if they were not self-directing, that daily rate may be used as the basis for calculating the member's budget. In all circumstances, the member selects the needs and outcomes for which she or he wants to direct supports. Within this overall approach, MCOs may use one of three prescribed methodologies, depending upon member circumstances and preferences, including:

1. Establish an Overall Rate. This approach starts with an established rate determined by the MCO for the cost of the authorized services and goods to be self-directed. MCOs use an average rate based on their contracted providers that offer the same or similar waiver services multiplied by the authorized amount. Using the established rate, the MCO creates the member's overall budget. Within that budget, the member has some flexibility to determine wages.

2. "Bottom Up" Budget. Under this approach, the process starts with the amount of services needed and the cost of goods and services to purchase through a Financial Management Services provider (for example, special medical equipment, assistive technology, or home modification). For direct care services, the interdisciplinary team works with the member to establish possible employee wage levels for the amount of authorized services. The MCO adds additional costs to the wage baseline for fringe benefit costs. This budget is set for a specific time period such as one month, six months, or one year.

3. Daily Rate. For members who choose to direct many or all of their services through self-directed supports, an MCO can use a member's current or projected care plan to establish a daily rate for services the member will receive. DHS indicates that this works well for members needing a significant amount of daily home care, up to 24 hours, especially where workers may not be doing hands-on care but need to be on-premises anyway, or where the provider lives with the member. It can also be used for members who, in the absence of self-directed supports, would be in community residential care, with the daily self-directed supports rate based on the daily facility rate of the alternate service plus a daily rate for any waiver services outside the facility rate. The daily rate is set to be sufficient to comply with applicable wage and hour requirements for member-employed home care workers.

In calendar year 2014, 8,761 Family Care members (approximately 20% of enrollees) self-directed at least one service. The most commonly self-directed services were supportive home care, financial management, specialized supplies/equipment, and transportation.

Proposed Self-Direction in Family Care/IRIS 2.0. For Family Care/IRIS 2.0, DHS would implement a CMS-approved standard budget methodology for setting self-directed support budgets, which would be set forth in IHA contracts. Budgets under Family Care/IRIS 2.0 would be based upon each individual's member-centered plan and the services the member elects to self-direct. Under Family Care/IRIS 2.0, when a member enrolls in an IHA and then decides to self-direct some or all of their long-term care waiver services, the member would choose an IRIS specialist who would be a member of the interdisciplinary team (IDT). IHAs would be required to provide a choice of at least two IRIS specialist agencies, one of which must be external to the IHA. The IRIS specialist would help the member develop and manage the self-directed portion of their plan. The self-direction budget would be based on the mix of services in the member's plan of care,

as under the current IRIS program. DHS has committed to continue with budget authority and employer authority for members who choose to self-direct. Members would continue to have authority to hire, manage, and direct their paid workers or care providers. Members would continue to manage and direct their own service budgets.

Several differences exist between the model proposed in the Concept Paper and the current IRIS program. First, the current practice of developing a preliminary budget would be discontinued. However, as under the current program, individual budget amounts for self-directed services would be determined following the development of a person-centered plan. Consequently, it is not clear how, functionally, the method of determining these budgets under the proposal would differ from current practice, since final IRIS service budgets are established as part of the person-centered planning process, and do not equal the preliminary budget amount generated by the functional screen.

Second, all qualifying individuals who wish to self-direct long-term care services would be enrolled in an IHA (or, at their option, enroll in a PACE/Family Care Partnership MCO if one offers services in the member's county of residence). Consequently, Medicaid-only members who wish to self-direct their long-term care services would be required to receive their Medicaid funded primary, acute and behavioral health services from the IHA. The Medicaid-funded, long-term care services an individual could choose to self-direct would be funded from the IHA's capitation rate, and be paid by the IHA.

The Concept Paper does not indicate whether each IHA would be required to use the same budget-setting tool. However, DHS has indicated that the state's Medicaid waiver agreement would require that the budget methodology be applied consistently to each member who chooses to self-direct services, and that DHS would prescribe the budget methodology in its contract with each IHA.

Provider Networks and "Any Willing Provider" Requirements. As previously indicated, under Family Care 2.0, Medicaid-only enrollees, who currently receive primary, acute, and behavioral health services on a fee-for-service basis and long-term care services through a Family Care MCO or through IRIS, would instead receive all Medicaid-covered health services (other than outpatient drugs) through a network of providers with contracts with their IHA, but could choose to self-direct most long-term care services. The IHAs would select the providers in their networks, and would establish payment rates that could differ from the current fee-for-service Medicaid rates for state plan services.

Under the current program, DHS requires Family Care MCOs to submit an application for certification, which requires that each MCO provide documentation of the network adequacy criteria detailed in the MCO contract. Family Care MCOs are required to develop standards for geographic access to services, monitor the performance of providers in relation to those standards, and take corrective action if deficiencies are discovered. Further, interdisciplinary teams are required to notify MCO network developers when they experience problems in accessing services for members. However, DHS does not establish geographic distance standards or provider-to-member ratio requirements for the Family Care MCOs.

Under Family Care/IRIS 2.0, the Department indicates that it would develop geographic distance standards and provider-to-member ratio requirements for acute and primary care services that are similar to those required of BadgerCare Plus and SSI HMOs.

Although enrolling Medicaid-only long-term care consumers into managed care programs may reduce options these individuals currently have with respect to selecting specific providers, it could be argued that HMO enrollees have potentially greater access to some types of medical services than Medicaid recipients who receive services on a fee-for-service basis. For example, individuals with disabilities have significantly higher rates of poor oral hygiene and needs for periodontal disease treatment than the general public. However, finding dentists that serve Medicaid enrollees with disabilities can be challenging for individuals not enrolled in an MCO. Managed care entities accept responsibility for ensuring that their enrollees have access to all Medicaid-covered services.

"Any Willing Provider" Requirement. Under the current Family Care program, MCOs are required to contract with any provider that accepts rates the MCO offers to other providers offering similar services, and that meet the MCO's quality standards. This provision, commonly referred to as the "any willing provider" requirement, also applies to commercial health plans sold in Wisconsin (although a plan may exclude a provider from participation in the health care plan for cause related to the practice of his or her profession), but not plans offered by HMOs, preferred provider plans, and limited service health organizations.

Act 55 directs the Department to propose maintaining the "any willing provider" requirement, as it applies to long-term care services, for at least three years following the implementation of Family Care 2.0. After this three-year period, the Department would have discretion with respect to whether to maintain the any willing provider provision.

In public testimony, stakeholders emphasized the importance of permanently maintaining the "any willing provider" requirement, as it applies to long-term care services, to ensure access to a diverse provider network, particularly in rural areas, and to maximize consumer choice. In response to these concerns, DHS has indicated that the commitment to maintain the requirement for at least three years following implementation was intended to comply with the Act 55 directive, but that the agency would be responsive to additional legislative guidance on this issue. As the current policy would not change for at least three years following implementation, this issue could be addressed by the Legislature before DHS makes any changes in IHA contract requirements.

Ongoing Stakeholder Input. The Concept Paper indicates that DHS would continue to have discussions with MCOs, potential IHAs, advocates, counties, and other stakeholders as the waiver is developed. Upon implementation, each IHA would be required to have a consumer advisory council and provider advisory council to provide consumers and providers regular and ongoing mechanisms to voice concerns about the operations of the IHA and to make recommendations about areas in which improvements can be made. The IHAs would be required to provide DHS with regular updates on the work of these groups. In addition, DHS would receive regular input from consumers, providers, and other stakeholders to advise DHS on procedures of the new program and the Department's oversight of ADRCs. Finally, the Concept Paper indicates that DHS would conduct quarterly listening sessions, attended by IHAs and ADRCs, in each zone

at least through the first year of the program.

DHS currently has a Long-Term Care Advisory Council and an IRIS Advisory Council to provide feedback regarding the state's long-term care programs. The Department also cites numerous other councils, including the Governor's Committee for People with Disabilities, the Council for the Deaf and Hard of Hearing, the Council on Physical Disabilities, the Council on Mental Health, and the State Council on Alcohol and Other Drug Abuse, from which it solicits feedback on the state's long-term care programs. However, the administration did not solicit the recommendations of the Long-Term Care Advisory Council before or during development of the Family Care/IRIS 2.0 proposal. Instead, DHS instructed the Council to address dementia and related issues. Council members and the groups they represent were provided opportunity to submit recommendations individually to DHS in the development of the Concept Paper.

In the "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs," CMS indicates that an essential element of a successful transition and program is stakeholder engagement, including a structure for regularly engaging stakeholders and a formal process established for involving stakeholders prior to, during, and following program implementation.

Family Care Partnership Program and Other Efforts to Expand Integrated Care. Under current policy, the Family Care Partnership program provides fully integrated care to enrollees in 14 counties, including Milwaukee County. In 2014-15, approximately 57% of all individuals participating in MA community-based long-term care programs resided in these 14 counties. While the program serves both Medicaid-only and dually eligible enrollees, approximately 81% of PACE and Family Care Partnership enrollees are dual eligibles. In the Family Care Partnership program, enrollees receive managed primary, acute, behavioral health, and long-term care services from one entity, similar to the model of integrated care proposed under the Concept Paper.

Under the Concept Paper, the Department indicates it would maintain the Family Care Partnership Program in the 14 counties in which it currently operates, and would continue to work with CMS to expand the program in the future to include additional counties, which would offer individuals a fourth option (three IHAs and a Family Care Partnership MCO) in counties where the Family Care Partnership program is offered.

Some stakeholders have questioned why the administration would propose such significant changes to the state's current long-term care programs, rather than seek incremental changes to increase the number of individuals receiving integrated care through programs such as PACE and the Family Care Partnership program. While DHS has, and continues to, demonstrate a commitment to the policy goal of providing more integrated care to Medicaid recipients, there remain considerable obstacles.

Virtual PACE. Several years ago, DHS received a \$1 million federal grant to develop an integrated program proposal, which it called "Virtual PACE." Under the Department's original proposal, CMS would have paid the state a Medicare capitation payment for each enrollee. DHS would have contracted with Family Care Partnership/PACE organizations, new entities composed

of the Family Care MCOs in collaboration with acute/primary care HMOs and clinics to provide the full range of Medicare and Medicaid benefits to dual eligibles with a nursing home level of care with the goal of eliminating the incentive for cost-shifting between the acute/primary and long-term care system.

In April, 2012, DHS submitted a proposal to CMS that would have provided integrated care services to full dual eligibles over the age of 18 who were residing in a nursing home on a long-term care basis and who were receiving Medicaid services on a fee-for-service basis at the time of enrollment, with a goal of eventually enrolling 15,000 to 16,000 Medicaid recipients. However, following over a year of negotiations, CMS indicated in November, 2013 that CMS could not approve DHS' proposed memorandum of understanding without major revisions. A month later, DHS informed CMS that it could not make further concessions to CMS, as they would detract from the state's goals of reform and integration. Consequently, the Virtual PACE proposal was never implemented.

Although there appears to be an opportunity to meet the administration's goal of increasing the number of Medicaid long-term care consumers who receive integrated care by expanding the Family Care Partnership program, DHS is limited in its ability to increase participation in the program, as these programs depend on the willingness of MCOs to offer these integrated services, and enrollees' willingness to participate in them. DHS indicates that, in the counties where the Family Care Partnership is available, only 11.9% of community-based long-term care members elect to enroll in the PACE or Family Care Partnership programs. This relatively low percentage suggests that, for dual eligibles, whose Medicare cost-sharing requirements are funded by Medicaid, there is little financial incentive to enroll in the Partnership Program and, by so doing, forgo the freedom to choose providers for Medicare-funded services. As previously indicated, states are prohibited from requiring dual eligibles to receive Medicare funded services from MCOs.

Dual Eligible Demonstrations in Other States. In recent years, there have been efforts initiated in other states and by CMS to integrate Medicaid service delivery for long-term care recipients. In particular, under the CMS Financial Alignment Initiative, sixteen states have proposed and seven states have implemented demonstration projects to test models of integrating care for dually-eligible enrollees. According to an October 15, 2015 report by RTI International prepared for CMS entitled "Early Implementation of Demonstrations under the Financial Alignment Initiative," there is insufficient data at this time to assess savings that may have been realized in other states that implemented dual alignment demonstration projects, except for managed fee-for-service demonstration in the State of Washington.

Washington implemented a duals demonstration alignment initiative under the Financial Alignment Initiative on July 1, 2013. This model was implemented in all but two of the state's counties, with a phase-in over two periods. The demonstration relies on health homes to coordinate primary, long-term, and behavioral health care for dually-eligible enrollees. This demonstration differs significantly from the Family Care/IRIS 2.0 proposal, in that payment for services still occurs on a fee-for-service basis and does not affect choice of providers or availability of services. Rather, the only change from the state's previous practice is that health homes work with members

in an effort to better coordinate care. The demonstration allows Washington to share in savings that may be realized to the Medicare program as a result of the increased coordination of care. According to a report prepared by RTI International for CMS entitled, "Preliminary Findings from the Washington MFFS Demonstration" on January 4, 2016, the results of a preliminary analyses of Medicare savings showed approximately \$21.6 million (approximately 6 percent savings) for all cohorts participating. This estimate is based on the estimated change in per member per month costs and the number of eligible member months during the demonstration, and therefore does not reflect a set time period for all cohorts. No Medicaid savings estimates are available at this time.

It is important to note that this model differs significantly from the model proposed under the Concept Paper in the payment mechanism and the opportunity for shared Medicare savings. In addition, broader differences could exist between Wisconsin and Washington's dual eligibles population and the model under which they were receiving care prior to the demonstration. Accordingly, these results should not be generalized to savings that would be generated under the model proposed in the Concept Paper, but a broad assessment of whether savings are possible under an integrated model of care.

COST SAVINGS ESTIMATES

The administration expects the Family Care/IRIS 2.0 changes will slow expenditure growth by improving the health of members, and ensure that the state's long-term programs will continue to be cost-effective and sustainable in the future.

Primary and Acute Care Cost Savings. The Concept Paper cites the recent growth of primary and acute care service costs for individuals enrolled in the state's long-term care programs indicating that, between 2010 and 2015, these enrollees' acute and primary care costs increased ten times faster than their overall Medicaid costs. DHS reached this conclusion by comparing the per member per month cost of Medicaid-funded primary and acute care costs (including outpatient drug costs) for individuals enrolled in managed care in April, 2010 (\$178), with costs incurred in April, 2015 (\$209), an average annual increase of 3.3%. In contrast, the total per member per month cost of all Medicaid-funded services to these individuals increased from \$3,116 in 2010 to \$3,166 in 2015, an annual increase of 0.3%.

While the percentage difference cited by DHS is substantial, the figures also show that primary and acute care costs are a relatively small percentage of the total average costs the state Medicaid program incurs for these individuals (approximately 5.7% and 6.6% in April, 2010, and April, 2015, respectively). Arguably, the percentages cited by DHS could also be used to demonstrate the effectiveness of the state's current programs in controlling total MA-funded long-term care costs.

While the Concept Paper does not include dollar estimates of savings the state might realize as a result of the proposed program changes, since the time that DHS released the Concept Paper, the agency has provided estimates of one source of potential savings -- primary and acute care services provided to the Medicaid-only (non-dual eligible) individuals who would be enrolled in

IHAs, and begin receiving most of these Medicaid funded services through an IHA, rather than on a fee-for-service basis.

For primary and acute care provided to these individuals, DHS has estimated that the proposal would result in the following:

- A savings of \$300 million (all funds) over the next six years, compared to the current programs, including \$24 million (all funds) during the first year and (\$33 million (all funds) during the second year of implementation;
- A reduction in the cost by more than \$1,000 per Family Care member, per year, by year six; and
- A reduction in medical care service expenditures for Medicaid only members enrolled in IHAs by a net of 7% compared to the costs in a fee-for-service model.

The Department developed the cost savings estimates by comparing projections of total primary and acute care costs for Medicaid-only Family Care and IRIS enrollees under the current Family Care/IRIS programs, based on current trends in enrollment and service utilization, with estimated costs under Family Care 2.0, based on the assumption that growth in these costs would be reduced by enrolling current Medicaid-only Family Care, IRIS, and legacy waiver participants in an IHA that would manage their acute and primary care services.

In order to ensure that the state, rather than each IHA, realizes these savings, DHS has indicated that it would pay capitation rates to the IHAs that reflect a "managed care service cost discount." The actual managed care discount DHS would apply to these primary and acute care services may be greater than 7%, but the final capitation rates offered to the IHAs may also reflect other factors, such as a health insurance tax assessed to for-profit managed care plans under the federal Affordable Care Act, which the state would be required to pay to ensure that plans meet the federal "actuarially sound" requirement.

Table 5 shows that DHS estimates that during the first six years following the program's implementation, the state would realize total savings of approximately \$301.3 million. Based on the assumption that the state's federal financial participation rate would continue to be approximately 58% during this period, GPR spending would be reduced by a total of approximately \$126.4 million over the six-year period, compared to the spending that would occur under the current programs. Since DHS projects that total Medicaid-related spending under these programs would be approximately \$17,822.5 million, the savings total represents approximately 1.7% of the total amount that would be expended under the current programs. As DHS has indicated that the program would not likely be implemented prior to 2018, these savings would potentially begin to be realized sometime in the 2017-19 biennium, although they may be offset, to some extent, by one-time transitional costs.

TABLE 5

**Summary of DHS Estimates of Total Family Care/IRIS Program Costs --
Comparison of Current Law and Family Care/IRIS 2.0**

Year	Total Enrollment*					Current Law		Family Care/IRIS 2.0		Difference				
	Family Care	IRIS	Legacy Waivers	PACE/ Partner	Total	Total Costs (\$ in Millions)	Average Annual Cost	Total Costs (\$ in Millions)	Average Annual Cost	Total Program Costs (\$ in Millions)			Annual Average Cost	
										GPR	FED	Total	Amount	Percent
0	41,599	13,366	3,828	3,649	62,441	\$2,508.3	\$40,170.6	\$2,508.3	\$40,170.6	\$0.0	\$0.0	\$0.0	\$0.0	0.0%
1	45,809	14,778	0	3,686	64,273	2,596.7	40,400.4	2,572.5	40,023.8	-10.2	-14.1	-24.2	-376.6	-0.9
2	46,834	15,653	0	3,723	66,210	2,731.6	41,256.0	2,699.0	40,763.6	-13.7	-18.9	-32.6	-492.3	-1.2
3	47,909	16,554	0	3,760	68,224	2,876.4	42,160.8	2,834.0	41,540.4	-17.8	-24.6	-42.4	-620.4	-1.5
4	49,112	17,521	0	3,797	70,431	3,036.7	43,116.0	2,983.0	42,353.8	-22.5	-31.1	-53.7	-762.2	-1.8
5	50,360	18,512	0	3,835	72,706	3,207.7	44,119.2	3,140.9	43,200.1	-28.0	-38.8	-66.8	-919.1	-2.1
6	51,458	19,372	0	3,872	74,702	3,373.5	45,159.0	3,291.9	44,066.7	-34.2	-47.3	-81.6	-1,092.3	-2.4
										<u>GPR</u>	<u>FED</u>	<u>Total</u>		
	Total Estimated -- Six Years Following Implementation									-\$126.4	-\$174.8	-\$301.3		
	Total Estimated Spending During First Six Years Following Implementation -- Current Law									\$7,485.4	\$10,337.1	\$17,822.5		
	Estimated Savings Percentage Compared to Current Law									-1.7%	-1.7%	-1.7%		

* Under Family Care/IRIS 2.0, all individuals would be enrolled in an IHA.

The DHS savings estimates include projected savings in Medicaid-funded outpatient drug costs, which represent a significant share of Medicaid-only enrollees' primary and acute care service costs. Table 6 shows the Department's estimates of average per member per month costs for Medicaid-funded primary and acute care services, for Medicaid-only individuals enrolled in Family Care and IRIS, by group. As shown in the table, drug costs range from 20% to 50% of the total primary and acute care services these individuals receive.

TABLE 6

**Base Year Per Member per Month Costs -- Primary and Acute Care Services
for Individuals with a Nursing Home Level of Care**

<u>Program</u>	<u>Amounts</u>			<u>Percentage</u>	
	<u>Pharmacy</u>	<u>Other</u>	<u>Total</u>	<u>Pharmacy</u>	<u>Other</u>
Family Care					
Developmentally Disabled	\$448	\$447	\$895	50.1%	49.9%
Physically Disabled	877	1,874	2,751	31.9	68.1
Frail Elderly	428	1,187	1,615	26.5	73.6
IRIS					
Developmentally Disabled	\$291	\$452	\$742	39.2%	60.8%
Physically Disabled	502	1,480	1,981	25.3	74.7
Frail Elderly	76	287	364	20.9	79.1

While the Department's total savings estimates include projected reductions in MA-funded outpatient drug costs, these costs will not be part of the IHA capitation rate. Instead, IHA enrollees will continue to obtain Medicaid-funded outpatient drugs on a fee-for-service basis. So, while these costs may decrease if IHAs succeed in improving enrollees' health, DHS could not apply a managed care service cost discount to these costs in developing the primary and acute care component of the IHA capitation rates.

It could also be argued that IHAs would have limited opportunities to reduce the growth in MA-funded primary and acute care service costs because individuals enrolled in these programs may already receive more assistance with addressing their primary and acute care needs than other elderly, blind, and disabled Medicaid recipients who receive all of their Medicaid-funded services on a fee-for-service basis. Under the current Family Care MCO contract, MCOs must ensure that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally responsible for coordinating the health care services furnished to the member. MCOs must coordinate the services the MCO furnishes to the member with the services the member receives from any other health care provider or insurance plan. In addition, the current contract requires MCOs to incorporate prevention and wellness components, including disease prevention, into the services they provide. The current MCOs indicate that the acute and primary care services enrollees receive, including a review of medications used by the member, are critical components of the MCOs care management responsibilities. Under Family Care, each IDT includes a licensed registered nurse.

DHS has not suggested that the current Family Care MCOs allow their members' acute and primary care needs go unaddressed, but believes that the current rate of increase in these costs can be reduced through the application of managed care practices directly to these services.

DHS has not assumed that the IHAs would be able to realize any cost savings by reducing provider reimbursement rates for any Medicaid-funded services. This appears to be a reasonable assumption, since MA payment rates are generally the lowest rates health care providers currently receive. Reducing rates to below MA fee-for-service rates for primary and acute care services may make it difficult for IHAs to retain an adequate provider network and to compete with other IHAs for enrollees. Although it is assumed that IHAs would be permitted to pay primary and acute care providers rates less than the Medicaid fee-for-service rates (as permitted under the current BadgerCare Plus health maintenance organization contract), the Wisconsin Hospital Association has indicated that, at least for inpatient hospital services, BadgerCare HMOs generally pay the MA fee-for-service rate.

Long-Term Care Costs. DHS has not assumed savings would result in providing long-term care services under Family Care 2.0, as DHS and most stakeholders would argue that the Family Care and IRIS programs have been cost-effective and have slowed the growth of long-term care costs for enrollees, especially when these programs are compared to the legacy waiver programs and institutional long-term care services that might otherwise be provided to the target populations. The Family Care MCOs would argue that the current MCOs have benefited from 16 years of the state's experience providing managed long-term care services, and that it would be difficult for IHAs that have not previously participated in Wisconsin's long-term care programs to immediately realize additional program savings in long-term care service costs. It is also possible that, without the participation of the current Family Care MCOs, the rate of growth in the costs of long-term care services could increase, compared with current trends.

Although not included in the administration's cost savings estimates, the proposed changes could result in cost savings in Medicaid funded long-term services. However, the opportunities for the state to realize these savings would depend on many factors that cannot be determined until after the Family Care/IRIS 2.0 program is implemented. Potential savings in long-term care costs could occur if the new program offers IHAs greater opportunities or incentives to minimize long-term care service costs. For example, the proposed changes in establishing service plans for individuals who choose to self-direct services could reduce service costs, as the member's initial budget (but not final) allocation would not be based on the results of the long-term care screen conducted by the ARDC (as under current policy), but instead be developed after the IHA has completed a functional assessment and the IRIS specialist has worked with the member to develop an MCP. The elimination of the initial IRIS budget allocation might reduce applicants' initial expectations regarding service plans that could be developed for new enrollees.

Additional savings that could be realized in long-term care service costs, through an initial review and potential modifications of current service plans by the new IHAs. The current Family Care contracts specify each member's rights, including the rights to all services identified in the member's member-centered plan. The contract specifies grievance and appeals procedures that a member may pursue under certain circumstances, including if the MCO proposes to reduce,

suspend, or terminate previously authorized services. However, despite these requirements and MCOs' efforts to inform members of their rights, some members may not benefit from the guarantees in the MCO contracts, as they may be unaware of appeal opportunities to appeal the MCO's decisions, or choose not to file an appeal. Under Family Care 2.0, similar provisions that guarantee service rights to enrollees would be included in the IHA contracts. However, a new IHA entity may have a greater incentive in re-examining service plans, especially plans for members with high service costs, previously developed by other MCOs or IRIS consultants.

Finally, it is possible that IHAs, may be able to reduce current payment rates for long-term care services, particularly if the current "any willing provider" requirement were eliminated.

In summary, it is not certain that any of the potential changes in long-term care costs would occur if the Family Care/IRIS 2.0 proposal were implemented. Further, it could be argued that competition among IHAs and the Department's commitment to retaining enrollees' appeal and grievance procedures would affect potential reductions in long-term care service costs.

Transition Costs. During the transition, ADRCs would need to provide information and counseling to approximately 55,600 current long-term Family Care and IRIS enrollees, as well as additional applicants who will be enrolled in these programs in counties that currently do not assist them in selecting an IHA. This would create a significant one-time workload for the ADRCs. Although not addressed in the Concept Paper, DHS has indicated that it is exploring ways to manage this additional workload, including strategies that would include hiring temporary staff, distributing materials so that members are informed prior to meeting with ADRC staff, managing workload across ADRCs, ensuring that necessary systems, provider networks, and procedures are in place prior to when enrollees seek ADRC services, and operating a toll-free hotline to triage calls to determine whether questions can be answered without the assistance of an ADRC. DHS has not estimated the one-time costs of conducting these activities, or the costs of any information systems changes that might be required to implement the new program.

ALTERNATIVES FOR THE COMMITTEE'S CONSIDERATION

If the Committee wishes to consider the DHS proposal, several options are available with respect to its action on the Concept Paper. If the Committee determines that the Concept Paper reflects the Legislature's intent to make revisions to the state's Family Care and IRIS programs, as expressed in Act 55, provides sufficient information regarding proposed amendments to the current waiver agreements for consideration by CMS, and that the proposed changes are worth making as a means of potentially reducing the growth in the costs of Medicaid-funded services to community-based long-term care consumers, it could approve the Concept Paper (Alternative 1).

Alternatively, if the Committee determines that there is insufficient detail in the Concept Paper or disagrees with specific provisions contained in the Concept Paper, it could disapprove the Concept Paper. Although Act 55 prevents the Committee from making modifications to the Department's plan, Committee members could continue to discuss possible changes and direct DHS to submit a revised Concept Paper for the Committee's consideration to address specific

concerns (Alternative 2).

Finally, if the Committee determines that the potential cost savings of the proposal do not address the broader issue of containing long-term care costs, or warrant the potential changes the proposal would have on members, the Family Care MCOs, and providers, the Committee could disapprove the Concept Paper. The Legislature could address other long-term care reform proposals as part of the 2017-19 budget (Alternative 3).

ALTERNATIVES

1. Approve the Family Care/IRIS 2.0 Concept Paper.
2. Disapprove the Family Care/IRIS 2.0 Concept Paper, and direct DHS to resubmit a revised concept paper for consideration by the Committee.
3. Disapprove the Family Care/IRIS 2.0 Concept Paper.

Prepared by: Charles Morgan
Attachments

ATTACHMENT 1

Family Care Services Funded through Capitation Rates 2016

Waiver Services

Adaptive aids*
Adult day care services*
Assistive technology/communication aids*
Care/case management services
Consultative clinical and therapeutic services for caregivers*
Consumer education and training services*
Counseling and therapeutic services*
Environmental accessibility adaptations (home modifications)*
Financial management services*
Habilitation services (daily living skills training and day habilitation services)*
Home delivered meals*
Housing counseling*
Personal emergency response system*
Prevocational services*
Relocation services*
Residential care (adult family homes, community-based residential facilities, and residential care apartment complexes)
Respite care services*
Self-directed personal care services*
Skilled nursing services
Specialized medical equipment and supplies*
Support broker*
Supported employment -- individual employment support services*
Supported employment -- small group employment support services*
Supportive home care*
Training services for unpaid caregivers*
Transportation (specialized transportation) -- community transportation*
Transportation (specialized transportation) -- for non-emergency, MA-covered services
Vocational futures planning and support*

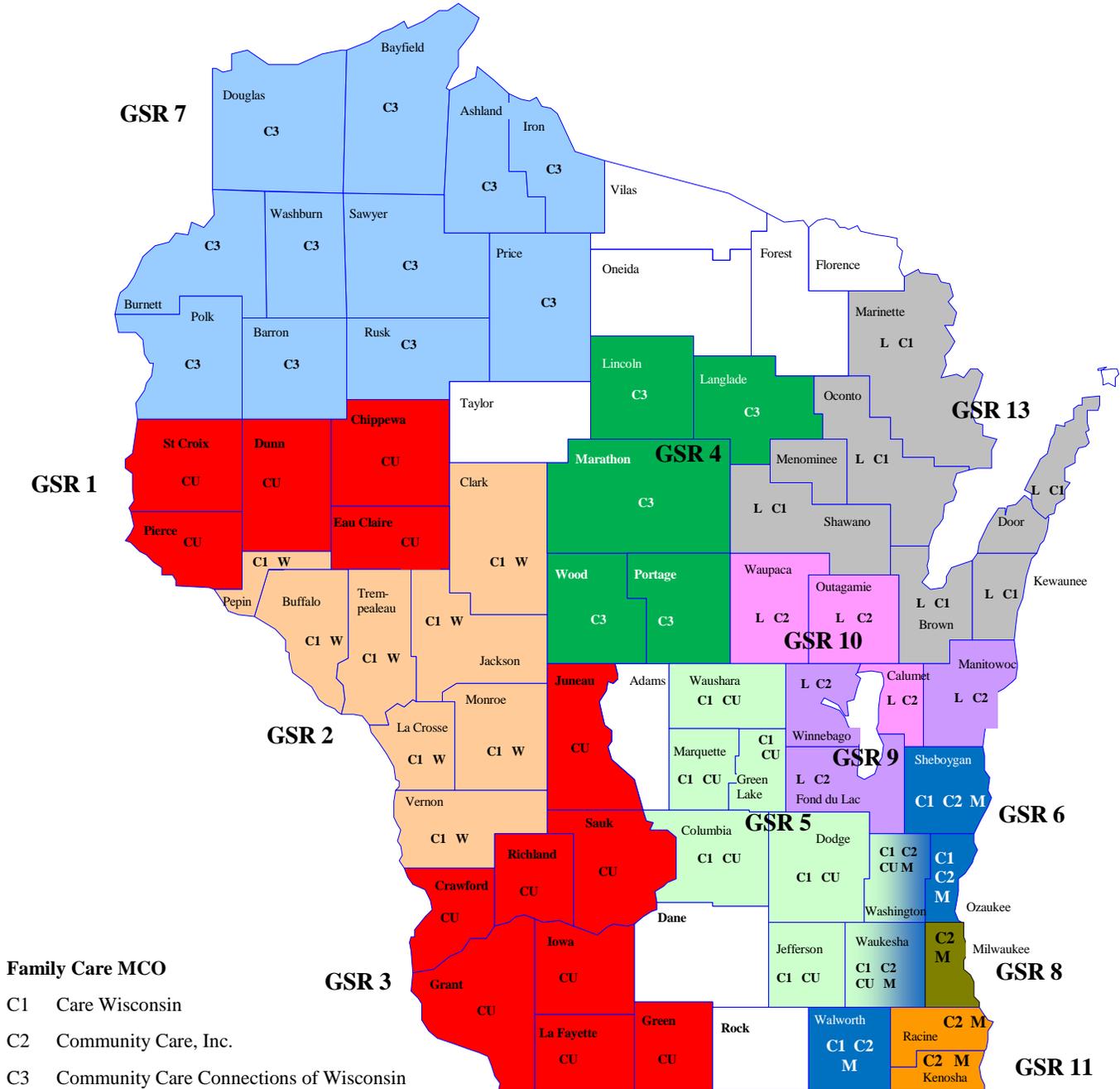
State Plan Services

AODA day treatment (other than inpatient hospital-based or physician provided settings)
AODA services (excluding inpatient hospital and physician-provided services)
Case management
Community support program
Durable medical equipment and medical supplies
Home health
Mental health day treatment
Mental health (other than inpatient or physician services)
Nursing home
Nursing (including respiratory care, intermittent and private duty nursing)
Occupational therapy
Personal care*
Physical therapy
Speech/language pathology
Transportation

*Indicates service that can be self-directed.

ATTACHMENT 2

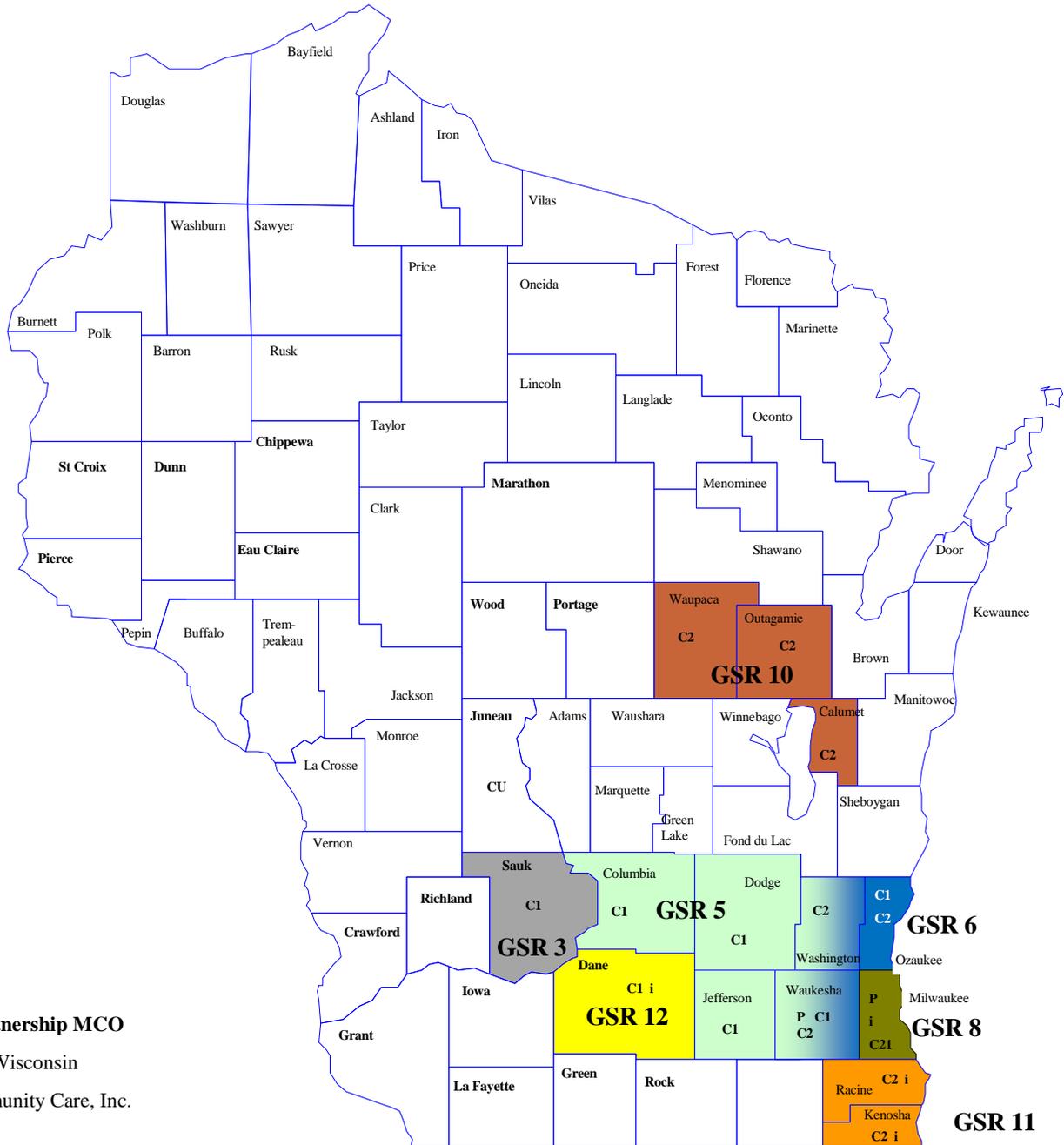
Family Care and IRIS Geographic Service Regions January, 2016



- Family Care MCO**
- C1 Care Wisconsin
 - C2 Community Care, Inc.
 - C3 Community Care Connections of Wisconsin
 - CU ContinuUs
 - L Lakeland Care District
 - M Milwaukee County Department of Family Care
 - W Western Wisconsin Cares

ATTACHMENT 3

Family Care Partnership and PACE Geographic Service Regions January, 2016

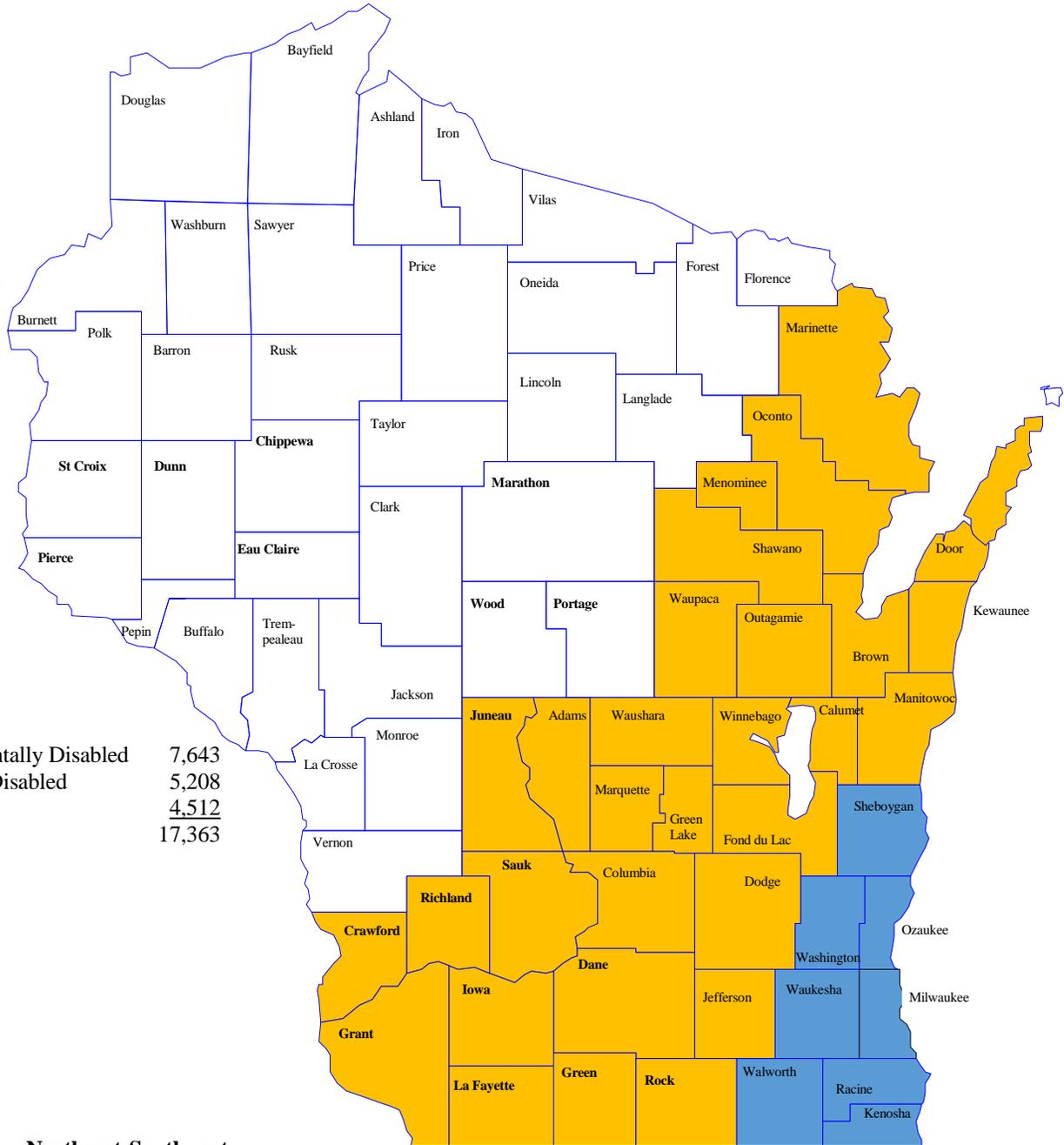


PACE/ Partnership MCO

- C1 Care Wisconsin
- C2 Community Care, Inc.
- i iCare
- P PACE (Community Care, Inc.)

ATTACHMENT 4-1

Diagonal Approach with 2020 Projected Membership



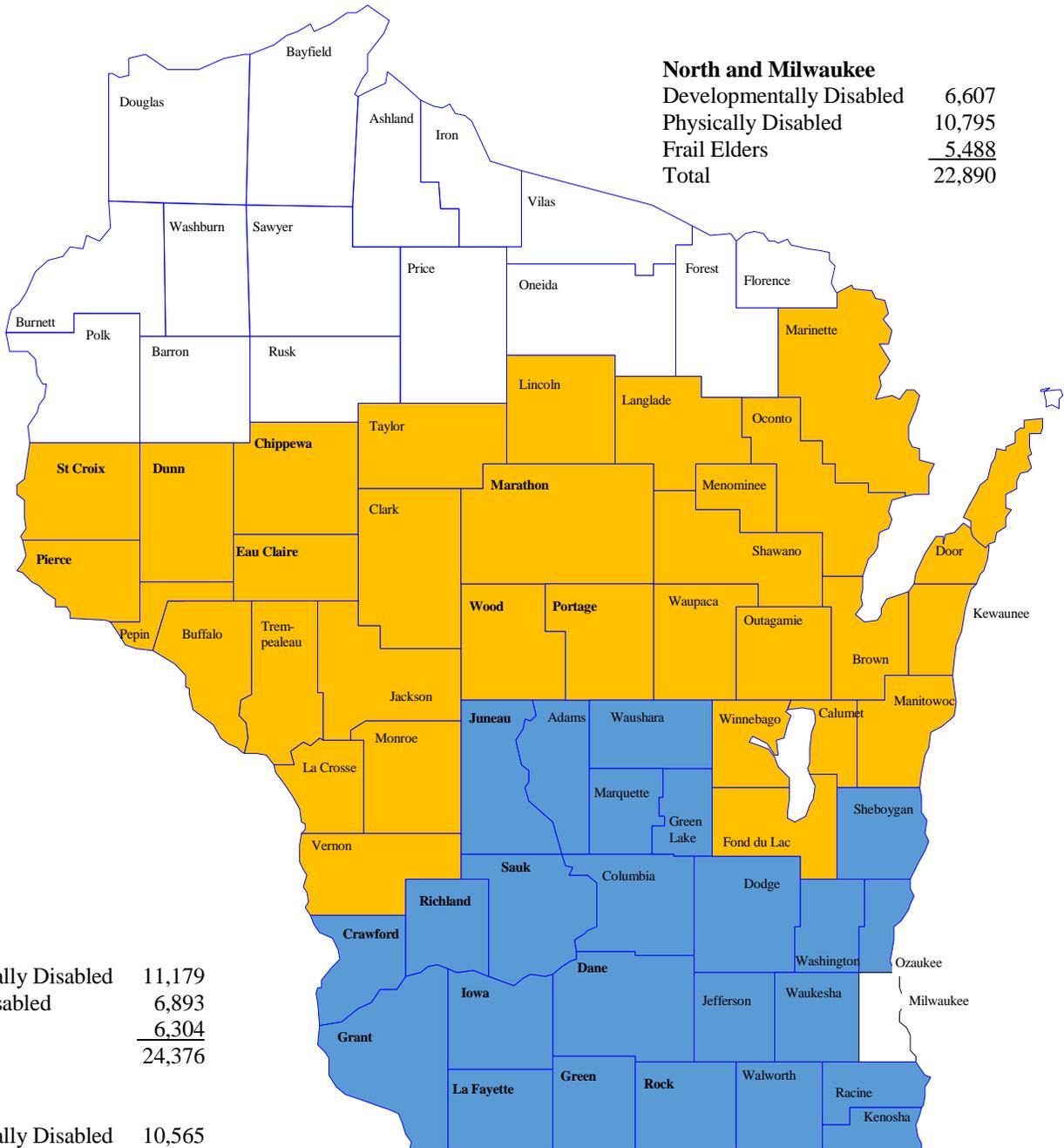
Northwest	
Developmentally Disabled	7,643
Physically Disabled	5,208
Frail Elders	<u>4,512</u>
Total	17,363

Northwest-Southwest	
Developmentally Disabled	10,704
Physically Disabled	6,203
Frail Elders	<u>5,503</u>
Total	22,410

Southeast	
Developmentally Disabled	10,004
Physically Disabled	12,487
Frail Elders	<u>7,028</u>
Total	29,519

ATTACHMENT 4-3

Non-Contiguous Approach with 2020 Projected Membership



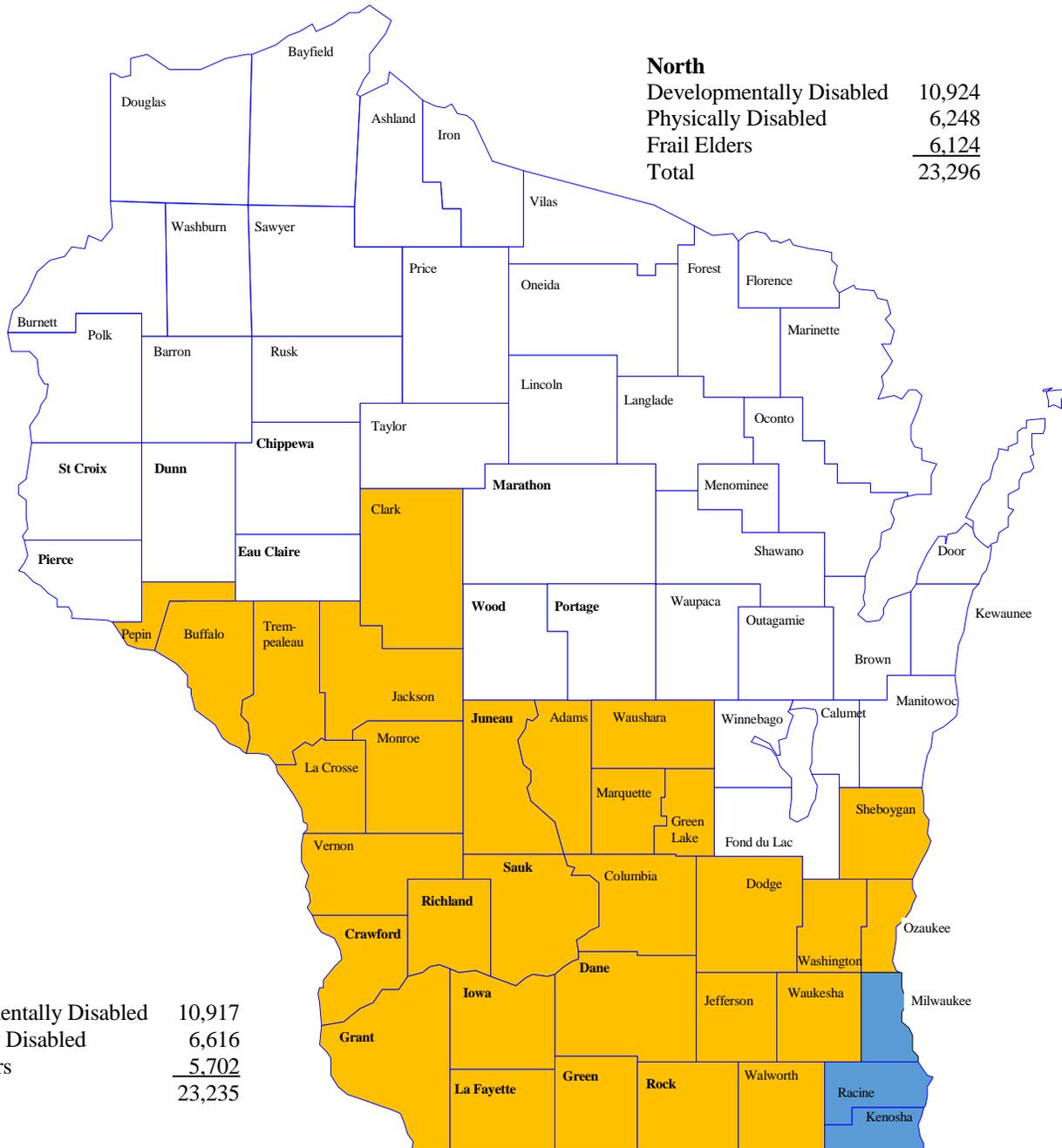
North and Milwaukee	
Developmentally Disabled	6,607
Physically Disabled	10,795
Frail Elders	<u>5,488</u>
Total	22,890

Central	
Developmentally Disabled	11,179
Physically Disabled	6,893
Frail Elders	<u>6,304</u>
Total	24,376

South	
Developmentally Disabled	10,565
Physically Disabled	6,210
Frail Elders	<u>5,251</u>
Total	22,026

ATTACHMENT 4-4

North/Midsouth Approach with 2020 Projected Membership



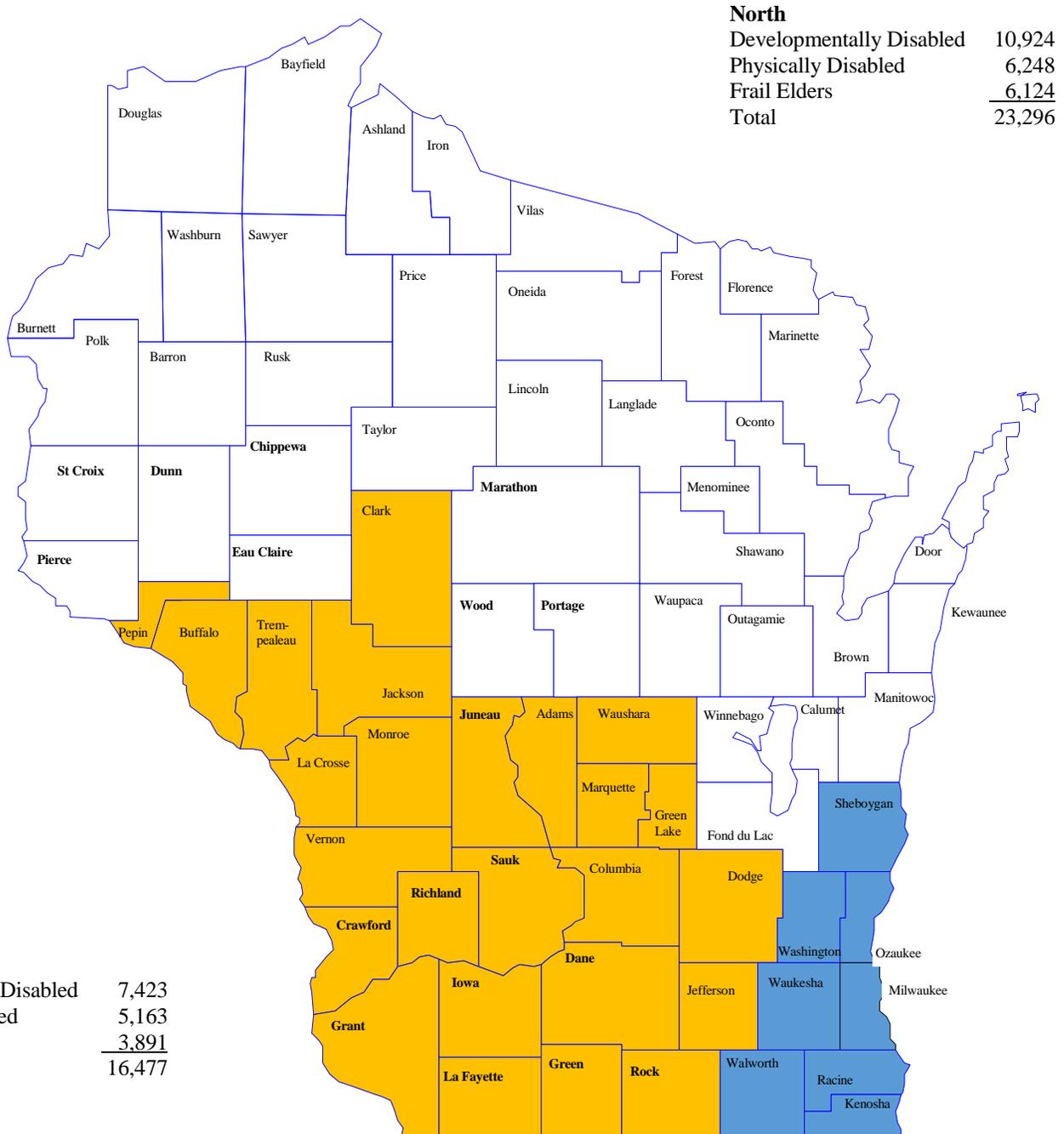
North	
Developmentally Disabled	10,924
Physically Disabled	6,248
Frail Elders	<u>6,124</u>
Total	23,296

Midsouth	
Developmentally Disabled	10,917
Physically Disabled	6,616
Frail Elders	<u>5,702</u>
Total	23,235

Milwaukee, Racine, Kenosha	
Developmentally Disabled	6,510
Physically Disabled	11,034
Frail Elders	<u>5,217</u>
Total	22,761

ATTACHMENT 4-5

North/Southwest Approach with 2020 Projected Membership



North	
Developmentally Disabled	10,924
Physically Disabled	6,248
Frail Elders	<u>6,124</u>
Total	23,296

Southwest	
Developmentally Disabled	7,423
Physically Disabled	5,163
Frail Elders	<u>3,891</u>
Total	16,477

Southeast	
Developmentally Disabled	10,004
Physically Disabled	12,487
Frail Elders	<u>7,028</u>
Total	29,519