ADRC Advisory Committee Agenda
Jefferson County Human Services Department
1541 Annex Road, Jefferson, WI 53549
Health/Human Services Conference Room

Date: Tuesday, August 2, 2016
Time: 1:00 p.m.

Committee Members: Earlene Ronk, Chair; Carol Battenberg, Ellen Haines, Dan Krause, Russell Kutz, Marcia Bare, Carolyn Niebler & Connie Stengel

1. Call to order
2. Roll call (establishment of a quorum)
3. Certification of compliance with Open Meetings Law
4. Approval of the agenda
5. Approval of the ADRC Advisory Committee minutes from 6/7/2016
6. Communication
7. Public comment (Members of the public who wish to address the committee on specific agenda items must register their request at this time)
8. Discuss and review 2016 Contract Workgroup
9. Discuss ADRC Report, Dominic Wondolkowski – ADRC Superivsor
10. View and Discuss Dining with Friends Age Friendly Film
11. Discuss The Funding Formula: Problems and Possible Solutions
12. Discuss and review Chapter 8 Policy for Nutrition Program
13. Discuss National Association of Area Agencies on Aging Releases Analysis of final Medicaid manged care regulations
14. Discuss possible agenda items
15. Adjourn

Next scheduled meetings: September 6, 2016
October 4, 2016
November 1, 2016
December 6, 2016

A Quorum of any Jefferson County Committee, Board, Commission or other body, including the Jefferson County Board of Supervisors, may be present at this meeting.

Individuals requiring special accommodations for attendance at the meeting should contact the County Administrator 24 hours prior to the meeting at 920-674-7101 so appropriate arrangements can be made.

Aging & Disability Resource Center Advisory Committee
Minutes of Meeting
Tuesday, June 7, 2016

Call to Order
The meeting was called to order by Ronk at 1:00 p.m.

Roll Call
Present: Earlene Ronk, Chair; Carolyn Niebler, Marcia Bare, Ellen Sawyers, Carol Battenberg, and Connie Stengel.

Also Present: Sharon Olson , Beth Eilenfeldt, Dominic Wondolkowski, staff. Guests: Jean Lynch

Certification of Compliance with Open Meetings Law
Olson certified compliance.

Approval of Agenda
The agenda was reviewed and approved in a motion made by Bare, seconded by Niebler and passed unanimously.

Approval of 5/3/2016 Minutes
A motion to approve the 5/3/2016 minutes was made by Niebler, seconded by Stengel and passed unanimously.

Communications
None

Public Comment
None

Discuss: and review Candidate for Committee Vacancy
A motion to approve Ellen Sawyers to be appointed the ADRC Advisory Committee was made by Connie Stengel and seconded by Caroline Niebler and passed unanimously.

Discuss: ADRC Report
Dominic Wondolkowski, the new ADRC Supervisor started on May 22nd. He reviewed with the committee his responsibilities and requested input on information and reporting statistics that the committee would appreciate.

Discuss Elder Abuse Day – June 15th

World Elder Abuse Awareness Day June 15th 2016

Every year an estimated 5 million, or 1 in 10, older Americans are victims of elder abuse, neglect, or exploitation, and experts believe that for every reported case of elder abuse or neglect, as many as 23 cases go unreported.

Everyone can act to protect seniors – no act is too small. World Elder Abuse Awareness Day (WEAAD) is an opportunity for people to take action to protect seniors by raising awareness about elder abuse. It starts with one person and one action.
Elder abuse can happen to anyone – a loved one, a neighbor, and when we are old enough, it can even happen to us. Elder abuse affects seniors across all income groups, cultures and races. Mistreatment is most often committed by the victim's own family members. Elder abuse can occur anywhere: In the community – for instance, in a person's home or in a public place, In nursing homes, assisted living facilities, and other institutional settings such as in a hospital. Olson discussed with Committee members looking for ways to promote awareness in Jefferson County. Will work on a plan for next to be connected with other ADRC to promote awareness such as the blue pinwheels and Educational outreach information?

Discuss: Senior Dining – Speaker Jean Lynch, from GWAAR, Greater Wisconsin Agency on Aging Resources

Jean Presented on Senior Dining, and shared the If you build it they will come documentary that showed how a community pulled together to share community meals. Jean also discussed alternative programs such as the restaurant model of senior dining.

Discuss: GWAAR Advocacy Updates

The Older Americans Act reauthorization –

It's been five long years since the last Older Americans' Act reauthorization expired, but on April 19th President Obama signed the OAA Reauthorization Act of 2016 into law! The reauthorization demonstrates the commitment of the president and Congress to the health and well-being of the nation's older adults.

State Aging and Resource Center offices moved to the Division of Public Health –

On April 11, DHS issued a news release regarding the creation of a new Division of Medicaid including details on the merger of the Division of Long Term Care and the Division of Health Care Access and Accountability as well as moving the Office on Aging and Office for Resource Center Development in the Division of Public Health.

The Deliver Act-

This bipartisan legislation would amend the tax code to increase the tax deduction for volunteers who deliver meals to homebound individuals from 14 cents per mile, where it has remained unchanged for nearly two decades, to the standard business mileage rate, which is currently 54 cents per mile. This legislation is a step in the right direction and gets this bill passed into law.

Family Care/IRIS 2.0 Update

Since the passage of the state 2015-2017 state budget last July, the state Department of health services has been working on designing a new care model, Family Care/IRIS 2.0, which will expand Family Care statewide and transition the program "to an outcome-based model that coordinates all of the individual's care needs." Advocates continue to have questions on key components of the plan and are asking for further details before the Joint Finance Committee takes action on DHS' plan to move ahead on the redesign.

Adjourn:

Discussion was to cancel the July 5th meeting and resume with the August 2nd meeting. A motion to adjourn was made by Sawyers, seconded Niebler and the meeting was adjourned.

Respectfully submitted,

Sharon Olson, Manager
Aging & Disability Resources Division

advocacy | action | answers on aging

National Association of Area Agencies on Aging

July 19, 2016

To: n4a Members

From: Sandy Markwood, CEO

Re: **n4a Analysis of CMS Final Regulations for Medicaid Managed Care**

Recently, the Centers for Medicare & Medicaid Services (CMS) released final regulations on Medicaid Managed Care. Last summer, after soliciting and receiving member feedback, n4a commented on how the draft regulations could affect the ability of the Aging Network and Area Agencies on Aging to support older adults and people with disabilities who are receiving Medicaid services. The final regulations went into effect this month, and must be fully implemented by July 2018. n4a is in the process of analyzing what the regulations will mean for AAAs and other community-based organizations (CBOs) serving older adults and people with disabilities. In addition to this initial analysis, n4a may release additional materials in the future, as CMS and states begin implementation of the rule.

About the Final Regulations

For the first time in over a decade, the Centers for Medicare and Medicaid Services (CMS) issued final regulations covering Medicaid services delivered by Managed Care Organizations (MCOs). The rule makes significant changes to the way the federal government, states and MCOs work together to deliver Managed Care, including Managed Long-Term Services and Supports (MLTSS).

The long-term services and supports (LTSS) landscape continues to change, with more states utilizing managed care for LTSS than ever before. As states have been adopting MLTSS to serve older adults and people with disabilities, Area Agencies on Aging (AAAs) have been playing a key role in those developments by contracting with MCOs for vended services, serving as care coordinators and case managers, or providing options counseling for the managed care and dually eligible population.

The prosed regulation introduced sweeping changes to the managed care delivery system, which affects AAAs and other community-based programs that provide these services. Now that the final regulations have been released, n4a is providing analysis of the specific points on which we commented on the draft regulation. n4a limited our

initial comments to those areas that we believed would have the greatest impact on AAAs and other community-based providers working within state Managed Care systems. We did not heavily focus on proposed changes affecting individual Medicaid beneficiaries, but supported the work of multiple national advocacy organizations focused specifically on beneficiary implications. As such, we have also limited this analysis to those areas of the regulation we commented on last summer.

Key Issues: n4a Position and CMS Response

We appreciate the significant effort and commitment made by CMS to develop a thorough and comprehensive package of proposed regulations for a quickly expanding Managed Care delivery system. However, we continue to remain concerned that a rapidly expanding adoption of MLTSS will, without protecting a strong community services role, not meet the health needs of the vulnerable populations that our members serve.

The comments n4a submitted reflect the important role that AAAs, disability groups and other CBOs play in delivering LTSS. Traditionally AAAs and other CBOs have served as the Medicaid HCBS waiver administrators and coordinators, and as more states are moving toward MLTSS, it's important to recognize the key and consumer-trusted role that these agencies are playing in ensuring improved beneficiary health outcomes. We believe the following issues are of particular importance in meeting these goals in the final regulation, and these areas also represent critical advocacy opportunities at the state level as states implement the final regulations over the next two years.

For brevity, our analysis generally refers to an "MCO" rather than listing all three types of entities: an MCO, a PIHP (Pre-Paid Inpatient Health Plan) and a PAHP (Pre-Paid Ambulatory Health Plan).

Beneficiary Support System (42. C.F.R. § 438.71) and Conflicts of Interest (42. C.F.R. § 438.816)

Summary of n4a comments: We agreed with CMS that states should be required to "develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment in a MCO." We also agreed that a support system must include choice counseling for all beneficiaries, assistance for enrollees in understanding managed care, and additional assistance for enrollees who use, or express a desire to receive, LTSS.

However, we expressed serious concerns that the way states implement this rule may not be in the best interest of beneficiaries, as it does not reflect the long-standing patterns and systems of support in the coordination and provision of LTSS in communities nationwide. We argued that inadvertent damage to these existing systems, no matter how well-intentioned, could reduce beneficiary understanding, access and options, as well as reducing the cost-effectiveness of LTSS delivery.

We noted that community-based organizations such as AAAs, ADRCs, SHIPs and CILs have long histories of providing consumers with independent, conflict-free options counseling. In order to ensure that any potential conflict of interest is prevented, we commented that AAAs have established sophisticated and transparent firewalls between programs where it is necessary to ensure proper administration of programs and appropriate protection of beneficiaries' interests. However, while we noted that firewalls and other mechanisms to prevent conflicts of interest are of great importance, we also emphasized that these proposed regulations or state interpretations should not unnecessarily limit AAAs to playing a single role in regards to MLTSS when consumers have looked to them for decades for multiple services supports.

Summary of CMS response on this issue: The final rule maintains the requirement that states develop and implement a beneficiary support system to provide support before and after managed care enrollment. The requirement makes choice counseling available to all beneficiaries and adds assistance for enrollees who either receive or desire to receive LTSS.

However, CMS maintains that states have the flexibility to provide or to decide what entities comprise a state's beneficiary support system, and notes that nothing prohibits states from using existing agencies—such as AAAs or SHIPs—as part of a beneficiary support system, but does not mandate that these entities be included as part of a state-developed beneficiary support system.

Recommendation on Enrollment Broker:

Summary of n4a comments: n4a asked CMS to reconsider the definition of enrollment broker as outlined in § 438.816, as it does not recognize that entities performing choice counseling services are not necessarily also serving as an enrollment broker. n4a argued that qualified CBOs can continue to provide choice counseling and support for beneficiaries without actually assuming the role of enrolling consumers into plans; therefore, the CBO should not be considered the enrollment broker just because it offers choice counseling.

We argued that this distinction is critical. If choice counseling or options management are considered part of enrollment brokerage, that automatically disqualifies the provider from contracting with an MCO for other vital services that beneficiaries may require in that community. We understand the importance of enrollment functions being carried out independently from provision of other services to ensure no conflict of interest exists (i.e., bias toward a particular plan), but a AAA or other CBO could conceivably provide choice counseling and/or options management for beneficiaries separate from another entity playing the official enrollment function. We urged CMS to change the wording in the proposed rule that bans all entities engaged in the enrollment broker process from offering other services to MCOs for contracting. We suggested separation of the choice counseling and options management functions from the enrollment broker role, keeping the restriction on contracting only applicable to the entity that performs the official

enrollment function.

Summary of CMS response on this issue: CMS maintains that states may determine the structure of an entity that provides choice counseling as part of the beneficiary support system for Managed Care enrollees, but that any individual or entity providing choice counseling services on behalf of the state is considered an enrollment broker under the regulations, and therefore must meet the independence and conflict of interest standards for enrollment brokers under Medicaid. CMS specifically "does not agree with commenters that we should separate choice counseling from the definition of enrollment broker."

The final rule further clarifies that, "this means that the entity cannot have a financial relationship with any managed care plan which operates in the state where the entity is providing choice counseling, which would also include the entity's participation with the managed care plan as a network provider." CMS clarifies that "entities receiving non-Medicaid federal grant funding are not within the scope of the rule and therefore may continue to perform such activities as long as such entities are not performing these activities [choice counseling] under a memorandum of agreement or contract with the state to provide choice counseling on the state's behalf."

Recommendation on Ombudsman:

Summary of n4a comments: Given the importance of the Aging and Disability Networks' services and supports to consumers, we commented that it is vital that any conflict of interest provisions ensure appropriate oversight, transparency and remediation, without unnecessarily reducing the beneficiaries' access to, quality of or options for community supports.

CMS asked for input on whether entities that provide non-Medicaid federally financed protections of beneficiaries that include representation at hearings, such as AAA-administered long-term care ombudsman programs, should be allowed to also contract with the Medicaid agency to provide choice counseling as long as appropriate firewalls are in place.

n4a strongly supported allowing entities to perform both roles, with established and appropriate firewalls in place. Many AAAs operate under the Older Americans Act as the local Long-Term Care Ombudsman. We argued that appropriate firewalls can function effectively without limiting service provision and continuity of care for beneficiaries as long as there is a separation of supervision and duties, and billing.

Summary of CMS response on this issue: CMS notes that the final rule intentionally differentiates the beneficiary support system from the long-term care ombudsman system, and relies on clarification and guidance offered in the June 2013 Centers for Medicaid & CHIP Services Informational Bulletin to specify which LTCO services may be Medicaid-reimbursable. The rule permits entities that provide non–

federally financed protections of beneficiaries to be allowed to provide choice counseling as long as appropriate firewalls are in place.

Training (42. C.F.R. § 438.71 (d))

Summary of n4a comments: After receiving various examples from n4a members, we argued that current managed LTSS programs have demonstrated the potential breakdown in coordination when the MCO or network provider does not understand the existing array of aging and disability services needed to serve the client base. We supported the requirement on training MCOs and suggested that CMS specify additional elements of the training, which we believed critically important.

We noted the extensive experience of AAAs, ADRCs, SHIPs and other CBOs in developing trainings and providing information about community-based services. We argued that an MCO's LTSS training should be provided by local entities that know and understand the unique aspects of LTSS and consumers in that state/community and that MCOs should be trained to understand the wealth of experience and knowledge that CBOs like AAAs have in providing HCBS. We supported that introducing MCOs to CBOs through adequate training can vastly increase service coordination. Overall, n4a recommended that CMS strengthen the training regulation by requiring that all MCO entities, network provider care coordinators, and interdisciplinary team leaders participate in the training; that training be required of new staff; and that training materials be updated on an annual basis. We suggested that CMS could consider using current training standards required of SHIP counselors to apply to MCO staff.

We also challenged the CMS estimate that it would only take three hours to create provider education materials, plus one hour annually for those same materials to be updated (see 80 Fed. Reg. at 31182).n4a believed that these timing projections vastly underestimated the amount of time it takes to develop training and education materials and to keep those materials updated in a continuously changing health care environment.

Summary of CMS response on this issue: CMS recognized the value of partnering with current community-based providers in delivering training to MCO entities. However, CMS ultimately concluded that it was "not appropriate for the beneficiary support system to provide training to MCOs." While CMS will "encourage managed care plans to include training related to the community-based support systems used by individuals with complex and special health care needs, including individuals using or needing LTSS," the agency decided that states are in the best position to determine whether or which training elements are necessary, and ultimately declined to finalize the regulatory requirements in this section.

Care Coordination (42 C.F.R. § 438.208(b))

Summary of n4a comments: In response to CMS's request for comments on

incorporating an "additional standard relating to community or social support services," including "Aging and Disability Resource Centers, Centers for Independent Living, [and] Area Agencies on Aging" in coordination between settings with services "outside of the MCO," we supported including this additional standard. However, we noted significant concern about some current MCO practices and the increased possibility that MCOs will interpret this standard as an endorsement to leverage AAAs' and ADRCs' resources, support and services without any and/or appropriate compensation.

We argued that with limited federal OAA funding, AAAs cannot be expected to extend their existing services and/or re-prioritize clients, especially if waiting lists exist, to accommodate MCO clients. We recommended that including this community and/or social support standard as part of a care coordination plan is essential, but that the expectation should not be that MCOs will receive payment for referring MLTSS beneficiaries to the Aging and Disability Networks without appropriately compensating those entities for the high-value services they offer the beneficiary.

Summary of CMS response on this issue: CMS indicated that they received many comments supporting the additional standard relating to community or social support services and included this standard in the final rule, but CMS failed to comment on the potential risk to community-based providers if MCOs do not appropriately compensate these entities for their services to Medicaid Managed Care beneficiaries.

Stakeholder Engagement (42 C.F.R. § 438.70)

Summary of n4a comments: We appreciate that CMS recognized the importance of stakeholder engagement to the success of state MLTSS systems and we supported adding §438.70 to create and maintain a stakeholder group to ensure that the "opinions of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation and oversight of the MLTSS program."

However, we did not believe the guidance given to states in meeting this standard was sufficient, and we argued that CMS should set stronger parameters around both the composition and expectations of state stakeholder groups. At a minimum, we requested that CMS establish parameters for the composition of state-level stakeholder engagement groups, as well as the supports provided to those stakeholders to ensure appropriate and meaningful participation.

We recommended that CMS add specificity around which types of stakeholders must be engaged and provide guidance identifying that representatives from the Aging and Disability networks, and specifically AAAs, should participate. Furthermore, we requested that CMS include requirements about the supports needed to appropriately create and maintain a meaningful and effective stakeholder engagement group and MCO member advisory committee proposed in §438.110. We recommended that CMS establish parameters around what meaningful engagement is; and we suggested that CMS require at least quarterly public meetings, with data and content from the meetings

being made publicly accessible in a timely manner.

Summary of CMS response on this issue: CMS acknowledged these recommendations and the value of including community providers of LTSS, in particular AAAs, in both statewide stakeholder engagement groups and specific MCO advisory committees, but declined to add specificity to the regulations regarding stakeholder engagement groups or advisory committees. CMS again indicated the agency thought that states were in the best position to determine the appropriate composition of these groups, noting "Our proposal specifically uses a "sufficiency" standard rather than setting quantitative parameters for the composition of the group or the frequency of meetings to permit states a significant degree of flexibility."

Medical Loss Ratio and LTSS (42 C.F.R. § 438.8(e)(3))

Summary of n4a comments: We supported that CMS implemented a minimum medical loss ratio (MLR) for managed care. We believe this is an important change and we supported aligning this standard for managed care with Medicare and private market health plans. We also supported including LTSS activities as health care service activities in the MLR numerator. Specifically, we appreciated that CMS recognizes that "the definition of activities that improve health care quality is broad enough to encompass activities related to service coordination, case management, and activities that support state goals for community integration of individuals with more complex needs such as individuals using LTSS."

However, we expressed concern that these activities are not separately identified in the rule. Given the significance of the inclusion of a minimum MLR for Managed Care plans, we believed it was important to specifically identify all activities that CMS intended to include in the MLR numerator and not assume that MCOs will include the cost of appropriate outreach, engagement and service coordination in the category.

We recommended that CMS specify that "activities related to service coordination, case management, and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS" can improve health quality. We asked that they add clarification around this expectation to ensure that those activities fall under the definition of "medically necessary" and be included in the MLR numerator.

Summary of CMS response on this issue: CMS acknowledged that these activities should be considered health care quality-improving activities and agreed that the types of activities described by the commenters should be included in the numerator. However, the agency disagreed that they should be listed explicitly given the concern that "if we provide a specific list of these activities, some unique state programs that offer similar types of activities with a different name would be precluded from the category and potentially not included in the numerator." CMS also declined "to institute an approval process for activities that could qualify as quality improvement activities as

that would be inconsistent with the MA and private market MLR requirements; however, states are able to do so if they choose."

Network Accessibility (42 C.F.R. § 438.10) and Adequacy (42 C.F.R. § 438.68(c)(2))

Summary of n4a comments: We appreciated the efforts of CMS to recognize and address the challenges inherent in delivering effective and adequate health care and community supports to older adults and people with disabilities who have functional and cognitive limitations. We acknowledged that requirements outlining 1) how states and MCOs disseminate beneficiary information (e.g., enrollee handbooks, provider directories, appeal and grievance notices and other critical communications); 2) what must be included in that information; and 3) what ensures an adequate provider network are important considerations in an expanding managed care landscape.

We expressed concerned that the detailed accessibility requirements proposed in the rule would be onerous for some providers. We also recommended that CMS ensure that MCOs leverage available networks and infrastructure, such as the Aging and Disability Networks—including AAAs—that have been providing information and LTSS to vulnerable populations with unique challenges for decades and that have a working knowledge of the needs of individual communities.

We recommended that CMS provide more clarity around the providers included in network adequacy assessment. We argued that the "expectation" that states will "consider all LTSS delivered through managed care" in developing standards is too vague to ensure that each state will develop adequate standards to ensure access to the broad range of critical LTSS. Furthermore, we recommended that CMS require that MCOs and states partner with, and appropriately compensate, HCBS and LTSS agencies and entities that have a long-standing history of developing and maintaining information and resources about available health care and LTSS providers and the accessibility of those providers.

Summary of CMS response on this issue: Overall, CMS cited diverse and non-specific recommendations around ensuring network adequacy and accessibility standards as the justification for declining to provide additional requirements around network adequacy and accessibility standards in the final rule. The agency is largely deferring to states to develop network adequacy and accessibility standards for their MLTSS programs, but states must develop time and distance standards for their LTSS providers. Additionally, states must account for language and disability access in designing time and distance standards for LTSS, but the final rule provides no specificity around what sufficient state standards should be.

Definition of Long-Term Services and Supports (42 C.F.R. § 438.2)

Summary of n4a comments: We supported CMS's proposal to add a definition of LTSS to these regulations. However, we expressed concern that the definition was not specific enough to adequately address the full range of LTSS.

We recommended that CMS add more clarity to adequately address the value that the broad range of LTSS services provide in ensuring the health and well-being of MLTSS beneficiaries and the critical role that LTSS providers play in offering those services; and we suggested including examples of services that some MCOs may consider to be non–medically necessary, but that are in fact critical to ensuring that MLTSS beneficiaries can live and work successfully in their communities.

Summary of CMS response on this issue: CMS noted that the definition of LTSS was "not intended to describe minimum service requirements for LTSS in states; rather, it defines the scope of supports and settings that would be covered by the regulatory requirements for managed LTSS programs." However, CMS did change the definition to add additional clarity. The final regulations state that, "long-term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting."

Important Opportunities for Ongoing Advocacy

While the release of the final regulations covering Medicaid Managed Care systems are an important step as MLTSS continues to expand, overall, the regulations released by CMS largely defer to states to determine and implement requirements for their respective Managed Care systems.

We know many n4a members are concerned that the role of AAAs and other CBOs as the traditional HCBS providers could be lost to a more medicalized system under Managed Care, which will be to the detriment of clients who have been depending on these services for decades as well as to newly eligible consumers. At the same time, there is uncertainty about whether MCOs new to LTSS have the experience or geographic scope to fully and properly assess enrollees, provide case management and provide direct services to vulnerable seniors.

Given the fact that CMS has given states a great deal of latitude in the regulation to define MLTSS systems, **it is imperative that the Aging Network in each state identify engagement opportunities and weigh in as states are implementing the final federal regulations.** There is opportunity to strengthen MLTSS programs by considering and capitalizing on the traditional HCBS infrastructure and supporting the inclusion of AAAs and other CBOs along with MCOs. As trusted resources with a long

history in the community, AAAs and other CBOs have important knowledge of the targeted population and skill sets that can complement those of MCOs and enhance a state's MLTSS program, and subsequently, beneficiary health outcomes.

We will continue to work on providing federal information and resources to n4a members to help them identify advocacy opportunities at a state level.

The Wisconsin Long-Term Care Coalition

Keep Our Care at Home

July, 2016

Recommendations to Improve Quality and Sustainability of Family Care, IRIS and Partnership Programs in the 2017-19 Budget while Containing Costs

Wisconsin currently operates highly successful and popular adult long-term care (LTC) programs (Family Care, IRIS and Partnership). The Legislative Fiscal Bureau found that overall Medicaid costs of LTC enrollees increased only 0.3%/year from 2010 to 2015. The portion of Wisconsin's Medicaid budget spent on LTC dropped by 10% for 2002 to 2011. We can continue to improve our LTC system without disrupting the lives of enrollees or the current cost-effective models of service. The ideas listed below are largely derived from the *Stakeholders' Blueprint for Long Term Care Redesign*. We believe that, if implemented, they will improve sustainability, continue to save LTC costs, generate new savings in health care, and improve outcomes for enrollees.

1. Achieve additional savings by expanding the current models of Family Care and IRIS to all 72 counties in 2017

-According to DHS, the current LTC system already saves Wisconsin taxpayers approximately $400 million per year compared to the previous county-based legacy waivers/ fee for service system

-DHS has projected that this would achieve additional savings

-This would also eliminate all waiting lists for adult LTC services in Wisconsin and prevent people moving into costly institutions because they can't obtain in-home services

2. Expand the Family Care Partnership program beyond the current 14 counties to increase access to integrated care

-DHS and the legislature have expressed interest in an integrated (LTC and health care) model; Wisconsin already has one in the Partnership program

-We support making the Partnership option available to people in every county

3. Explore various ways to contain health costs of people in the LTC system

-We now know that Family Care and IRIS have already generated substantial savings in the cost of LTC services - - the real future savings opportunities are in primary and acute care

-We recommend that DHS initiate an in-depth study of all the cost drivers in primary and acute care (for LTC enrollees and others) in Wisconsin's Medicaid program and focus on those with the greatest potential for cost savings

-Several ideas for health care savings for LTC enrollees have been suggested by stakeholders; now is the time to start analyzing the pros and cons of each one

-Offer a managed care option for health care coordination which IRIS participants could enroll in while continuing to be enrolled in IRIS

4. Leverage the strengths of Wisconsin's proven effective model of ADRCs

-ADRCs have a track record of preventing and delaying reliance on publicly-funded LTC services

-Increased funding is necessary to address the increased demand for ADRC services since current ADRC funding levels were set, and ensure that all ADRC functions are available on a timely basis to people who need them

5. Expand provider capacity to remedy lack of service access and choice

-The current lack of appropriate services in many areas results in excessive transportation costs (to get to another county where the service is available) and unnecessary hospitalization/health care costs (when a person cannot get a service which is crucial to his/her health or safety)

-We recommend that a) DHS analyze current gaps in various service categories in every region of the state, and b) DHS and MCOs team up to develop strategies to fill the gaps

6. Ensure that real self-direction is available to everyone in the LTC system who wants it

-Adopt the IRIS Advisory Committee recommendations to eliminate unnecessary red tape in the IRIS program that hampers budget and employer authority

-Strengthen the self-directed support option inside Family Care

7. Increase accountability for providing quality services

-DHS should strengthen requirements for MCOs and providers to serve people in the "most integrated setting" (in keeping with recent federal Medicaid rules changes)

-Increase accountability in current areas of deficiency, e.g. lack of effective support for obtaining community employment, inadequate provision of mental health services

8. Restructure funding to reward quality service delivery

-Review funding levels for Family Care, IRIS, and Partnership to ensure that there is sufficient funding/person to provide quality services that meet the person's goals and comply with federal rules

-Prioritize funding for supports that keep people in their own homes, increase self-sufficiency/community employment, and enable participation in community life

-Institute "pay for performance" measures

9. Increase the availability of high-quality behavioral health services for Family Care, IRIS and Partnership enrollees to reduce utilization of costly institutional care

-Take the steps necessary to strengthen the partnership between MCOs and county mental health systems

-Ensure that community-based crisis services are readily available to anyone who needs it

-Improve the level and quality of services available to people with complex needs (e.g. people with a dual diagnosis of developmental disability and mental illness/challenging behaviors)

10. Address the LTC Workforce Crisis to keep enrollees safe and healthy at home, reduce costly hospitalizations, and prevent acute health and safety crises

-There is a substantial (and growing) number of people in the LTC system who cannot obtain the services authorized in their service plans because of worker shortages - - this is a *de facto* denial of service, it puts enrollees at risk, and it increases the use of costly institutional settings

-Analyze and address the causes of the current high turnover rates among direct care staff

-DHS, MCOs and providers can team up to develop new initiatives to address the crisis

11. Increase cultural competence in all LTC programs

-Track relevant data to ascertain whether and how the experience of various sub-populations varies in the LTC system

-Require MCOs and ICAs (IRIS Consultant Agencies) to maintain a diverse staff and provide cultural competency training to all staff

-Increase accountability for cultural competence and language access in DHS-MCO and DHS-ICA contracts

12. Strengthen ongoing Stakeholder Input

-Create a sense of shared ownership and responsibility between government and enrollees

-Create overlapping membership between the DHS LTC Advisory Council and the IRIS Advisory Committee, and broaden the role of the LTC Advisory Council to oversee overall quality in the LTC system

-Create the "Consumer Advisory Councils" and "quarterly listening sessions" in each region as proposed by DHS in the DHS Concept Paper

-Explore other opportunities to ensure stakeholder involvement in guiding and evaluating the LTC system

13. Strengthen effective prevention programs that reduce hospital and institution utilization

-Wisconsin is currently missing opportunities to prevent, delay and reduce the need for LTC services, including costly institutional care, because evidence-based prevention programs are only available in some counties

-Provide sufficient statewide funding to ensure that evidence-based prevention programs that have proven effective in preventing hospitalization and nursing home admissions, and saving Medicaid funding, are available in <u>every county</u> (vs. the current "hit and miss" access that is dependent on local funding availability)

14. Continue the process of requiring approval of the Joint Finance Committee (JFC) before DHS makes major proposals to the federal government regarding Adult LTC Medicaid Waiver Programs

-Require a formal vote of JFC before DHS can eliminate or make major changes in an existing Adult LTC Medicaid Waiver Program, or create a new Adult Medicaid Waiver Program

-This would not require JFC approval for minor changes to an existing Adult LTC Medicaid Waiver program

-This will ensure an open and transparent culture of dialogue between DHS, stakeholders, and the legislature as a permanent feature of Wisconsin's' LTC system

-With so much at stake in the lives of 60,000 enrollees and their families when there is upheaval in the system, this is an appropriate form of legislative oversight