Federal Surface Transportation Act Reauthorization (2014)

BACKGROUND

Transportation offers access to life-saving medical services and the ability to continue working, stay active and civically-involved, and contribute to the economic vitality of the community.

The current surface transportation act — MAP-21— is a 2-year bill that expires in 2014. This legislation made policy reforms and streamlined programs, but its short duration did not allow for planning and implementation of some of the changes. It also left many concerned about funding for creating connected multi-modal transportation systems for people in communities of all sizes.

Transportation outside urbanized areas tends to be more expensive and is least likely to be provided by public transit. Essential services like grocery stores or medical facilities are often miles away and because of the dispersed population, there is little opportunity to share rides. Rural areas are also disproportionately populated with older adults, low-income individuals and our nation's veterans, many of whom need transportation services with a higher level of assistance.

WAAN's Position

Keep transportation funding in the segregated fund and authorize a long-term surface transportation bill.

This will provide stability and funding to ensure transportation options are available and adequate for individuals who cannot or choose not to drive.

Without new and diversified sources of revenue, the Trust fund will be totally depleted by 2015.

The PROBLEM

Despite the increasing need for funding for all modes of transportation, current revenue generation for the transportation fund is not adequate. Without new and diversified sources of revenue, the Trust fund will be totally depleted by 2015.

Several transportation programs were repealed and others were consolidated under MAP-21. The proposed formula designations for these consolidated programs do not take into account the significant challenges for specialized transportation programs, especially outside of

metropolitan areas. With only 20% of the newly expanded federal 5310 program allocation dedicated to small urban and rural areas respectively, increasing needs, and little flexibility for state Departments of Transportation to reallocate funding according to the needs of their state, lack of funding for transit and specialized transportation programs is a significant concern.

In counties with large urban areas, there must be a balance between adequately funding financially starved public transit systems and creating viable and affordable options for those who are unable to use transit due to geographic area and service times of transit systems or those who need higher levels of service due to chronic and/or disabling conditions. When someone can no longer drive and has no way to get around, medical appointment visits decrease dramatically, food insecurity increases, and they are at higher risk of poor health, isolation, institutionalization and loneliness.

The SOLUTION

Passing a 6-year bill will allow transportation systems to plan long-term, multi-year projects, attract investors, and create jobs. Providing additional funding for alternative modes of transportation, coupled with investment in policies like complete streets to integrate land use planning, housing and transportation, and will create communities where people can age in place. Supporting all transportation programs from the segregated transportation fund ensures reliable, predictable funding that allows the state to plan and establish a comprehensive, connected multimodal transportation system for those who drive and those who do not or choose not to drive.

Funding multiple transportation options and livability initiatives makes good fiscal sense. Planning communities where people can age in place and still remain active and engaged is less expensive than institutionalization and provides a higher quality of life for older adults and anyone who does not or chooses not to drive.

Reauthorization of the federal surface transportation act (currently MAP-21) must ensure stable, long-term funding using a balanced approach and keep all transportation funding in the segregated Trust fund. There must be equity in funding transportation infrastructure whether it is a transit system, pedestrian bridge, bike trail or road. Reauthorization should aim to create communities with complete streets that enhance mobility choices, improve health, address environmental concerns and allow people the freedom and independence to move around, regardless of their age and ability.

What is WAAN?

The Wisconsin Aging Advocacy Network is a collaborative group of individuals and associations working with and for Wisconsin's older adults to shape public policy to improve their quality of life.

Core member organizations:

Aging and Disability Professionals Association of Wisconsin (ADPAW)

Alzheimer's Association SE Wisconsin Chapter

Wisconsin Adult Day Services Association (WADSA)

Wisconsin Association of Area Agencies on Aging (W4A)

Wisconsin Association of Benefit Specialists (WABS)

Wisconsin Association of Nutrition Directors (WAND)

Wisconsin Association of Senior Centers (WASC)

Contact WAAN

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Find this and other WAAN issue briefs at:
http://www.gwaar.org/advocacy-and-grassroots-resources1/wisconsin-aging-advocacy-network.html

Sue Torum

From: Badgeraginglist@yahoogroups.com on behalf of Carrie Porter carrie.porter@gwaar.org [Badgeraginglist] <Badgeraginglist-noreply@yahoogroups.com>
Sent: Tuesday, September 02, 2014 8:12 AM
To: Badgeraginglist@yahoogroups.com
Subject: [Badgeraginglist] Federal transit & highway funding advocacy [1 Attachment]
Attachments: Transportation-federal-2014.pdf

Good morning,

The transit and highway funding bill is in need of a long-term solution to continue to fund our infrastructure including transit and alternative transportation programs. Below is a letter you can sign to keep the pressure on Congress to make the hard choices that will be necessary to find a long-term solution. The House Ways and Means Committee has a large role in this discussion so conversations with Rep. Paul Ryan and Rep. Ron Kind who are on the Ways and Means Committee are particularly helpful.

Attached is the WI Aging Advocacy Network (WAAN) issues brief on this topic. You know and have seen the effects of being unable to get to appointments or remain socially connected. This is important work. Thank you for your continued advocacy on transportation.

Congress Acts to Avert Highway Trust Fund Insolvency

On July 31st, Congress approved legislation to avert the insolvency of the federal Highway Trust Fund (HTF), which provides funding for federal transit and highway programs. This short-term or "patch" bill provides approximately $10.8 billion in revenues to the HTF and extends the authorizations for federal transit and highway programs funded from the HTF through the end of May 31, 2015. This means that Congress still needs to develop and pass a long-term authorization and funding bill before the short-term bill expires next May. In the meantime, your coalition's help is needed to keep the pressure on Congress to pass a comprehensive, long-term transportation bill. As a start, please urge your fellow transit advocates to contact U.S. Senators and Representatives who represent your community and tell them to pass a long-term bill that provides increased, predictable funding for federal transportation programs.

Take action: You can take action now by generating a letter to your Congressional delegation here.

Carrie Porter
OAA Consultant
Transportation Specialist
Greater WI Agency on Aging Resources
608-228-8092

See www.GWAAR.org for the latest information and resources.

GWAAR Elder Law & Advocacy Center

Medicaid Estate Recovery and Divestment

March 2014

Changes to Wisconsin Medicaid law

Inside this issue:

In June 2013 the Legislature enacted Wisconsin Act 20. The Act made several changes to Wisconsin's Medicaid estate recovery and divestment program. Although the Legislature later repealed some of the Act's harshest provisions, many of the changes remain in effect.

This publication will discuss the changes to Wisconsin's Medicaid estate recovery and divestment program. It will also briefly outline the relevant parts of Wisconsin Act 20 that the Legislature repealed.

Overall, the changes to Medicaid greatly expand Wisconsin's estate recovery and divestment program. Consequently, Medicaid beneficiaries, and their spouses, will need to be more conscious about what property the State may recover after the beneficiary passes and which property transfers are categorized as divestments.

Special points of interest:

- *In June 2013, the Legislature made several changes to the state's Medicaid law*
- *Many of the changes pertained to estate recovery and divestment*
- *Recently, the Legislature repealed some of the harshest estate recovery and divestment provisions*

Estate Recovery

When a Medicaid Beneficiary dies, DHS may recover certain payments the State made on behalf of the beneficiary, including payments for long-term care.

Prior to Wisconsin Act 20, DHS was generally limited to only recovering property that went through probate and recovering assets in the beneficiary's bank account.

DHS was also limited in its ability to recover property from the community spouse.

However, after Act 20, DHS now has the ability to recover some of the deceased beneficiary's non-probate assets, as well as some marital property, which is owned in part by the Community Spouse.

Estate Recovery: Beneficiary's Non-Probate Property

DHS may now recover the deceased beneficiary's non-probate property, including revocable trust assets, life insurance, annuity benefits, and life estates.

Revocable Trusts
DHS may recover assets in revocable trusts. Under Medicaid, a trust is generally considered 'revocable' if:

- The Medicaid beneficiary is the trust's settlor
- The settlor can revoke the trust at any time

Life Insurance Policies & Annuities
DHS may recover death benefits from a life insurance policy or annuity if:

- The Medicaid beneficiary was the policy holder or annuitant
- DHS will not be able to recover the benefits if the surviving community spouse is the beneficiary

Life Estates
DHS may recover the beneficiary's interest in a life estate:

- The beneficiary must have had an interest in the life estate at the time of death
- The value of the life estate is value of the beneficiary's interest immediately before death

Estate Recovery: Community Spouse's Property

Under Wisconsin's old law, when a Medicaid beneficiary died, DHS was generally limited to recovering only the beneficiary's individual property. Now, after the surviving community spouse dies, DHS may recover any interest the beneficiary had in marital property as well.

Limitations on Recovery
DHS will presume all property in the surviving community spouse's estate is marital property. However the community spouse may rebut that presumption. Moreover:

- Marital property does not include the community spouse's individually owned property
- The beneficiary must have had an interest in the marital property at the time of death
- In Wisconsin, as each spouse has a 50% interest in marital property, DHS will most likely be limited to recovering the beneficiary's 50% interest in the marital property

Liens
If a surviving community spouse, child under 21, or disabled child is living in the deceased beneficiary's home, DHS may not recover the home. However, DHS may place a lien on the home.
Further:

- If anyone—including the spouse or child—sells the home for less than fair market value, then that spouse or child must place the proceeds into a trust or bond that is payable to the state when the spouse or child dies
- DHS may place liens on real estate other than the home

Medicaid Estate Recovery and Divestment

Estate Recovery: Effective Dates

The new estate recovery law applies to Medicaid beneficiaries who die or who receive benefits after **July 1, 2014.**

Divestment

Under Medicaid law, a Medicaid applicant may incur a divestment penalty—such as having to wait longer before being approved for Medicaid benefits—if the applicant divestments herself of her property.

A divestment is when a Medicaid applicant transfers property to another for less than fair market value.

Under the old law, divestment penalties generally only applied to Medicaid applicants who divested their own property. Now, however, the law may also apply to property the community spouse divests.

Moreover, the new law creates stricter requirements for Medicaid application reporting, including the type of information the applicant and her community spouse must provide when filling out the Medicaid application.

> "A divestment penalty may be assessed, when the community spouse transfers property."

Divestment: Transfers Involving the Community Spouse

Before the new law, divestment penalties generally only applied when the Medicaid applicant transferred her own property.

Now, a divestment penalty may be assessed when the community spouse transfers property as well.

Timing

If a community spouse transfers property within 5 years after the Medicaid spouse becomes eligible for Medicaid benefits, then the State may impose a divestment penalty.

Partial Cures

Under the old law, a divestment penalty could have been removed—or 'cured'—if the Medicaid applicant paid the State a partial amount of the divested property's value.

In contrast, the new law does not allow partial cures. If the Medicaid beneficiary wants to remove the penalty, then the beneficiary must pay the State 100% of the divested property's value.

Penalty Period

Before the new law, the divestment penalty period began on the date the Medicaid applicant applied for benefits. This meant that the penalty period began before the Medicaid applicant received notice of the penalty. Accordingly, the penalty period ran faster.

Now, the penalty period begins a month after DHS sends out the penalty notice. This means the penalty will run slower.

Minimum Monthly Maintenance Needs Allowance (MMMNA)

In order to raise the community spouse's income to the MMMNA, the Medicaid spouse may allocate part of her income to the community spouse.

Under the old law, an Administrative Law Judge (ALJ) would determine how much income the Medicaid spouse could allocate to the Community Spouse.

Under the new law, the ALJ must use a precalculated annuity formula to determine the amount.

Divestment: Medicaid Applications and Reporting Income and Assets

The new law expands the reporting requirements for Medicaid applications.

Estranged Spouses

Under the old law, if a couple were still legally married, but the two were estranged, the spouse applying for Medicaid would be treated as a single individual on her application. Subsequently, the application would not have required the applicant to obtain the estranged spouse's signature or required the estranged spouse to report his income and assets.

Now, even if the couple is estranged, the spouse applying for Medicaid, must obtain the estranged spouse's signature for the Medicaid application and must also obtain the estranged spouse's asset and income information.

Loans to Family Members

If a Medicaid beneficiary makes a loan to a family member, *which cancels upon the death of the lender (beneficiary)*, then DHS will classify the loan as a divestment.

"The Medicaid applicant must obtain the estranged spouse's signature, income and asset information."

Divestment: Effective Date

The effective date for the divestment changes is on or after **November 11, 2013.**

However, it is important to note that the requirement for obtaining the estranged spouse's information will be applied to current Medicaid beneficiaries' annual reviews.

Miscellaneous

Life Insurance Values

For purposes of Medicaid, a life insurance policy is valued according to its face value. Previously, the face value did not include riders and other attachments.

Under the new law, the face value of the policy includes riders and other attachments.

Repealed Provisions

Although Wisconsin Act 20 made several changes to Medicaid law, the Legislature recently repealed some of those changes. The following outlines the repealed provisions and clarifies what the state cannot do:

Estate Recovery Provisions

- Estate Recovery will not apply to irrevocable trusts
- There will be not special reporting or special notice and repayment requirements for living and/or special needs trusts
- Trustees will not be personally liable for failing to notify DHS within 30 days of a trust beneficiary's death
- The definition of *financial institution*, is still the definition under 12 U.S.C. § 3401(1).
- Pooled trustees will not be required to pay DHS 70% of the deceased beneficiary's remaining trust funds

Divestment Provisions

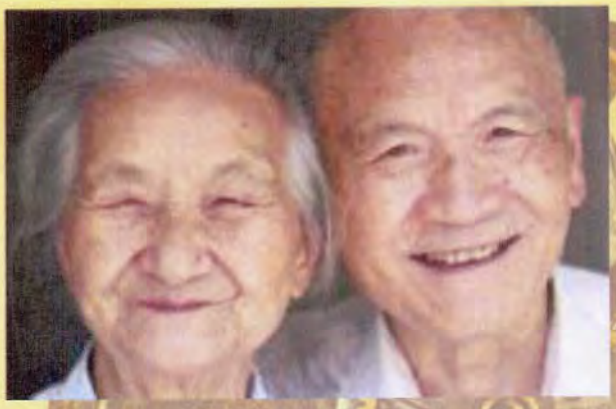
- Except for the home, DHS cannot penalize Medicaid beneficiaries and/or their spouses for transferring property that is a federally exempt resource for the purpose of determining Medicaid eligibility
- If a Medicaid beneficiary transfers real estate, and does not notify DHS, DHS cannot void the real estate transfer
- DHS will not *presume* a loan to a family member is a divestment, but the loan may still be a divestment. See above section

Spousal Impoverishment Protections Under the Wisconsin Medicaid Program

Spousal Impoverishment Prevention Provisions

- Enacted to protect a spouse at home from becoming poor when his or her spouse is considered "institutionalized," either because he or she resides in a nursing facility or because he or she receives certain long-term care services in the community.

- Include asset and income protections that were created both to allow an institutionalized spouse to become eligible for Medicaid without depleting all the couple's financial resources and to enable the community spouse to maintain financial independence during his or her spouse's institutional care.



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ASSET PROTECTIONS

At the beginning of the first continuous period of institutionalization, the couple's total liquid assets from all sources is determined and added together regardless of title ownership. Wisconsin marital property law does not apply. Also, any "pre-marital agreement" the couple signed has no effect for Medicaid purposes. In general, certain resources are considered to be "exempt" and are therefore not counted in the asset assessment. For instance, the couple's household goods and personal property are exempt, regardless of value. The house that is used as the community spouse's primary residence is excluded, as long as he or she continues to reside there or as long as either spouse intends to return to it. At least one vehicle owned by the couple is exempt, regardless of value or purpose. Certain pre-paid burial arrangements for each spouse are excluded, and a small life insurance policy for the institutionalized spouse (face value of $1,500 or less) is exempt.

IF COUPLE'S COMBINED ASSETS ARE:	AT-HOME SPOUSE MAY KEEP:
$0 - $50,000	ALL
$50,001 - $100,000	$50,000
$100,001 - $234,480	HALF
$234,480+	$117,240

Once the total amount of assets is computed, the community spouse is entitled to retain a "community spouse resource allowance" (CSRA). ***For Medicaid applications made after January 1, 2014, the community spouse may retain the GREATER amount of $50,000 or one-half of the couple's combined assets, up to a maximum of $117,240.*** (The latter figure is adjusted for inflation each January.) This formula is illustrated in the chart on the left.

ASSET PROTECTIONS CONTINUED

The institutionalized spouse may retain $2,000 in liquid assets. It is crucial that the institutionalized spouse's assets not exceed this limit in order to maintain Medicaid eligibility. Any month in which the institutionalized spouse's assets exceed $2,000, he or she will be found ineligible for Medicaid and can be billed for his or her care at the facility's private pay rate. If the couple has more assets than the community spouse resource allowance (CSRA) plus $2,000, the couple must spend the excess funds on daily living expenses, the nursing home spouse's care, bills and other permitted expenditures until the couple has only the CSRA, plus $2,000. **Thus, it is extremely important that the couple determine the extent of their assets at the time one spouse is first institutionalized.**

It is not necessary to have all assets in the community spouse's name at the time the Medicaid application is submitted. However, the transfer of the assets to the community spouse must be made "as soon as practical" after Medicaid eligibility is established. In general, this means that the institutionalized spouse has until his or her first annual review of Medicaid eligibility to transfer to the community spouse all assets in excess of the $2,000 limit. If assets that should be in the community spouse's name are still in the institutionalized spouse's name at the date of the first review, eligibility may be terminated.

Once Medicaid eligibility is established, none of the community spouse's resources are considered available to the institutionalized spouse. Therefore, the community spouse's assets can increase beyond his or her resource allowance after Medicaid eligibility is in place.

Examples

EXAMPLE #1

Mr. Winthrop entered a nursing home in 2014. Mrs. Winthrop remains in their home. The couple's combined assets total $120,000 (not counting their home, car, personal property or burial items). Mrs. Winthrop may keep the GREATER of $50,000 or one-half of the combined assets, up to a maximum of $117,240. Thus, Mrs. Winthrop may keep $60,000 (½ of $120,000 = $60,000). Because Mr. Winthrop may only keep $2,000 in assets to qualify for Medicaid, he will not be eligible until the couple has spent the excess of $58,000 ($60,000 - $2,000). This amount can be spent, for example, on repairs to the home, paying off any remaining mortgage, Mr. Winthrop's monthly nursing home bill, items Mr. Winthrop needs for his move to the nursing home, unpaid medical bills, and so forth.

EXAMPLE #2

Mr. and Mrs. Winthrop, from Example #1, spent their excess $58,000 on Mr. Winthrop's nursing home bill, some previous medical bills and a new furnace for their home (where Mrs. Winthrop continues to live). Later in 2014, Mr. Winthrop is eligible for Medicaid. After Mr. Winthrop is found eligible, Mrs. Winthrop receives a $5,000 inheritance from her sister. This $5,000 is hers to keep, in addition to the $60,000 community spouse resource allowance. Medicaid law does not require her to pay any of the $5,000 to the nursing home. In addition, her receipt of the inheritance has no effect on Mr. Winthrop's continued eligibility for Medicaid.

EXAMPLE #3

Mr. and Mrs. Gorski's only assets are their house, car and $62,000 in savings. Mr. Gorski will enter a nursing home in 2014. Mr. Gorski can keep $2,000. Mrs. Gorski will be able to retain the greater of $50,000 or one-half of the remaining $60,000 (½ of $60,000 = $30,000). Thus, Mrs. Gorski may retain $50,000.

INCOME PROTECTIONS

Step 1

The spousal impoverishment prevention provisions protect a portion of monthly income to allow the community spouse to maintain financial independence. This amount of income is called the Community Spouse Income Allocation (CSIA) and was formerly known as the Minimum Monthly Maintenance Needs Allowance (MMMNA). The CSIA limit is established annually according to the federal poverty guidelines. Currently, the CSIA is set at **$2,621.67**. If the community spouse's income is below $2,621.67, there are two possible steps to raise his or her income to the CSIA.

In the first step, some or all of the institutionalized spouse's "excess" income is allocated to the community spouse. If an income allocation is not sufficient to raise the community spouse's income to the CSIA, then either spouse can request the second step--an increase in the community spouse resource allowance (CSRA) above the standard allowance for the strict purpose of protecting assets that generate income. For some community spouses, both of these steps will be necessary to raise their incomes to the CSIA.

The community spouse's income can be raised to the CSIA by allocating some or all of the institutionalized spouse's excess income to the community spouse. Excess income is any income remaining after a $45 personal needs allowance is deducted from the institutionalized spouse's income.

> *"Currently, the CSIA is set at **$2,621.67**."*

Examples

EXAMPLE #4

Mr. O'Reilly is in a nursing home; his monthly income is $1,900. Mrs. O'Reilly lives in the community; her monthly income is $1,000. Because Mrs. O'Reilly's income is under the current CSIA of $2,621.67, she can receive an allocation of $1,621.67 from Mr. O'Reilly's income. This allocation will raise Mrs. O'Reilly's income to the $2,621.67 CSIA income limit ($1,000 income in her own name and $1,621.67 allocated from Mr. O'Reilly's income). The remaining $233.33 of Mr. O'Reilly's income ($1,900 - $45 personal needs allowance - $1,621.67 allocation to Mrs. O'Reilly) will be paid to the nursing home as his Medicaid cost-sharing obligation.

EXAMPLE #5

Mr. Osterman is in a nursing home; his monthly income is $850. Mrs. Osterman lives in the community; her monthly income is $500. After deducting $45 for Mr. Osterman's personal needs allowance, the remaining $805 will be allocated to Mrs. Osterman. That allocation will bring Mrs. Osterman's income to $1,305 ($500 in her own name and $805 allocated from Mr. Osterman's income). **Note that the government does not provide Mrs. Osterman with additional funds to bring her income to the CSIA of $2,621.67.**

INCOME PROTECTIONS

Step 2

The second step in raising the community spouse's monthly income to the CSIA is to protect additional assets by seeking an increased community spouse resource allowance (CSRA). If the community spouse's income is still below the CSIA after an allocation from the institutionalized spouse's income is included, and if the couple own assets that generate income, then the community spouse's resource allowance can be raised above the standard allowance for the sole purpose of generating additional income from those assets. This increase in the resource allowance **can be accomplished only by asking a state administrative law judge to set a higher CSRA** than the chart on page two indicates. County economic support specialists have no discretion to authorize this. This method is illustrated in example #6.

EXAMPLE #6

Mrs. Larson is in a nursing home; her monthly income is $500 (from Social Security). Mr. Larson is in the community. His income is $1,200 ($200 from a pension and $1,000 from Social Security). Mr. Larson's income is below the CSIA of $2,621.67, an income allocation from Mrs. Larson would be necessary. Mrs. Larson could allocate $455 to Mr. Larson ($500 - $45 personal needs allowance), bringing Mr. Larson's income to $1,655. Because Mr. Larson's income still falls short of the CSIA by $966.67, the Larsons are candidates for the second step in raising a community spouse's income--increasing Mr. Larson's resource allowance. The couple has $80,000 in assets, consisting of two CDs. Together the CDs generate $250 per month in interest income. According to the chart on the second page, Mr. Larson's community spouse resource allowance would be set at $50,000. However, Mr. Larson may appeal that determination. He can request that an administrative law judge establish an increased resource allowance to include all of the couple's assets because the income generated by the assets is necessary to raise his income from $1,655 to $1,905 ($1,655 + $250 interest income). This $1,905 is still below the CSIA of $2,621.67. Thus, an administrative law judge can decide to raise Mr. Larson's CSRA to include the additional assets.

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INCOME PROTECTIONS

Step 2 Continued

It is possible for the community spouse to receive more than $2,621.67/month if the community spouse has "excess shelter expenses" and additional funds are available, either from the institutionalized spouse's income or the couple's assets. Currently, the $2,621.67 allowance can be increased to as much as $2,931. If the community spouse's monthly shelter expenses exceed $786.50, his or her income allowance can be increased by the amount of shelter expenses above $786.50, either by receiving an increased income allocation from the institutionalized spouse or by raising the community spouse's resource allowance as described in Example #6.

The specific expenses that the county economic support office will use to determine the community spouse's shelter expenses are: (1) rent or mortgage (principal and interest); (2) second mortgage(s); (3) mobile home lot rent and loan payments; (4) property tax liability; (5) insurance for the residence; (6) required condominium or cooperative fees; (7) special assessment(s); and (8) a monthly utility allowance established under the FoodShare Program. Currently, that allowance is $450 if the community spouse pays for heat; $313 if the community spouse pays for at least 2 non-heat utilities; and $30 if the only utility expense is the telephone bill.

This increase in the monthly income allowance can be accomplished simply by presenting appropriate bills, receipts and other documents to the economic support office. In addition, a community spouse may seek an increased income allowance above the CSIA to pay for basic, necessary living expenses by requesting a hearing before an administrative law judge. The community spouse must prove that "exceptional circumstances" require an income allowance above the CSIA.

If the community spouse's own monthly income is greater than $2,621.67 (or the higher allowance if there are excess shelter expenses), the institutionalized spouse **cannot** give any of his or her income to the community spouse. Additionally, the community spouse's income above $2,621.67 is not automatically paid to the nursing facility as part of the institutionalized spouse's cost-sharing obligation. Rather, the community spouse simply keeps all of his or her income, absent a court order requiring contribution to the institutionalized spouse's cost of care.

Examples

EXAMPLE #7

Mrs. Ward (a community spouse) has a mortgage payment of $350 per month, a pro-rated property tax obligation of $195 per month and a pro-rated insurance obligation of $25 per month. She pays all of her utilities, including heat (thus, she is entitled to a $450 utility allowance). Her monthly shelter costs are $1,012. Therefore, her excess monthly shelter costs are $225.50 ($1,012 - $786.50 = $225.50). As a result, Mrs. Ward's monthly income allowance can be increased to $2,847.17 (the standard CSIA of $2,621.67 + $225.50 in excess shelter expenses).

EXAMPLE #8

Mrs. Rodriguez is in a nursing home and eligible for Medicaid. Mr. Rodriguez continues to live in their home. Mr. Rodriguez's monthly income is $2,700 (from Social Security, his retirement pension and interest on several investments). Mrs. Rodriguez's monthly income is $1,000 (from Social Security and a small pension). Because Mr. Rodriguez's income is greater than the $2,621.67 limit, none of Mrs. Rodriguez's income will be allocated to him. Mrs. Rodriguez will pay $955 ($1,000 less her $45 personal needs allowance) to the nursing facility. However, none of Mr. Rodriguez's income will be used to pay the nursing home bill.

DIVESTMENT

Divestment penalties may occur when you give away, transfer or sell any asset for less than fair market value. Disposing of certain assets for less than fair market value prior to applying for Medicaid may be considered divestment. This includes transfers to trusts. Transfers between spouses are not divestments. Most transfers to other people, however, are considered divestments and may make an applicant ineligible for benefits under the Medicaid program.

Significant changes in Medicaid law have made permissible transfers of resources more difficult, and potential penalties for disqualifying divestments have increased. It is important that you are aware of these rules and have accurate and up-to-date information about any changes.

If you have questions about financial planning or transfers of assets or property, consult a private attorney who practices elder law.

BACK BY POPULAR DEMAND:

PUZZLED ABOUT MEDICARE?

Putting the Pieces Together!

Jefferson Co. Elder Benefit Specialists invite you to attend a free Medicare Seminar featuring: Tracy Lipinski, Medigap Counselor for the State of Wisconsin Board on Aging and Long Term Care.

Tuesday, September 9, 2014
Fort Memorial Hospital, Auditorium
611 Sherman Avenue East
6:30-8:30pm

Original or Private Medicare health coverage, Supplemental Insurance and prescription drug options often raise questions when navigating confusing choices. Looking for answers? Tracy Lipinski is an expert with the State of Wisconsin on Medicare coverage and how Medicare Supplements can help seniors fit all the pieces of their Medicare Puzzle together. Ms. Lipinski will present the **free** seminar at the Fort Memorial Hospital for Jefferson County Seniors that helps beneficiaries understand and compare the differences between the assortment of Medicare Health options.

The seminar is ideal for people who will be turning 65 in the upcoming months and will be newly eligible for Medicare.... But it will also very helpful to ANY Medicare beneficiary who has questions or concerns on the newly complicated Medicare options and benefits.

The seminar is free and open to the public but reservations are encouraged. Attendees can pre-register by calling 920-674-8734.

Denise Grossman and Doug Carson, Jefferson County Elder Benefit Specialists will also be on hand to answer questions about Medicare! This event is sponsored by the Jefferson County Elder Benefit Specialist Program, and is NOT affiliated with any insurance companies.

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Denise Goessman and Doug Carson, Jefferson County Elder Benefit Specialists will also be on hand to answer questions about Medicare! This event is sponsored by the Jefferson County Elder Benefit Specialist Program, and is NOT affiliated with any insurance companies.

ADRC of Jefferson County Semi Annual Report 2014

Since January of this year, the ADRC has had 2,651 contacts with consumers by providing Information & Assistance, options counseling, enrollment and disenrollment counseling.

January thru June 2014 Call report

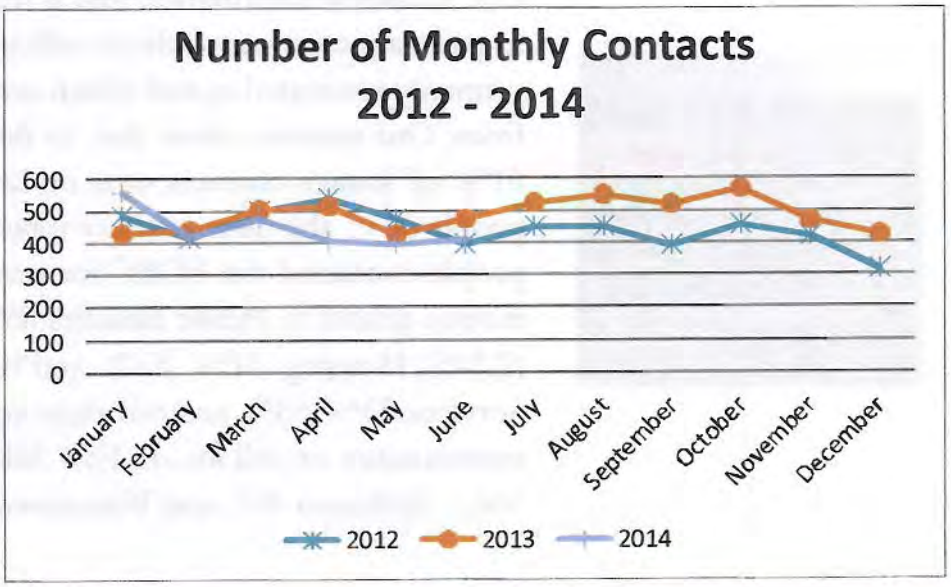
Aging and Disability Resource Centers (ADRC's) offer the general public a single entry point of access for information and assistance on issues affecting older people and people with disabilities, regardless of their income. Individuals, family members, friends or professionals working with issues related to aging, physical disabilities, or intellectual disabilities can receive information specifically tailored to each person's situation.

SAMS Call Profiler Report

January—June 2014

Email	227
Fax	12
Home Visit	283
Incoming Calls	1,179
Office Visit (scheduled)	120
Outgoing	436
Walk-In's	128
Written Correspondence	266

	2012	2013	2014
January	483	431	558
February	413	439	417
March	500	502	472
April	539	511	402
May	473	424	395
June	393	474	407
July	449	520	
August	448	548	
September	389	516	
October	451	569	
November	420	468	
December	313	426	
Totals	5271	5828	2651



Nursing Home Relocation Consumer:

"I have a well organized worker "Dominic" also prompt and informed"

"Get your Wheaties in the morning and your Twinkies in the evening"

Customer Satisfaction Survey January 2014

Farmer Market Voucher's

All the 2014 Farmer Market Voucher's have been distributed to 201 individuals in Jefferson County.

Just an FYI ~ farmers' market U.S. postage stamps that will be available August 7

Farmer Market Voucher Wait List

At this time, the ADRC is not required to maintain a wait list for the Farmer's Market Voucher as per Judy Allen, Coordinator WIC and Senior Farmers' Market Nutrition Program, as there not enough to serve additional participants.

Who's Calling and What Information are Consumers Hot Topics

Our statistical information that is tracked within our database allows us to paint a picture as to who is calling the ADRC, what topics they are primarily interested in and which communities are consumers calling from. Our statistics show that in this quarter 61% of known contacts were on behalf people 60+; the three primary topics that people contacted the ADRC for was information related to Public Benefits 85% (2,245), Housing 31% (832) and In - Home Services 23% (633); and our three primary communities of call ins are Fort Atkinson, 566, Jefferson 457, and Watertown 441.

"I was not aware of your 'program' until Sara called me; came over to me , with all the info"

Customer Satisfaction Survey

Visit location: Hospital

Did your Representative follow-up with you?

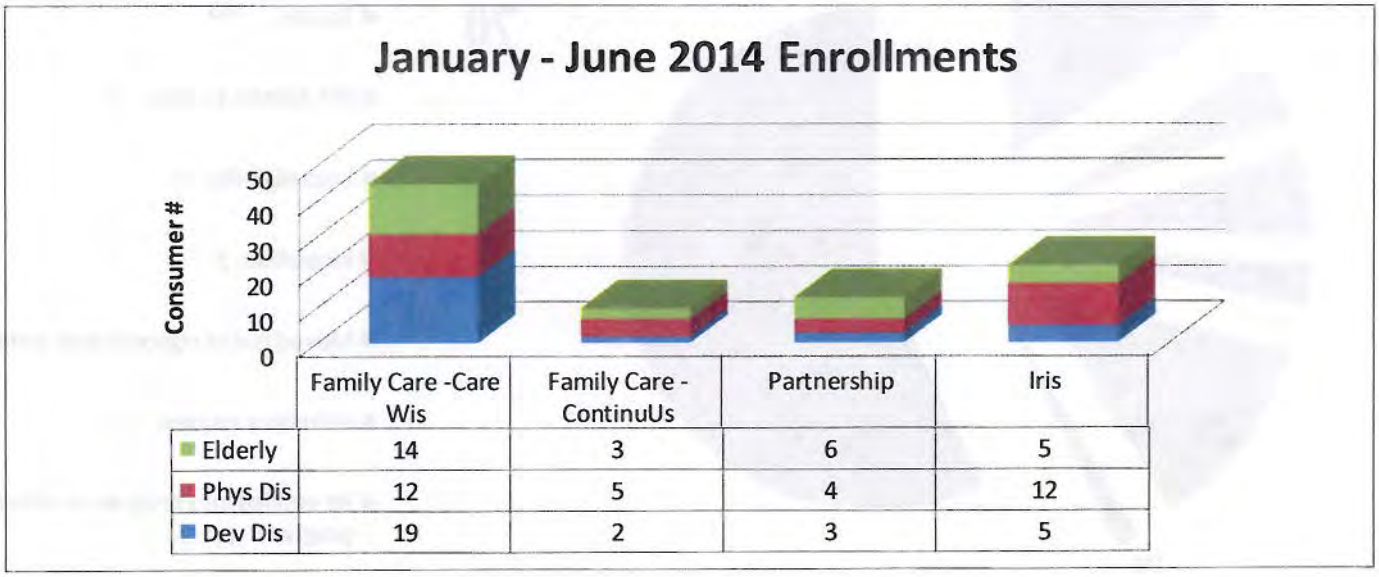
"With the Nurse (Karen), that was a plus".

Customer Satisfaction Survey April 2014

Training

All Staff attended training by State Staff on Spousal Impoverishment and Estate Recovery Changes. Some cases are very complex and require additional staff attention.

ADRC Enrollments into Publicly Funded Long Term Care Programs—90

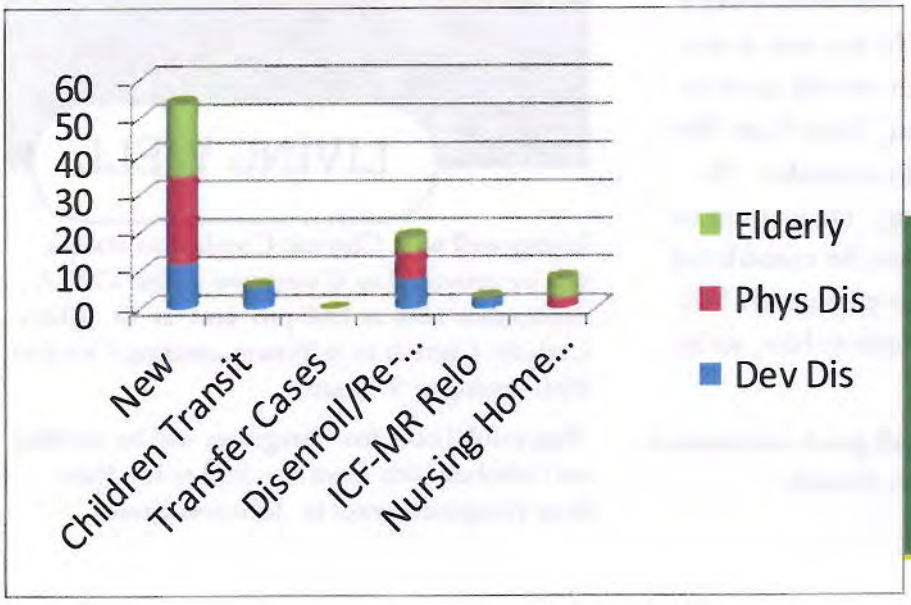


	Family Care -Care Wis	Family Care - ContinuUs	Partnership	Iris
Elderly	14	3	6	5
Phys Dis	12	5	4	12
Dev Dis	19	2	3	5

January 16 Enrollments ~ February 13 Enrollments ~ March 17 Enrollments
April 14 Enrollments ~ May 13 Enrollments ~ June 17 Enrollments

Enrollment Status

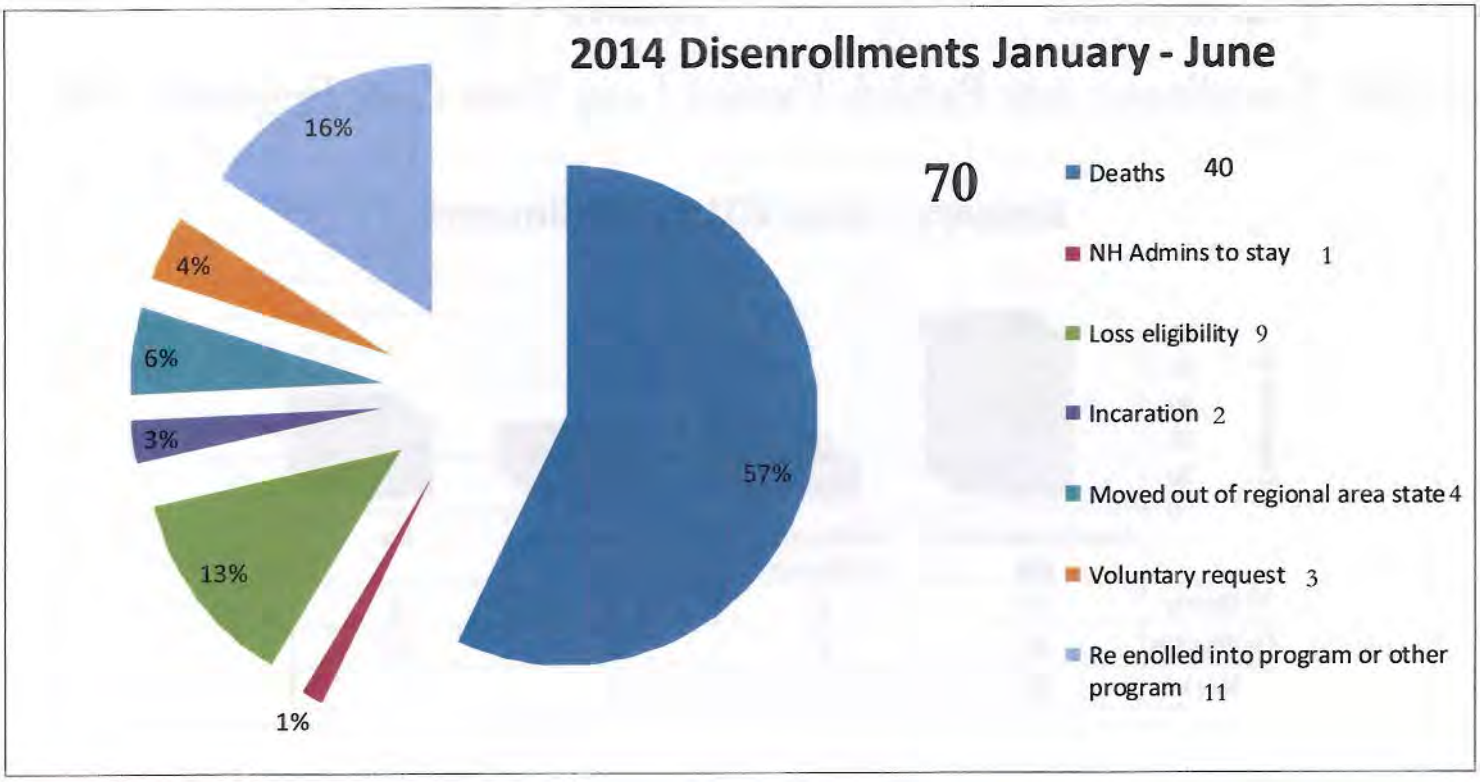
Target Group	New	Children Transit	Transfer Cases	Disenroll/Re-enroll	ICF-MR Relo	Nursing Home Enrollments
Dev Dis	12	6	0	8	3	0
Phys Dis	23	0	0	7	0	3
Elderly	19	0	0	4	0	5



"I am looking forward to working with the program that Sara has told me about"

Customer's response

January 2014 Satisfaction Survey



A Consumer 's Story.....

A friend called to ask how a consumer can apply for disability as he is now legally blind with glaucoma and diabetes. He had sudden eye loss, walked out of a store and his vision in one eye was gone. After three surgeries on one eye and 2 on the other, his vision is now consider to be legally blind. He can no longer drive or work and the friend has been helping him, but her parents now need help. His family has been helping, but there is just a limit on what they can assist with. Our DBS assisted with disability and presumptive Medicaid. He was able to enroll into a long term care program., but that is not always the easiest decision. He went from a working income to a disability payment. His income is not $1,600. For medical assistance eligibility he would need to cost share over $700 to be eligible for Long Term Care Programs. That did take a little time for him to consider. He needed to move into lower income housing. He wanted to go into IRIS but he had a small IRIS budget, he considered Partnership but he would possibly need to change his Milwaukee doctors who are extremely important to him, so he chose Family Care.

"Nancy Toshner—very personable, patient and good communication, made things seem less confusing and user friendly".

Customer Sat. Survey July 2014

LIVING WELL

Living well with Chronic Conditions classes will be provided in Watertown at the YMCA , September 18th at 1:00 pm and at St. John's Catholic Church in Jefferson starting October 16th staring at 9:00 am.

Powerful Tools for Caregivers will be starting on October 16th from 1—3:30 at the Rainbow Hospice Center in Johnson Creek.

Supporting Individuals with AUTiSM

Transitioning from School to Work

Important Details

By Invitation Only

Date:
October 2, 2014

Time:
8:00 - 12:00

Location:
Jefferson High School
700 W Milwaukee St.
Jefferson, WI 53549
Park in Teacher lot on Taft Ave.

Registration:
Click here to Register

Registration Deadline:
September 30, 2014

Questions:
Contact the ADRC
(920) 674-8734

Sponsored by
Jefferson County Transition Network

October 2, 2014
From School to Work for Students with Autism

Presented by: Kate McGinnity, Autism Consultant & Judy Endow, MSW

For: Educators and Service Providers

Adults on the spectrum often have difficulty getting and keeping a job. This difficulty is unrelated to their job skills. In this presentation, Judy Endow and Kate McGinnity will address transition planning that needs to occur while students are school aged, as well as strategies to support and bridge their entry into the work world post HS, including forms for initial and ongoing assessment of job and related skills, video technology, and prioritizing the most effective use of school time. The presentation is based in part on the book ***The Hidden Curriculum of Getting and Keeping a Job: Navigating the Social Landscape of Employment***, a book that provides necessary yet often untaught information on a variety of topics related to getting a job such as finding a mentor, networking, using agencies, interviewing, talking with supervisors, dealing with on-the-job frustrations, understanding the social rules at work and many other topics. This presentation will focus on strategies proven to be helpful to people with autism in navigating the social landscape of the workplace.

Supporting Individuals with AUTISM

Transitioning from School to Work

Workshop Presenters:

October 2, 2014

Agenda

Registration
8:00-8:30

Presentation
8:30 - 10:00

Break
10:00-10:15

Presentation
10:15 -11:45

Q&A & Survey
11:45-noon

Kate McGinnity, Autism Consultant

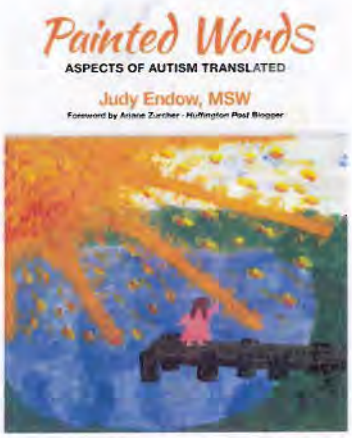
Kate is an experienced classroom teacher, trainer, author as well as a nationally recognized consultant in the field of autism. She has over 30 years experience working with individuals with autism and their families. During her tenure as a teacher, Kate was recognized as the Wisconsin and National Teacher of the Year by the Autism Society of America. She is currently involved in private practice providing training and consultation to professionals and parents as well as counseling and yoga to individuals on the autism spectrum. Kate has been a core trainer and developer for the Wisconsin Statewide Autism Training project through DPI, since its inception over 25 years ago. Kate regularly teaches graduate level autism related courses, through a variety of universities. Kate is the co-author of the following books, both available through CBR Press: "Walk Awhile in My Autism"(2005) and "Lights! Camera! Autism! Using video technology to enhance lives" (2011) and "Lights! Camera! Autism!2 Using video technology to support new behavior (2013). She is committed to bringing her passion and compassion to every aspect of her work and life.

Judy Endow, MSW

Judy Endow, MSW is an author and international speaker on a variety of autism-related topics, is part of the Wisconsin Department of Public Instruction Statewide Autism Training Team and a board member of both the Autism Society of America, Wisconsin Chapter and the Autism National Committee. In addition, Judy works for Common Threads Family Resource Center in McFarland, Wisconsin and with Autistic Global Initiative (AGI), a program of the Autism Research Institute.

Judy maintains a private practice in Madison, Wisconsin, providing consultation for families, school districts and other agencies. Besides having autism herself, she is the parent of three now grown sons, one of whom is on the autism spectrum.

In her spare time Judy enjoys expressing her thoughts and ideas by creating one-of-a-kind hand-built pottery sculptures and painting with acrylics.



Workshop Presenters

Kate Kostinsky
Autism Consultant

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Long-Term Care in Motion

Wisconsin's Long-Term Care Programs

2012 Annual Report

Wisconsin Department of Health Services
Division of Long-Term Care
P.O. Box 7851
Madison, Wisconsin 53707-7851
dhs.wisconsin.gov/LTCare
P-00318 (06/2014)

Values of Family Care

CHOICE – Give people better choices about the services and supports available to meet their needs.

ACCESS – Improve people's access to services.

QUALITY – Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.

COST-EFFECTIVENESS – Create a cost-effective long-term care system for the future.

Values of IRIS

INCLUDE – Wisconsin elders, adults with physical disabilities and adults with developmental disabilities who are Medicaid eligible are included in communities across Wisconsin. IRIS can help participants remain connected to others.

RESPECT – You choose where you live, the relationships you build, your work, and your participation in your community.

I SELF-DIRECT – IRIS is a self-directed long-term care option in which you use an individual budget allocation to help meet your long-term care needs.

Table of Contents

Introduction

In 2012, about 53,500 frail elders and adults with physical, developmental or intellectual disabilities received long-term care services from Wisconsin's Medicaid (MA) long-term care (LTC) programs at some point during the year. These programs are Family Care and IRIS (Include, Respect, I Self-Direct).

IRIS is a program in which participants self-direct their care plan and services within an individual budget. The Family Care programs (Family Care, Family Care-Partnership, and PACE) work with members to develop individualized care plans and provide or coordinate services.

The Wisconsin Department of Health Services (DHS) began Family Care in 2000 to help improve its long-term care system. IRIS began in 2008 as an option for people who wanted to self-direct all of their long-term care services. DHS collaborated with consumers, providers, and advocates to develop these publicly funded programs.

Family Care and IRIS are based on the belief that all people – including frail elders and people with disabilities – should be able to live at home with the supports they need and participate in communities that value their contributions.

The programs help individuals stay in their own homes or other non-institutional settings whenever possible. Most people in Family Care and IRIS live in their own homes or other community settings. This allows people to have more power over their lives and be more involved with their communities. They can decide when to do certain things, such as when to wake up and eat meals, and how to organize their daily activities.

What is Family Care?

FAMILY CARE
Options for Long-Term Care

DHS contracts with Managed Care Organizations (MCOs) to operate Wisconsin's three managed long-term care programs:

- Family Care
- Family Care Partnership
- PACE

These are voluntary programs where eligible individuals can choose to enroll and become members of an MCO. MCOs provide or coordinate cost-effective and flexible services tailored to each individual's needs.

DHS provides the MCO with a monthly payment for each member. The MCO uses these funds to provide individually planned services for all of its members.

Care managers work with members to identify their needs, strengths and preferences. Together, they identify the resources available and develop a care plan that may include help from family, friends and neighbors. When this help is not available, the MCO will purchase necessary services.

Members may also choose to self-direct their care by choosing who will provide their services or when to receive certain services. Members who self-direct their services still have access to their care teams for help.

Family Care MCOs do not provide primary health care services such as regular medical checkups or medications and acute care such as hospital stays. Members receive these services through Medicaid or Medicare.

The Partnership and PACE (Program of All-Inclusive Care for the Elderly) programs cover all of the long-term care services in Family Care, plus primary and acute care, and prescription drugs. The difference between these two programs is that PACE is only for people age 55 or older who live in Milwaukee or Waukesha County.

What is IRIS?
(Include, Respect, I Self-Direct)

Individuals who want to direct all of their long-term care services can choose to enroll in and become an IRIS participant.

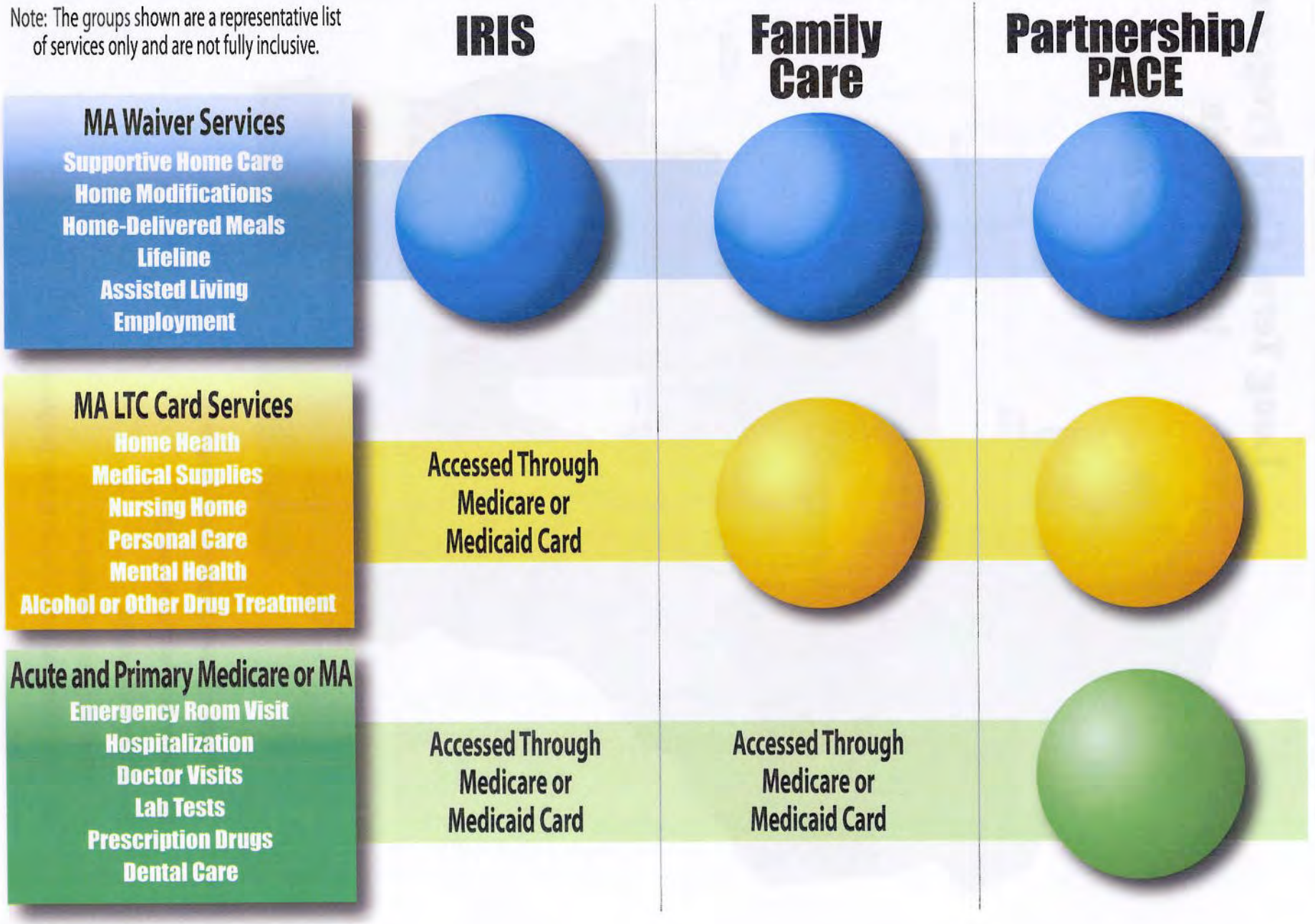
In IRIS, participants are in charge of their own support and service plan and work with an IRIS Consultant to create a plan within an individual budget. The budget is used toward the cost of long-term care supports, services, and goods. Participants are responsible for managing within their budget.

Participants may hire their own workers directly, or purchase goods and services from an agency. They choose the services necessary to meet their long-term care needs, and decide whom they will hire to provide supports or where to purchase those services. IRIS does not include long-term care Medicaid services such as home health care, primary and acute care. These services are available through Medicaid or Medicare.

The IRIS Financial Services Agency (FSA) handles bill paying and accounting. The participant hires workers directly, and the FSA completes background checks on providers, processes timesheets, generates paychecks and handles payroll taxes.

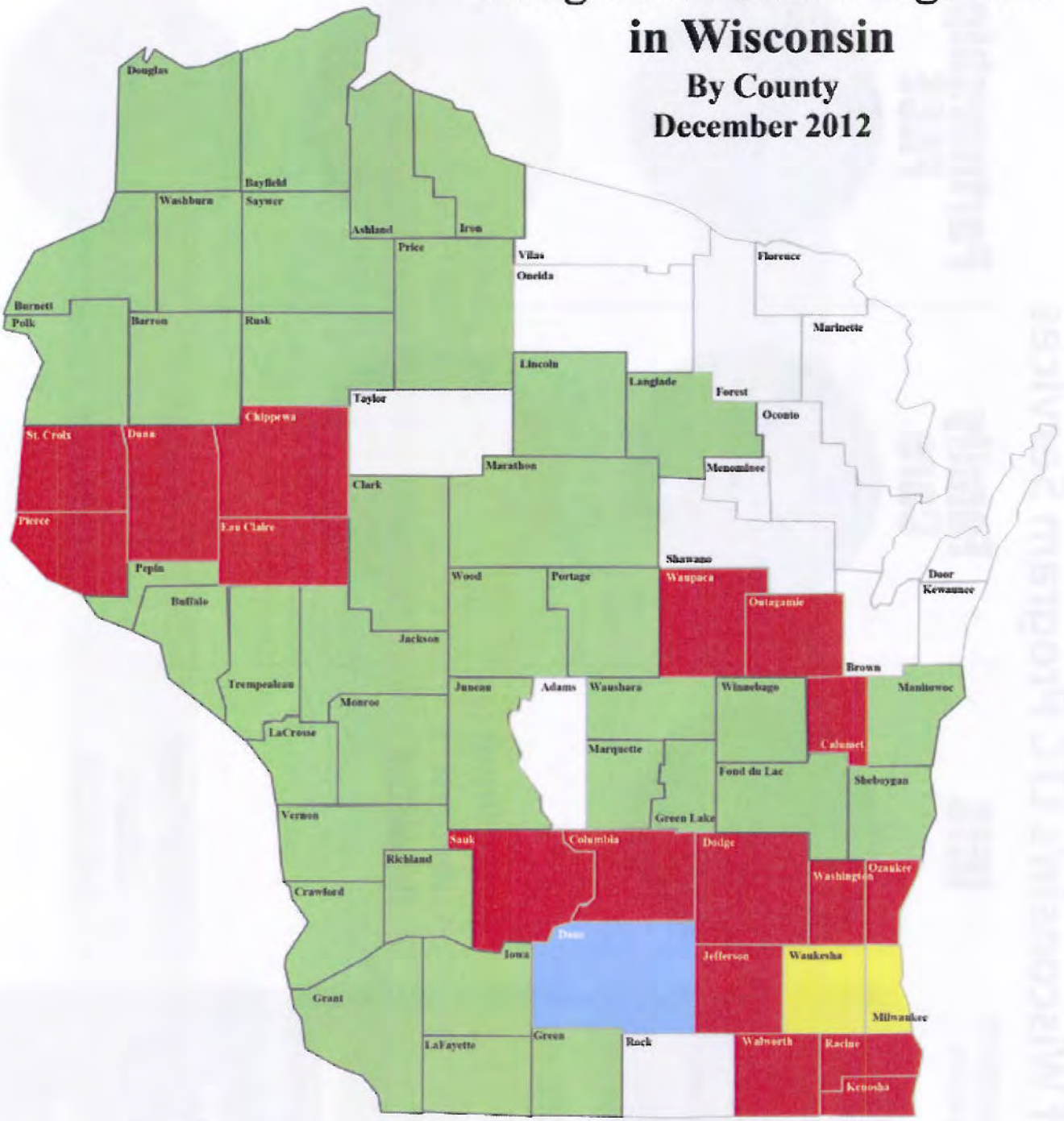
Examples of Wisconsin's LTC Program Services

Note: The groups shown are a representative list of services only and are not fully inclusive.



Long Term Care Programs in Wisconsin

By County
December 2012



All long-term care programs, including PACE

Family Care, Partnership and IRIS

Family Care and IRIS

Other long-term care programs

Partnership and other long-term care programs

Who Can Enroll?

To enroll in Family Care or IRIS, individuals must be at least 18 years old, financially eligible for Medicaid, have certain health conditions and need help with daily activities. Only people in the following three 'target groups' are eligible to enroll:

- **Frail elders** are 65 and older who have serious and long-lasting physical health problems or dementia that significantly limits their ability to care for themselves. Common conditions are diabetes, disabling arthritis, heart failure, cancer, Alzheimer's disease or the effects of a stroke.

- **Adults with physical disabilities** have a physical condition that significantly limits their ability to care for themselves. Example conditions include amputations, paralysis, multiple sclerosis, lung disease and brain injuries.

Want to find out if you are eligible for Family Care or IRIS?

Contact your local Aging and Disability Resource Center (ADRC). ADRCs are places to get information and help with finding services and applying for benefits. For ADRC information, go to:

www.dhs.wisconsin.gov/adrc

- **Adults with developmental or intellectual disabilities** have the onset of developmental or intellectual disabilities before the age of 22, and may have cognitive functioning that limits their ability to care for themselves. The person must have limitations in at least three of the following areas: learning, use of language, self-direction, mobility, self-care (bathing, dressing, eating, etc.), or the ability to live independently without help from another person.

2012 Program Highlights - Family Care and IRIS

Program Initiatives

In order to meet the future long-term care needs of Wisconsin's residents in the coming years, it is essential that the Department design long-term care programs to be cost-effective. In 2012, DHS consulted with consumers, family members, advocates, MCOs, ADRCs, providers, tribes and other experts about ideas to improve Wisconsin's long-term care programs. DHS then developed a package of reforms and savings measures to help make the programs sustainable on an ongoing basis while keeping consistent with the interests of current and future program participants. Program improvements included:

Supporting Integrated Community Living:
Most people want to live in their own home in the community among family and friends. These settings provide people with more control over their lives and the opportunity to be more involved with their communities. In 2012, DHS issued program policy stating that the person's own home, whether owned or rented, is the most integrated setting.

The IRIS program limited the use of restrictive residential settings (including 3-4 bed Adult Family Homes, Community-Based Residential Facilities, Residential Care Apartment Complexes, and assisted living facilities) to short-term utilization. DHS will complete the implementation of this policy in 2014.

Promoting Natural Supports:
Family Care and IRIS increased the focus on fully supporting individuals as members of their communities rather than solely on care provision. MCO care managers and IRIS Consultants talk with individuals about their strengths and resources. Needed services then are built on, rather than replacing, the assistance the individual gets from family, friends, faith connections and the community. This helps people to maintain these important relationships and assures the use of public dollars to areas where needed. This includes helping people to make connections with all community resources, as well as develop new informal resources and connections.

Improving Program Administration and Reducing Costs:
In 2012, DHS worked to improve the efficiency and cost-effectiveness of program operations. For example, DHS:

- Improved the process MCOs use for approving a member's services. The process reinforces cost-effectiveness, and encourages members to self-direct their services in Family Care.
- Increased the flexibility for MCOs in assigning care management staff.
- Improved the operation and management of the IRIS program.
- Strengthened the IRIS program to better support choice, self-determination and more cost-effective options.
- Aligned IRIS budget allocations to improve consistency with Family Care.
- Added Area Lead Consultants to IRIS to provide guidance and leadership to Consultants in the field and assistance in resolving difficult situations for participants.
- Created a new office in DHS to provide oversight and direction for the IRIS program.

Family Care Program Activities

Medication Management and Falls Prevention

In 2012, MCOs implemented projects to avoid unnecessary hospitalizations, emergency room (ER) visits and nursing home placements for its members. Identifying potential health problems early on may prevent the need for an ER visit, hospital stay or nursing home admission. This helps to reduce the amount of money spent on primary, acute and long-term care services. The projects focused on:

Managing Medications:
Making sure members take their medications properly contributes to overall wellness and decreases preventable events. In 2012, DHS and MCOs designed a process to ensure member take their medications as prescribed and decrease errors in dispensing medications. MCOs began identifying members who could benefit from medication management services.

Preventing Falls:
In 2012-13, five MCOs did performance improvement projects related to falls prevention. Projects included evidence-based exercise programs and nutritional interventions. After MCOs identify effective ways to prevent falls, they develop guidelines and implement quality improvement strategies for members.

External Reviews

DHS contracts with an External Quality Review Organization (EQRO) called MetaStar to evaluate the quality of each MCO. Federal rules require an EQRO process for managed care. MetaStar reviews MCO systems and processes in several areas. The annual review conducted from July 1, 2011 to June 30, 2012, found that MCO administrative systems, processes and tools provided:

- Care management practices that are member-centered and show respect for the rights of members.
- Sufficient qualified providers to provide access to all services in the benefit package.
- A basis to measure and improve quality of care, effectiveness of quality assessments and performance improvement programs.
- Accurate performance measures data.
- Assurance of member health and safety.
- Support for care management practices. MetaStar noted that MCOs made progress in some key areas; however, there are further opportunities to improve care management systems and practices.
- Compliance with DHS reporting requirements. Results indicated areas of strength, as well as opportunities for improvement in this area.

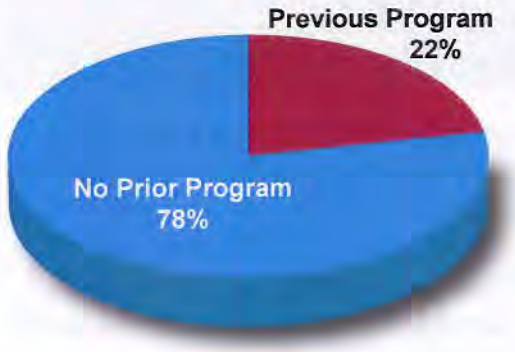
Program Transition

On December 31, 2012, an MCO that served a five-county area in western Wisconsin stopped operating the Family Care and Partnership programs. All members were successfully transitioned either to a new MCO, IRIS or to another Medicaid program.

IRIS Program Activities

Program Growth

The IRIS program continued to grow in 2012. At the beginning of the year there were 5,081 participants and by the end of the year enrollment reached 7,455 participants. The number of IRIS Consultants also increased along with the growth in enrollment.



About 78% of people who joined IRIS were not previously enrolled in a long-term care program meaning that only 22% of IRIS participants came from another long-term care program, such as Family Care or the Children's Long-Term Support Waivers.

Participants who self-directed their personal care services nearly doubled again in 2012. The IRIS Self-Directed Personal Care program grew from 881 participants at the end of 2011 to 1,657 participants at the end of 2012. Part of this growth is likely due to participants' growing confidence in their abilities to self-direct their services and manage their own employees.

Quality Improvement Projects

In 2012, DHS observed results of several IRIS improvement projects that began in 2011:

- Saw a decrease in the percentage of participants for whom the period of time from referral to start date exceeded 62 days (2011 averaged 31.8% while 2012 averaged 10.1%). This is an improvement of 21.7 percentage points.

- Of the 5,081 people enrolled in IRIS as of December 31, 2011, 32.6% had completed an assessment indicating their current employment status. Of those with an assessment, 19.4% indicated they were currently employed. Of the 7,455 individuals enrolled in IRIS on December 31, 2012, 82.2% had completed an assessment indicating their current employment status. Of those with an assessment, 16.9% indicated they were currently employed.

The number of IRIS participants with employment continues to increase, but is increasing at a lower rate than new participants are joining the program. This is why there was a decrease in the percent employed even though there are more participants employed at the end of 2011 versus the end of 2012.

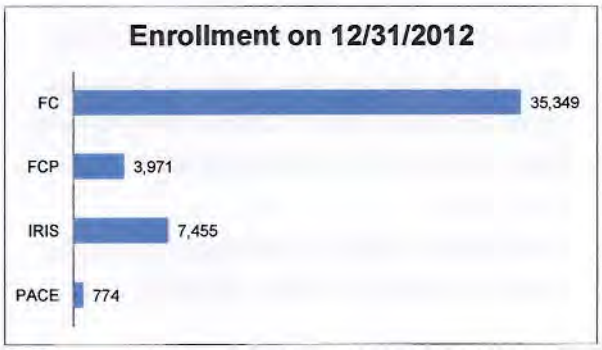
Employer Authority

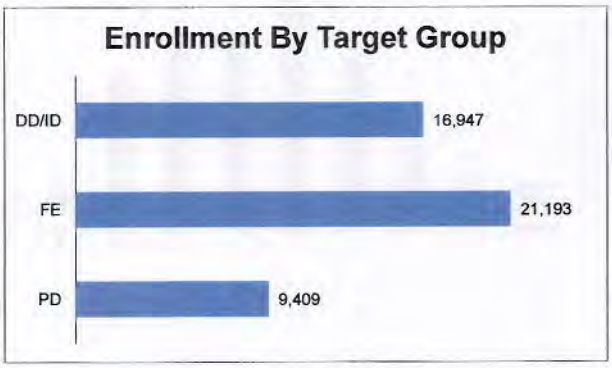
A key goal of Wisconsin's self-directed long-term care programs is to give people more choice and control over who provides their services by employing their own workers. By the end of 2012, IRIS participants employed 9,853 individuals as caregivers. On average, each participant employed 1.34 workers. Most workers provided supportive home care services.

Demographics and Service Highlights

Enrollment by Program

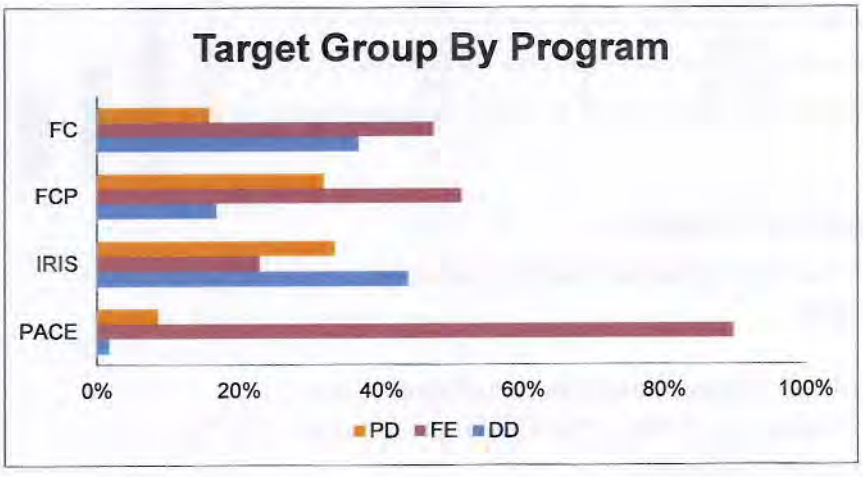
- At the end of 2012, 47,549 people were enrolled in Family Care and IRIS.
- About three-quarters (74%) of all enrollees were in Family Care (FC). IRIS was the next largest program (16%), followed by Family Care Partnership (FCP) (8%), and then PACE (2%).





- Just under half (45%) of all people enrolled were frail elders (FE).
- About a third of the people enrolled (36%) had a developmental or intellectual disability (DD/ID).
- The remaining people enrolled (20%) had a physical disability (PD).

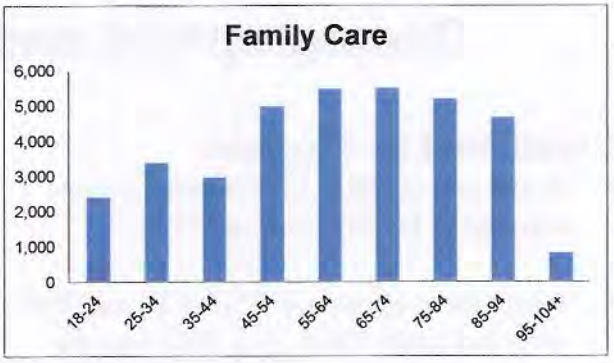
- Each program serves all three target groups. The proportion of these groups varies by program.
- PACE had the highest percentage of frail elders (90%). This is due in part to PACE eligibility beginning at age 55.

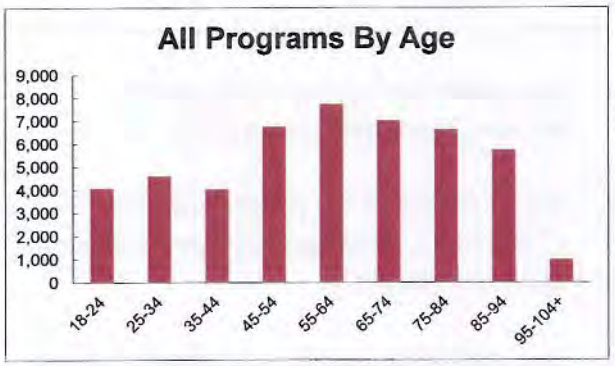


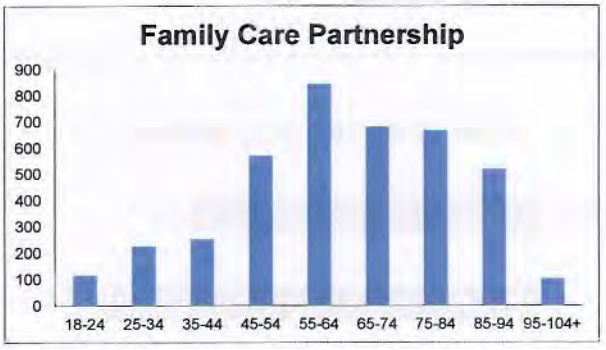
- IRIS had the highest percentage of participants with developmental or intellectual disabilities (44%).
- IRIS and Partnership had almost the same percentage of members with a physical disability (33% and 32% respectively).
- About half (45%) of Family Care and Partnership members were frail elders.

Enrollment by Age

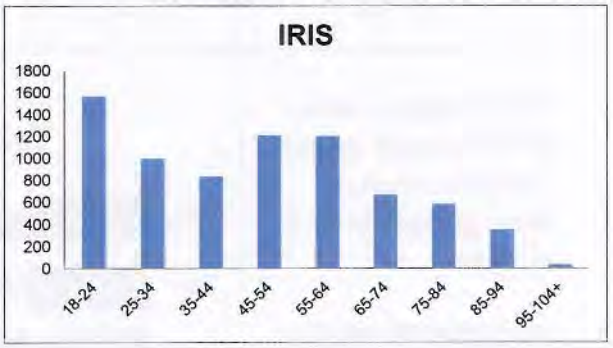
- In 2012, people in Family Care and IRIS were between 18-107 years old.
- Just under half (43%) were 65 and older.
- IRIS had a higher percentage of younger enrollees than Family Care or Partnership. Only 22% of IRIS participants were age 65 and older.
- PACE had a higher percentage of elderly members than any other program.







Program	Average Age
Family Care	60
Partnership	64
IRIS	47
PACE	76



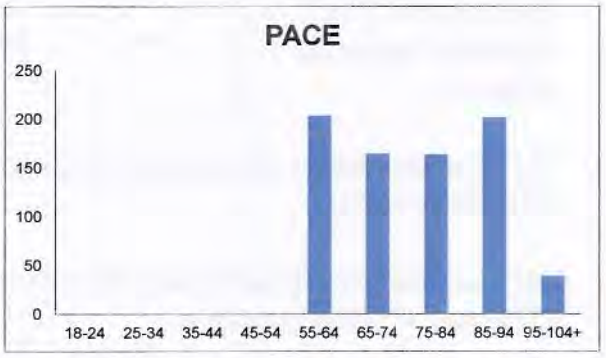
Age by Program

The average age of individuals varies by program.

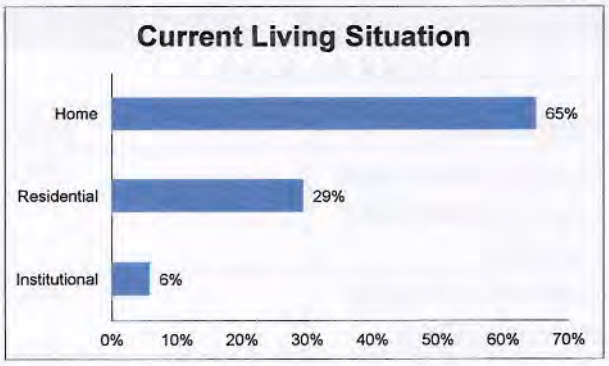
IRIS has younger enrollees than Family Care or Partnership. Only 23% of IRIS participants are age 65 and older.

PACE has a higher percentage of elderly members than any other program.

The following charts show the number of individuals in each age category by program.



Living Situation



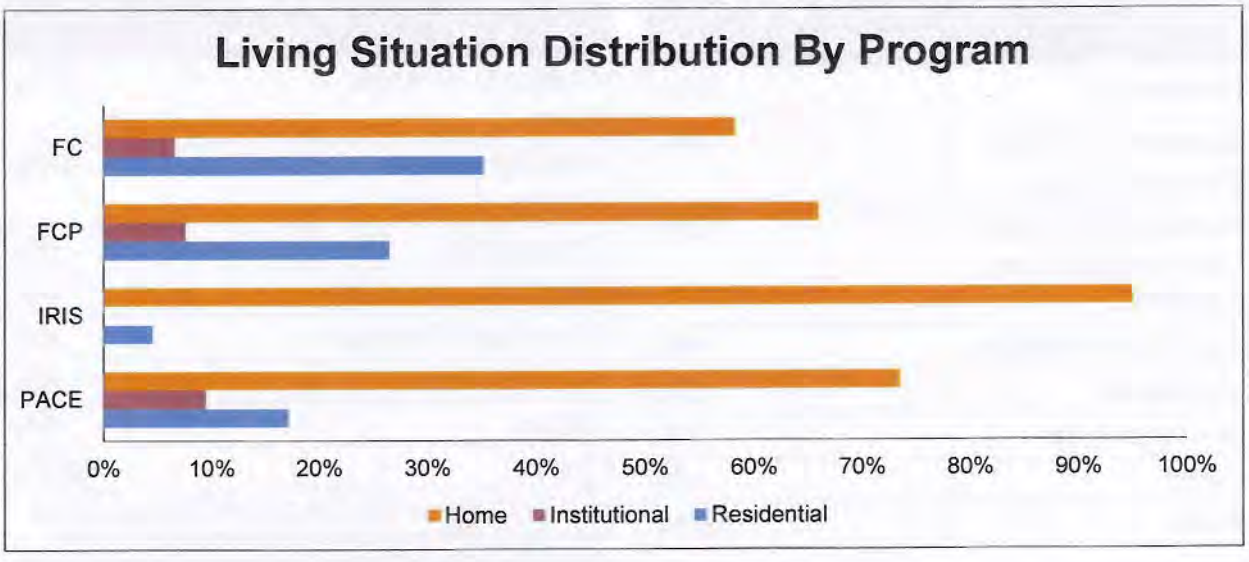
- In 2012, almost two-thirds (65%) of the people enrolled in Family Care and IRIS lived in a home setting.

- Nearly all (95%) IRIS participants lived at home. Most Family Care, Partnership and PACE members lived at home as well.

- Overall, 94% of people living at home identify home as their preferred living setting.

- Sometimes it is not safe for people to remain in their own homes and they may move to a setting where they can get 24/7 care, such as an Adult Family Home, Community-Based Residential Facility or Residential Care Apartment Complex.
  - About a third (29%) of the people in Wisconsin's long-term care programs lived in such a residential setting.
  - Of those, 73% said this was their preferred setting.
  - Family Care members were the most likely to live in a residential setting.

- When people live in an institutional setting like a nursing home or an Immediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), they can be enrolled in Family Care, Partnership or PACE, but not IRIS.
  - Six percent (6%) of the people in Family Care, Partnership and PACE lived in an institutional setting.
  - PACE serves only people age 55 and older, and had the highest percentage of members that lived in an institutional setting (9%), followed by Partnership (8%) and Family Care (7%).
  - Only 28% of the members in an institutional setting said this was their preferred setting.



Service Expenditures

In calendar year 2012, total expenditures for services purchased for Family Care, Partnership, PACE and IRIS were just under $1.6 billion.

Family Care and IRIS data are from the Department's encounter reporting system. Partnership and PACE data are from annual MCO financial summaries. The table below shows total expenditures.

Program	Total Expenditure for Services (millions)
Family Care	$1,141
Partnership & PACE	$290
IRIS	$158
Total	$1,589

The top six services account for around 90% of each program's total service spending. These services are shown below by program. The percentages do not include care management services.

Family Care

Service	Percent of Total Expenditure
Residential	51%
Supportive Home/ Personal Care	19%
Nursing Home and Intermediate Care Facilities	12%
Adult Day Activities	6%
Vocational	5%
Transportation	3%
Other	4%
Total	100%

Care Management accounts for 13% of total service expenditures.

Partnership and PACE

Service	Percent of Total Expenditure
Long-Term Care Services	
Residential	19%
Nursing Home and Intermediate Care Facilities	11%
Supportive Home/ Personal Care	8%
Transportation	3%
Medical Equipment and Supplies	2%
Adult Day Activities	2%
Other (LTC)	9%
Acute & Primary Care Services	
Inpatient Hospital	14%
Medications (Pharmacy)	13%
Office or Outpatient Assessments	5%
Other	14%
Total	100%

Care Management accounts for 12% of total service expenditures.

IRIS

Service	Percent of Total Expenditure
Supportive Home Care	57%
Self-Directed Personal Care*	15%
Residential	8%
Adult Day Activities	6%
Vocational Services	4%
Transportation	4%
Other	6%
Total	100%

*IRIS Self-Directed Personal Care (SDPC) is a service available to IRIS participants who are eligible to self-direct their personal care. This service is provided under a 1915(j) Self-Directed Personal Assistance Services State Plan Amendment.

Employment

DHS is committed to integrated employment outcomes for all people with disabilities and has prioritized its resources and activities toward that end. The DHS goal is to increase the integrated, community-based employment rate for working age people with disabilities.

Integrated employment at a competitive wage offers people a meaningful path toward economic security, as well as the respect and dignity associated with employment. The Department's efforts focused on increasing integrated employment, provides people with long-term care needs access to the fullest range of employment choices and outcomes, and it gives people opportunities to participate fully in their community.

In October 2012, DHS collected the following data about working age people (18-64 years of age) enrolled in Family Care, Partnership or IRIS.

Family Care/Partnership:

There were 20,647 working age people enrolled in Family Care/Partnership.

- Of these people, 6,516 (32%) worked in an integrated employment setting, a facility-based setting or in a group/enclave setting.
- 1,800 people were in integrated employment.
- 4,950 people were in facility-based employment.
- 306 people were in group/enclave employment.
- 540 people worked in more than one setting, such as in integrated employment in the morning and in a facility-based setting in the afternoon.

IRIS:

There were 5,124 working age people enrolled in IRIS.

- Of these people, 758 (15%) worked in an integrated employment setting, a facility-based setting or in a group/enclave setting.
- 247 people were in integrated employment.
- 461 people were in facility-based employment.
- 65 people were in group/enclave employment.
- 15 worked in more than one setting, such as in integrated employment in the morning and a facility-based setting in the afternoon.

Program Results

Influenza and Pneumonia Vaccinations

Family Care encourages members to receive appropriate vaccinations. This is because influenza and pneumonia can lead to health complications, hospitalization, and sometimes death. MCOs monitor their members' immunization status.

The following table shows the percentage of members that received an influenza or pneumonia vaccination during 2012.

Program	Influenza	Pneumonia
Family Care	71%	77%
Partnership and PACE	82%	92%

Member Satisfaction Survey Results

MCOs survey members each year to determine their level of satisfaction. The survey questions ask members to respond with one of five choices:

- Always
- Almost always
- Sometimes
- Hardly ever
- Never

In 2012, Family Care members reported the highest percentage of 'Always' responses, followed by the Partnership members. PACE members had the lowest percentage of 'Always' responses.

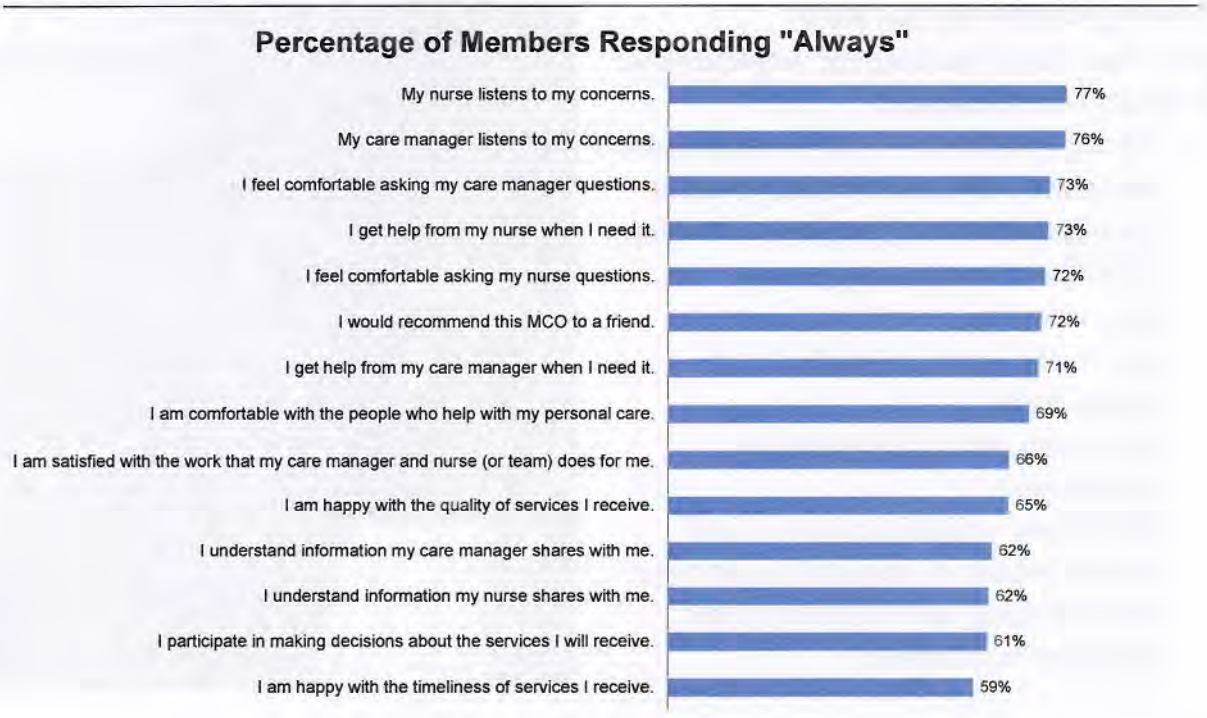
The top two scoring questions were:

- My nurse listens to my concerns (77% 'Always').
- My care manager listens to my concerns (76% 'Always').

The two lowest scoring questions were:

- I participate in making decisions about the services I receive (61% 'Always').
- I am happy with the timeliness of the services I receive (59% 'Always').

Nearly three-quarters (72%) of respondents indicated that they would 'always' recommend their program to a friend.



Supporting Personal Experience Outcomes

An important goal of Wisconsin's long-term care programs is that services and supports help people with long-term care needs have the quality of life they want as stated in the following outcome statements:

- I am involved in deciding where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends I care about.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect

Between July 2011 and June 2012, interviews were conducted with 549 people enrolled in Family Care, Partnership and IRIS or their representatives. During the interviews, people identify the goals and outcomes that are important to them and assess whether the program is working to address their goals and desired outcomes. People also report how well the program supports their outcomes and goals.

Outcomes Achieved or In Progress

This indicator shows the percent of people who are having the quality of life they desire. Outcomes that are achieved are those that relate to the person's desires. For example, "I want to continue living with my parents in this house." Outcomes that are in progress also represent a positive situation. For example, "I want to keep going to school to learn to be a car mechanic."

- As reported by members and participants, 82% of outcomes were achieved, or in progress.
- IRIS had the highest rate of outcomes that were achieved, or in progress at 87%, compared to Family Care (81%) and Partnership (78%).
- People with physical disabilities were less likely to report that outcomes were achieved or in progress (77%) than were frail elders (86%) or people with developmental/intellectual disabilities (85%).

Outcomes Fully Supported

This indicator reports on how well the Family Care and IRIS programs support a person's outcomes. An outcome may require one or more supports to maintain or make progress toward the person's desired goal. Outcomes are "fully supported" only when all needed supports are available and acceptable to the person.

- As reported by members and participants, 85% of all outcomes were fully supported.
- IRIS had the highest rate of support for outcomes (89%), compared to Family Care (85%) and Partnership (82%).
- People with physical disabilities were less likely (79%) to have outcomes fully supported than were frail elders (90%) or people with developmental/intellectual disabilities (88%).

Family Care Member Profiles

Eleanor's Story

Eleanor was an 88-year-old elderly woman with Alzheimer's/dementia. She lived with her husband, Robert, who was her primary caretaker. Eleanor had been placed into a nursing home and then an assisted living setting prior to enrolling in Family Care.

In the facilities, without her husband, Eleanor would become upset, yelling out, and at times was physically aggressive. She was lost without her husband at her side in these unfamiliar surroundings and she would frantically search for him.

When Eleanor returned home, Family Care set up her services and daily care providers, and obtained equipment and supplies to supplement the care her husband and family provided. This allowed Eleanor to be with her husband, safe at home. Just having him in her sight, and being in her own home, put Eleanor at ease. Her dementia was progressing quickly; Family Care increased her supports to include respite and hospice services.

Everyone involved worked together to best support Eleanor, her husband, and her family, while keeping her in her home until her passing only a few months later. Without Family Care, Eleanor would have likely been in a facility; alone, afraid and searching for her soul mate of 66+ years. With Family Care, her final days were spent reading the newspaper and her personally-written poetry, while smiling toward the recliner next to hers, where her loving husband smiled back from behind his book. Eleanor gently slipped away in her sleep in her own bed during her morning nap. Peaceful, comfortable and feeling the love of her family around her.

Family Care is not just about the wheelchair or ride it can provide, it's about that smile and look in Eleanor's eyes that said she was happy being where she wanted to be.

James' Journey to Happiness

In a well-kept apartment building located in a northern Wisconsin neighborhood, 25-year-old James has found a life of happiness and independence.

After five years of living in an Adult Family Home, with the help of his care team, he moved into his own apartment. One of his goals has been to live independently, and his care team was very proud to have helped him accomplish his goal.

James has thrived since moving into his apartment. He likes to be active in the community. He likes to walk in the park, ride his bike around town, and enjoys playing softball in the summer. In addition to his active lifestyle, James is a weather watcher for a local television channel. He has an outdoor weather system, which includes a thermometer and a rain gauge. He calls in once a day to report the weather in his area.

James does most of his own cleaning, laundry and cooking. His daily routine includes making his bed, showering and brushing his teeth. There are signs on the wall to remind him of some of the rules. His caregiver helps him with his household chores and takes him grocery shopping. James likes to clip coupons to save money on the items he uses regularly. He has a representative payee to help him manage his money and he shares his living expenses with his roommate.

Reaching his goal of living independently has been a huge accomplishment for this outgoing and kind-hearted young man. It has been a long journey filled with a lot of learning and hard work, and it has been truly worth the effort. James wears a mood ring, which is almost always dark blue in color, showing he is very happy.

Leslie's Story

Family Care promotes independence and self-determination for all members. That may mean something different for each member, depending on the individual's strengths, needs, and personal preferences. For Leslie, it meant an opportunity to change everything about the way she lived.

Leslie is a young woman with cerebral palsy, an intellectual disability, depression and obsessive-compulsive disorder (OCD). After she turned 18, she moved out of her family's home and lived in several residential settings until she was about 30 years old.

Leslie's family decided that the residential facility she was living in did not provide the care they expected. Her care team explained how the Family Care self-directed support (SDS) option might work well for Leslie.

Her family decided to use SDS and with the help of her mother and sisters, as well as support from her care team, Leslie hired her own personal care and supportive home care staff. Today she is living in her own apartment and has more control over her life. She is doing things for herself that she had never done before. For example, she is able to shower independently and assist with meals and clean up, not to mention the many other household chores she completes with pride. Leslie and her family could not be happier.

Roger's Ride to Independence – A Care Manager's Perspective

I have been Roger's care manager for three years. He is a kind-hearted man with a wonderful personality and sense of humor. Roger has a developmental disability but that does not keep him down. He has always been a

hard worker striving to do his best and willing to do extra. It has always been his goal to lead a productive life and become an integral part of society.

Roger worked at a pre-vocational site for many years and has struggled to "make ends meet." In 2011, he registered with the State of Wisconsin's Division of Vocational Rehabilitation (DVR) and began to receive services. Roger wanted to work for a local transportation company and asked if I would go with him to talk to the owner. Roger approached the owner to let him know he was interested in driving for him. The owner was willing to hire Roger. I explained supported employment services through DVR. The owner contacted the local DVR office and supported employment was set up. Roger was hired to work 20 hours a week at Bob's Medical Transport. Roger did well with only minimal assistance from the supported employment specialist.

Roger continues to work as a driver for Bob's Medical Transport. His employer is very happy with his work. He has an excellent work record. He treats clients with respect and kindness. It is Roger's goal to work full time for Bob's Medical Transport.

Stephen's Story

Stephen's story is about the power of hard work and determination. He had been living in a nursing home due to a surgery that he knew would leave him paralyzed from the waist down. When he first enrolled in Family Care, he told his care team that his main goal was to live in his own apartment.

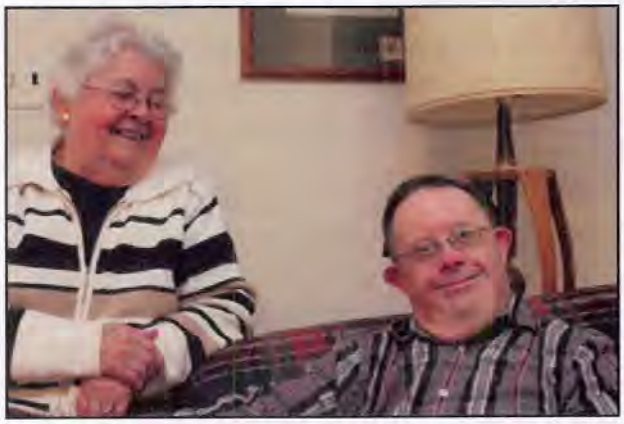
Stephen was persistent in physical therapy and he eventually was able to move to an Adult Family Home. He continued his therapy after he moved, and eventually he was able to stand with a walker and was almost independent with transfers. As he built his strength and independence, he started participating in 5K wheelchair races. Throughout it all, Stephen remained committed to his goal of living in his own apartment.

With the help of Family Care, Stephen researched public housing options and filled out rental applications. Finally, after years of hard work and determination, he got the good news – he had been approved for his own apartment. In three short years, Stephen went from being in a nursing home and using a wheelchair, to living in his own apartment, and being able to walk a few steps.

IRIS Member Profiles

John, Newell and Todd

John, Newell and Todd are roommates living together in Neenah, Wisconsin. One of the best features of their house is the room they call the "man cave," which includes a couple of comfy chairs pointed directly at a television. It sends the message that this is definitely a "guys" place!



John

The men work together to do household chores such as mowing the lawn, shoveling snow, going to the store, and shopping for their own groceries. Since they all have unique hobbies and interests, they each like to do their own things, but sometimes decide to attend events or visit places together.

Todd, John, and Newell use their IRIS funds to purchase the individual services that they need to meet their long term care needs. They each control when and how their services are delivered.

Connie, who helps to coordinate services, observes that this is the first time she worked with people who are their own bosses. It changes the focus from other places she has worked.

Todd is happy and comfortable in his home and really enjoys relaxing in his favorite chair. "Todd's life is here," says his mother, Alice. Both parents like to talk about how Todd's world will remain stable, even if something happens to them, because of all the planning and work that went into creating the life he has now. They describe how Todd's home acts as a launching pad for everything else that he does. Their advice for people who want to find homes of their own and learn more about community living is "Take it step-by-step."

John and Newell first met each other in nursery school. Growing up, they drifted apart and went to different public schools. Now, later in life, they have reunited as roommates.

Since moving into his new place, John says he has been very happy and especially likes making his own decisions. He has a job he likes, but says it is nice to come home after a day of work and relax in a place that he loves.

His mom, Rosie, says it is important that his place look and feel like a home. Since John grew up in a busy house with several brothers and sisters, he appreciates having two other roommates who help create an active household.

Newell

Todd

When asked what advice she would give to others who were interested in community living, John's mom smiled sweetly and said, "Go for it!"

Newell and his mom looked for a good place to live for a long time and talked to lots of people before meeting Todd's parents.

Newell feels that moving in with Todd and John was the right way to go and says he is very happy. His mother, Marian, says that it was important for Newell to stay involved with the community he knows and for her to live near her son.

The parents of all three men say they wanted their sons to live where they are happy and could have a good life without parents being around all the time (although they joke that the guys do telephone quite often). Having their own place makes it easier for Todd, John, and Newell to spend time in their community, building relationships and doing the things they enjoy.

LeAnn's Story

LeAnn is a vivacious young woman who enjoys deer hunting, shopping at the mall, and giving back to her community. She volunteers her time by working with several physical therapy students at the local technical college, and wrapping donated gifts to give to others during the holidays.

She chose to enroll in the IRIS program because she liked how IRIS Consultants highlight the many different possibilities available to her through self-direction; but she feels that the best part of IRIS is in choosing the people she wants to work with her.

Her biggest goal right now is to become physically strong enough to attend a technical school in Eau Claire. She gets up every day to exercise, and says that the workers she hired with her IRIS funds provide the support she needs at home so she can focus on achieving her dream.

LeAnn also has her sights set on getting her driver's license, so she can attend classes and expand on the work she does helping others.

When asked about her IRIS Consultant, LeAnn smiles and says, "She's very informative; I like her a lot." LeAnn loves how her IRIS Consultant is always ready to share ideas and suggestions. "IRIS is awesome."

Ralph's Story

Ralph is an avid outdoorsman living in Ladysmith with his wife, Jo. More than eleven years ago, he lost his eyesight due to unforeseen complications during a lower back operation. Though his life had changed, he felt that being inactive and "sitting all day" would be the worst thing he could do.

Drawing inspiration from his love of the outdoors, Ralph decided to create and sell items made from deer antlers and diamond willow branches. To get started, he spoke with Wisconsin's Division of Vocational Rehabilitation (DVR). They helped him get his first tools and connected him with someone who taught him a few beginning techniques.

Ralph founded "Ralph's Rack Shack," to sell the items that he makes, such as hat racks, cup holders, shelves, and walking sticks. He utilizes IRIS funds to help meet his transportation needs and provide the care he uses at home, so he can continue working and pursuing his dream.

Ralph with a handful of his antler zipper pulls

This hunter's greatest happiness comes from giving back to others. While he makes plenty of antler zipper-pulls to sell, he also gives away many thousands to children with terminal-illness through "Shed of Hope," a non-profit organization he started a few years ago.

Ralph likes how his work keeps his mind and body occupied. "It helps you mentally and physically," he says with a smile. "As long as I can make a few dollars and keep going, I'll be happy."

Glossary

Adult Family Home (AFH) – A type of residential setting. One-two bed AFHs are places in which the operator provides care, treatment, support, or services above the level of room and board for up to two adults. Three-four bed AFHs are places where three-four adults who are not related to the operator reside and receive care, treatment or services above the level of room and board and that may include up to seven hours of nursing care per resident per week.

Aging and Disability Resource Center (ADRC) – ADRCs are the first place to go with aging and disability questions. ADRCs offer information and advice and help people apply for programs like Family Care and IRIS. To find an ADRC, visit: www.dhs.wisconsin.gov/adrc.

Care Manager – Every Family Care member has a care manager. Care managers help members identify their goals and the long-term care services they need to work toward those goals. The care manager is part of the member's team along with a nurse and others the member wants included. The care team authorizes, coordinates and monitors the member's services.

Community Based Residential Facility (CBRF) – CBRFs are a type of residential setting where five or more unrelated people live together in a community setting. Residents receive care, supervision, support services, and up to three hours of nursing care per week if needed.

Employment Training Services – Training, instruction and placement services to help people get and keep jobs.

Facility-Based Employment – Services that are provided in a facility to develop general, non-job-task-specific skills, which are designed to create a path to integrated employment. These services are expected to occur over a defined period of time with six-month progress reports.

Family Care (FC) – A Medicaid managed long-term care program for frail elders, adults with developmental or intellectual disabilities, and adults with physical disabilities. Family Care includes the Family Care Partnership program and PACE.

Family Care Partnership (FCP) – A Medicare and Medicaid program that provides long-term care services, plus acute and primary care and prescription drugs.

Financial Services Agency (FSA) – The agency that handles bill paying and accounting for IRIS participants. The FSA helps participants monitor their spending and they can also provide employer services on behalf of participants, including processing timesheets, generating paychecks and handling payroll taxes.

Group/Enclave Employment – Paid work in small group settings (2-8 workers with disabilities) such as work crews or enclaves that occur in community businesses. Typically, the vocational provider (e.g., community rehabilitation facility/supported employment provider) pays the worker's wages.

Institution/Institutional Setting – Includes nursing homes, state centers for persons with developmental disabilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), and institutions for mental disease.

Integrated Employment – Competitive employment in community businesses with co-workers who do not have disabilities. This includes supported employment.

IRIS (Include, Respect, I Self-Direct) – Wisconsin's self-directed supports program for older people and adults with disabilities. IRIS participants are in charge of their own support and service plan. They use a monthly budget to buy their long-term care services, supports, and goods. Participants decide who will provide their services and when and where they will be provided.

IRIS Area Lead Consultant – Area Leads are assigned to oversee a team of IRIS Consultants and IRIS Consultant Supervisors. They are responsible for providing guidance and leadership to Consultants in the field and resolving difficult situations for participants.

IRIS Consultant – A trained individual who provides ongoing assistance to IRIS participants. IRIS Consultants help develop and implement the participant's support and service plan. They also provide resources and give participants information to aid in decision-making.

Long-Term Care (LTC) – Services an individual needs due to having infirmities of aging, a disability or a chronic health condition. Long-term care services include help with bathing, dressing, eating, and going to work. Long-term care can be provided at home, in residential settings and institutional settings.

Long-Term Care Program – Family Care, Partnership, PACE and IRIS are some of Wisconsin's long-term care programs. Other long-term care programs in Wisconsin include the Community Options Program (COP) and the Community Integration Program (CIP).

MA LTC Card Services – Long-term care services someone gets using their Medicaid Forward card or through a Managed Care Organization (MCO).

MA Waiver Services – "Waivers" provide services so people can live in the community instead of a nursing home or other institution. The federal government waives certain rules for Medicaid when the State provides these services in the community instead of an institutional setting. Waiver services are generally non-medical services that help with daily activities.

Managed Care – A way to improve the quality and cost-effectiveness of care. Managed Care Organizations (MCOs) operate Family Care and they must authorize services before the member receives care. Members have to get their services from the MCO's network of providers.

Managed Care Organization (MCO) – The organizations that operate the Family Care, Partnership and PACE programs.

Medicaid – A health insurance program that provides coverage for lower-income people, families, the elderly, and people with disabilities. Medicaid is also known as "Medical Assistance," "MA," and "Title 19." The federal and state governments fund Medicaid. To enroll in Family Care or IRIS, individuals must be eligible for Medicaid.

Medicare – The federal health insurance program for people age 65 or older, people with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant), and some younger people with disabilities. Different parts of Medicare cover specific services. Partnership and PACE are Medicare and Medicaid programs.

PACE (Program of All-Inclusive Care for the Elderly) – PACE is like Partnership but is only available for people age 55 or older who live in Milwaukee or Waukesha County.

Personal Experience Outcome – Personal experience outcomes represent what Family Care members and IRIS participants identify as important, including their goals, hopes, and dreams. One person's outcome might be being healthy enough to enjoy visits with her grandchildren, while another person might want to be able to be independent enough to live in his own apartment.

Residential Care Apartment Complexes (RCAC) – A type of residential living setting. RCACs are independent apartment units where five or more adults reside in their own living units. Services include up to 28 hours per week of supportive care, personal care, and nursing services.

Residential Setting – Residential care settings include adult family homes (AFHs), community based residential facility facilities (CBRFs) and residential care apartment complexes (RCACs).

Self-Direct – A way for individuals to arrange, purchase and direct their own long-term care services. People who self-direct may have more control over how, when, and where services are provided.

Supportive Home Care (SHC) – Services that directly assist people with daily activities and personal needs. Examples of SHC services are assistance with shopping, cooking, and routine housekeeping.

Vocational Supports – Services to help get, maintain and succeed in meeting a person's employment goals.