Family Care/IRIS 2.0 Concept Paper

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Executive Summary

Since the Family Care Program was developed almost 20 years ago, it has provided greater independence, more consumer choice, and community inclusion for adults with disabilities and frail elders. Family Care was built on principles of self-determination and a true member-centered approach to designing care plans and services to meet each individual's long-term care needs and include each individual's preferences about how and where they live. The Include, Respect, I Self-Direct (IRIS) program was implemented in 2008 and offers the opportunity for adults with disabilities and frail elders to have an even greater say in the services and supports they need and how they want those services and supports to be delivered.

2015 Wisconsin Act 55 offers the opportunity to build upon the foundation of Family Care and IRIS, by enhancing the scope of services available to long-term care consumers and extending the programs to every county. All eligible adults with disabilities and frail elders will have access to coordinated primary, acute, and behavioral health services, in addition to long-term care services. The next generation of Family Care and IRIS will support the person's overall health and well-being, not just their long-term care needs.

Act 55 directs the Department of Health Services (DHS) to make a variety of changes to the Family Care program. Under the direction of Governor Scott Walker, DHS will implement a new care model, Family Care/IRIS 2.0, which will expand Family Care statewide and transition to an outcome-based model that coordinates all of an individual's care needs. These changes will preserve this essential safety net program for Wisconsin's frail elders and adults with disabilities by maintaining essential health care services while slowing expenditure growth.

Wisconsin will establish a coordinated-care model that focuses on the overall health of the individual and will coordinate all of an individual's care needs, including long-term care, primary and acute care, and behavioral health care. This model will allow Wisconsin to shift away from a more fragmented approach of providing care to frail elders and adults with disabilities, to ensuring that the total health outcome of an individual is coordinated. Care coordination reduces the likelihood of long-term nursing home stays and improves the member's overall health, which may reduce the need for other long-term care services. Family Care/IRIS 2.0 will improve the delivery of long-term care services and will establish a strong link between an individual's long-term, behavioral health, acute, and primary care needs. This will lead to better health outcomes, improved utilization of long-term care services, and more independence for frail elders and adults with disabilities who are living in the community.

It is essential that changes are made now to ensure Wisconsin's long-term care programs will continue to be cost-effective, sustainable, and available for years to come.

Among the most significant challenges facing Wisconsin in the next 20 years will be caring for the rapidly increasing older population. The population of those aged 65 and older will double by the year 2035. In addition, adults with disabilities are living longer, fuller lives in the community because of the support and services they receive through Wisconsin's Medicaid programs. The state's overall population growth, coupled with changing demographics, will greatly increase demand for Wisconsin's long-term care programs.

Wisconsin is committed to maintaining excellence in health and long-term care coverage for our residents, while recognizing that significant growth in the cost of the Medicaid program impacts other essential priorities including education, transportation, and tax relief. The long-term care population, including elderly and people with disabilities, comprise less than 20 percent of the Medicaid enrollment, yet in fiscal year 2016, long-term care costs for this group is budgeted at $3.4 billion, or 40 percent of the Medicaid budget. For individuals currently in long-term care managed care programs, acute and primary care costs grew 10 times faster than their overall Medicaid costs from 2010 through 2015. For individuals currently in IRIS or a legacy county-based long-term care program, their acute and primary care costs grew 12 times faster. The combined impact of an aging population and increase in cost requires bold reform to protect these essential services for future generations. These reforms work to slow the growth of expenditures by improving health rather than more drastic options of decreasing eligibility or reducing benefits.

Act 55 requires DHS to submit this Concept Paper to the Joint Committee on Finance to serve as the foundation for the waiver and/or state plan submission to the federal Centers for Medicare and Medicaid Service (CMS) for approval to implement these significant reforms to Family Care. The waiver will be developed in accordance with principles determined by CMS to be essential elements of a strong managed long-term care services and supports program. As required by CMS, the draft waiver will be released for public review and comment before it is submitted to the federal government for approval.

This reform builds upon Wisconsin's successful managed long-term care system by supporting the overall health and well-being of individuals, not just their long-term care needs. Improving health outcomes will not only allow individuals to live longer, fuller lives, but also will slow expenditure growth in Medicaid.

The Concept Paper outlines the following features of the proposed new model, Family Care/IRIS 2.0.

- Consistent with the current program, Family Care/IRIS 2.0 will continue to serve adults with physical disabilities, adults with developmental disabilities, and frail elders who meet financial and functional eligibility requirements.
- Members will decide whether to fully self-direct their long-term care services, have their long-term care services fully managed, or have a blend of care management and self-direction. They can change this decision as their needs change.
- DHS will contract with integrated health agencies (IHAs).
- Wisconsin will have three Family Care/IRIS 2.0 zones and three IHAs will serve each zone.
- DHS will select IHAs through a competitive Request for Proposal (RFP) process.
- Aging and Disability Resource Centers (ADRCs) will continue to provide unbiased enrollment counseling to assist individuals in making a choice of which IHA to select.
- There will be continuous open enrollment in Family Care/IRIS 2.0.
- Under Family Care/IRIS 2.0, individuals dually eligible for Medicaid and Medicare will continue to have the right to choose to obtain their Medicare benefits through fee-for-service Medicare or through a managed Medicare program. Act 55 directed the Department to request from United States Department of Health and Human Services a Medicaid State Plan amendment or amendment to the Family Care/IRIS waiver that includes providing both long−term care and primary/acute care services through integrated health agencies including, to the extent allowable by the United States Department of Health and Human Services, to consumers who receive both Medicaid and Medicare

funded services. The United States Department of Health and Human Services has advised the Department that mandatory enrollment of Medicare consumers in managed care is not allowable under a State Plan or Family Care/IRIS waiver amendment.

While Act 55 only required two public hearings to create this Concept Paper, DHS developed and executed a robust plan to collect stakeholder input. DHS conducted 10 public hearings; met with councils, boards, and committees that advise DHS on its long-term care programs; and held additional meetings with a variety of stakeholders to collect more focused input.

Introduction

The Family Care and IRIS programs serve more than 55,000 of Wisconsin's frail elders and adults with physical and/or developmental disabilities, who meet both the Medicaid financial eligibility requirements and who have functional limitations that meet statutorily established thresholds. The Family Care and IRIS programs are currently offered in 64 counties. DHS was authorized by 2015 Wisconsin Act 127 to implement Family Care in Rock County in July 2016. The remaining seven counties have not implemented Family Care and operate the legacy county-based long-term care programs. In these counties, some people in need of services are on waiting lists. Family Care/IRIS 2.0 will be available in all 72 counties and will eliminate waiting lists for services.

Both Family Care and IRIS have been successful and have received broad stakeholder support. Both programs have proven to be fiscally prudent compared to the legacy county-based long-term care system, while meeting the growing demand for long-term care services. Act 55 offers the opportunity to build upon the foundation of Family Care and IRIS by enhancing the scope of services available to long-term care consumers, and extending the programs to every county. All eligible adults with disabilities and frail elders will have access to better-coordinated primary, acute, and behavioral health services, in addition to long-term care services. The next generation of Family Care and IRIS will support the person's overall health and well-being, not just their long-term care needs.

The Family Care/IRIS 2.0 plan outlined in this document reflects the Department's approach that remains centered on the fundamental principles of self-determination, empowerment, member-centeredness, quality, consumer choice, and fiscal stability.

Public and Stakeholder Engagement

Recognizing the significance and importance of Act 55 provisions related to Family Care/IRIS 2.0, DHS developed and executed a plan to solicit stakeholder input that was used to create this Concept Paper.

Initial Public Hearings

- More than 770 people attended eight public hearings held throughout Wisconsin in the fall of 2015.
- These hearings were live-streamed via a webcast to allow people to participate remotely. The archived webcasts have been viewed more than 3,400 times.
- DHS received testimony from 556 people. Testimony was accepted in person at the public hearings or in writing by email or U.S. mail.

Concept Paper Hearings

- Two additional public hearings were held regarding the Concept Paper on March 7, 2016. Approximately 350 people attended in person and, in addition, as of March 21, the webcasts have been viewed 1,900 times.
- DHS received testimony from 202 people. Testimony was accepted in person at the public hearings or in writing by email.

Additional Stakeholder Outreach

- A dedicated Family Care/IRIS 2.0 web page was created to provide a centralized and easily accessible point for information and to allow people to be notified when updates are posted. The web page is available at https://www.dhs.wisconsin.gov/familycareiris2/index.htm
- DHS made presentations to and had discussions with stakeholders, including:
    - Tribal representatives.
    - Statutorily established boards and councils charged with providing input to DHS on its long-term care programs, including the Governor's Committee for People with Disabilities; State Council on Alcohol and Other Drug Abuse; Statutory Council on Blindness; Board on Aging and Long Term Care; Tribal Long Term Care Study Group; Wisconsin Council on Physical Disabilities; Council on Mental Health; Board for People with Developmental Disabilities (BPDD); Independent Living Council of Wisconsin; and the Council for the Deaf and Hard of Hearing.
    - Centers for Medicare and Medicaid Services (CMS).

Upon the Legislature's approval of the Concept Paper, DHS will develop formal waiver and/or state plan authority documents to submit to CMS. DHS will release these documents for public review and will conduct another formal public comment period prior to submission to CMS.

Ongoing Consumer and Stakeholder Engagement in Family Care/IRIS 2.0

An important aspect of Family Care/IRIS 2.0 will be a multi-faceted approach to solicit input and feedback from consumers and other stakeholders about Family Care/IRIS 2.0 once it is implemented.

DHS will continue to have discussions with MCOs, potential IHAs, advocates, counties and other stakeholders as the waiver is being developed.

Upon implementation of Family Care/IRIS 2.0, the following steps will be taken to remain engaged with consumers and stakeholders.

- All IHAs will be required to have a consumer advisory council. IHAs will also be required to have a provider advisory council and to provide DHS with regular updates on the work of these groups. These councils will provide consumers and providers regular and ongoing mechanisms to voice concerns about the operations of the IHA and to make recommendations about areas in which improvements can be made.
- DHS will receive regular input from consumers, providers, and other stakeholders to advise DHS on procedures of Family Care/IRIS 2.0 and its oversight of IHAs and ADRCs.

- DHS will conduct quarterly listening sessions in each zone at least through the first year of the Family Care/IRIS 2.0 program. Representatives of IHAs and ADRCs in the zone will be required to attend in person.

Guiding Principles

Early in the planning process, DHS identified the following key principles and concepts to guide the development of Family Care/IRIS 2.0.

- Program participants have the right to live independently, with dignity and respect.
- Personal choice, self-determination, person-centered planning, and cultural competence will remain key tenets.
- A strong emphasis will be placed on quality, health, and safety.
- Family Care/IRIS 2.0 will build on the strengths and key features of the current Family Care and IRIS programs.
- Program participants have the choice to live in the least restrictive and most integrated setting appropriate to their needs.
- Program participants will continue to have a choice of self-direction as well as a choice of providers in the communities in which they live, including the option to receive services from tribal providers.
- Program participants who wish to self-direct their long-term care services will continue to have the ability to self-direct all current IRIS services.
- The focus on natural supports and connections to family, friends, and community will continue.
- The current range of benefits is unchanged. The management of the primary, acute, and behavioral health benefits will be added to the existing array of long-term care services.
- Functional and financial eligibility will remain the same as it is today.
- Person-centered plans will continue to be developed in the most cost-effective manner possible.
- Appeal and grievance rights will be preserved.
- All enrollees (frail elders and adults with physical and/or developmental disabilities) will have access to independent external ombudsman services for all Family Care/IRIS 2.0 services (long-term care, primary, acute, and behavioral health services)
- Independent and unbiased enrollment counseling will be available through the ADRCs to all program participants.
- DHS will develop strong contractual obligations for IHAs and DHS staff will continue rigorous oversight to assure contract compliance and high-quality programs.
- Transparency and public access to contracts, policies, outcomes, and procedures will continue.
- These changes will help ensure that these programs will continue to be cost-effective, sustainable, and available for years to come.

Program Design

Family Care/IRIS 2.0 will provide a continuum along which an individual may choose how much self-direction they prefer. Individuals may choose to be in a fully managed program, choose to self-direct some long-term care services, or choose to fully self-direct all long-term care services. Program

participants will be able to choose the amount of self-direction that best meets their needs and preferences.

Family Care/IRIS 2.0 will include long-term care services currently covered under Family Care and IRIS as well as Medicaid-covered acute, primary, and behavioral health services. Addendum 1 provides a list of covered services and indicates which services can be self-directed.

IHAs will focus on the overall health of the individual by establishing a coordinated care model that covers the individual's long-term care, behavioral health, and primary care needs.

- IHAs must offer all services that are currently provided in the Family Care program, including home-delivered meals, supported employment, transportation, and supportive home care.
- In addition, IHAs must offer most services that are currently provided through fee-for-service to members today, including outpatient acute care, inpatient hospitalization, therapy services, and personal care.
- Prescription drugs will continue to be provided through fee-for-service similar to other managed care contracts like BadgerCare Plus and SSI Managed Care.
- IHAs are required to support personal choice, self-determination, person-centered planning, and cultural competence.
- Each member will have a care team that is unique to the individual to develop a care plan that is custom tailored to the individual.
- Members who are also eligible for Medicare (dual eligibles) may choose to receive Medicare benefits through fee-for-service or from any Medicare Advantage plan available to them, regardless of whether the IHA has a relationship with that Medicare Advantage Plan.

Member Self-Direction of Long-Term Care Services

The option for members to self-direct long-term care services is a key feature of the current Family Care and IRIS programs. When an IRIS member self-directs long-term care services the member, in consultation with the IRIS Consultant Agency (ICA), develops a plan to meet the member's needs. The member determines who will provide the services specified in the care plan and manages and directs payments to service providers.

The right of members to self-direct long-term care waiver services will remain a fundamental principle in Family Care/IRIS 2.0. The long-term care services that are available to IRIS participants today will continue to be available under Family Care/IRIS 2.0. Members will be able to self-direct all or some of the long-term care services that are able to be self-directed. See Addendum 1 for a full list of services that may be self-directed.

Members who choose to self-direct their long-term care services will continue to have employer and budget authority and responsibility, as summarized below.

Employer Authority and Responsibility: Consistent with the current program structure, participants will continue to have the authority to hire, manage, and direct their paid workers or care providers, as a common law employer, or as a co-employer with an agency.

Budget Authority and Responsibility: Participants will continue to manage and direct their own individual service budget.

- IHAs will be required to offer IRIS specialist services (currently provided by the ICA) and fiscal-employer agency (FEA) services. The IHA will provide a choice of at least two IRIS specialists, one of which must be external to the IHA, i.e., not employed by or otherwise affiliated with the IHA. Members may choose if they want to work with an external IRIS self-direction specialist or work with the IHA's designated staff to develop a member-centered plan.
- The IHA will establish an individual's budget after the IHA has completed a functional assessment and the IRIS specialist has worked with the member to develop a member-centered plan. The member's budget will be based on the individual's member-centered plan and services the member elects to self-direct. This is a significant enhancement over the current method to set the IRIS budget, which is not based on individually assessed needs or the member-centered plan.
- The established budget will be required to be sufficient to support the member's care plan. The individual will have budget authority to purchase the necessary goods and services to meet their needs. Participants will continue to be accountable for the use of funds consistent with their long-term care support and service plan, established policies and procedures, and the federal waiver authority.
- DHS will approve and rigorously monitor the IHA assessment and budget-setting processes. Members will have the ability to appeal the self-direction budget to DHS.
- IHAs will be required to obtain DHS approval on the process they will use to establish budgets for self-directed services.
- If the member believes the budget does not adequately support the care plan, there are a number of actions a member can take, including those listed below. The member does not need to follow these steps in any particular order.
    - Work with the IHA to resolve concerns.
    - Work with the IRIS specialist.
    - Work with the independent external ombudsman.
    - Contact DHS about the concerns.
    - Appeal to DHS or make a request to the Division of Hearings and Appeals for a review through the fair hearing process.

IHAs will be required to have a budget amendment process available. In addition, all participants will have access to independent ombudsman services and the ability to switch, at any time, to another IHA that better meets their needs.

Under Family Care/IRIS 2.0, members will also continue to have maximum flexibility regarding self-direction of long-term care services and will have greater flexibility to change the number and type of services they self-direct. Members will not be required to return to the ADRC if they want to begin to self-direct services or stop self-directing services.

Member Freedom of Choice

Wisconsin will establish a coordinated-care model that focuses on the overall health of the individual and will coordinate all of an individual's care needs, including long-term care, primary and acute care, and behavioral health care. Family Care/IRIS 2.0's model for providing coordinated care will also allow members to self-direct long-term care services. Since members are not able to directly employ physicians, hospitals, or similar providers, self-direction is not applicable to primary, acute, and behavioral health services. Members will be enrolled in an IHA that will continue to be responsible for the member's acute care, primary care, and behavioral health needs. If a member does not self-direct all or some of their long-term care services, the IHA will also coordinate these services.

While members will not be able to directly employ providers or have budget authority for acute, primary, and behavioral health care needs, they will still be in control of their health care as members will be able to choose the IHA that best meets their needs. Members will have a choice of three IHAs, each with distinct provider networks, and they will be able to select the IHA with the providers and specialists that they prefer and best meets their needs.

Freedom of choice of willing and qualified providers is a fundamental part of Medicaid. Family Care/IRIS 2.0 will ensure members continue to have freedom of choice of providers to the greatest extent possible.

Members that choose to self-direct long-term care services will have a care team that will include an IRIS self-direction specialist. The care team will be required to guarantee that long-term care services are coordinated with primary and behavioral health care services.

Family Care Partnership

The Family Care Partnership Program is an integrated Medicare and Medicaid program that provides comprehensive services for frail elders and adults with developmental or physical disabilities. The program integrates health and long-term support services, and includes home and community-based services, physician services, and all medical care.

Family Care Partnership is currently available in 14 counties. DHS will continue to offer Family Care Partnership in these counties. Individuals in these counties may enroll in Family Care/IRIS 2.0 or Partnership. Individuals who choose Partnership must enroll in a managed care organization's (MCO) Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) for their Medicare benefits. The MCO is then responsible for providing all Medicare and Medicaid primary, acute, behavioral health, and long-term care services.

MCOs are the entities currently contracted with DHS to provide Family Care Partnership. These MCOs are similar to IHAs and are required to be licensed by the Office of the Commissioner of Insurance (OCI) as insurers. DHS intends to continue contracts with current Family Care Partnership MCOs to ensure continuity for members enrolled in the Family Care Partnership program. DHS will continue to work with CMS to expand Partnership to more counties to increase consumer choice.

Integrated Health Agencies

DHS will contract with IHAs to provide Family Care/IRIS 2.0. OCI will require IHAs to be licensed as insurers. IHAs will coordinate all of a member's care needs that are in the IHA benefit package, including long-term care, primary and acute care, and behavioral health services. IHAs will also have a process for facilitating a member's ability to self-direct long-term care services.

Act 55 requires that DHS have multiple IHAs in each zone. DHS intends to contract with three IHAs per zone in an effort to achieve several important goals and requirements.

- CMS requires that members have a choice of managed care entities.
- Members will have a choice of IHAs.
- Providers will not be limited to negotiating with one IHA, which will create a more level playing field for negotiations.
- There will be greater program stability for members, providers, and DHS. If one IHA fails to meet contract obligations or does not wish to continue its contract with DHS, members can transition to the remaining IHAs.

DHS will use the RFP process to select the three IHAs for each zone. An RFP allows DHS to select IHAs who scored the highest compared to its peers and to control the number of IHAs in each zone. This will help to ensure an adequate population base to manage IHA financial risk.

Once selected through the RFP process, DHS will enter into a contract with the IHA that is contingent upon a successful financial and operational readiness review that will be conducted by DHS. Readiness reviews will ensure that each IHA is prepared to serve Family Care/IRIS 2.0 members and has:

- An adequate provider network for long-term care, primary, acute, and behavioral health services throughout the zone.
- Adequate staffing levels and training, including 24/7 on-call support, competence in areas such as behavioral health, integrated employment, and member rights.
- Appropriate systems capacity for member and provider enrollment, functional assessments, service authorizations, quality monitoring, financial tracking, analytics, reporting, and claims processing.
- Appropriate procedures and staffing to support members who choose to self-direct long-term care waiver services.
- Culturally competent staff that meet the needs of people of diverse identities.

DHS will provide oversight to ensure ongoing compliance with program requirements.

Family Care/IRIS 2.0 Procurement and Rate Setting Zones

Act 55 directed DHS to increase the size of the current Family Care regions such that in Family Care/IRIS 2.0, each region has sufficient population to allow for adequate risk management by the IHA. DHS contracted with an external firm and applied an actuarial analysis to determine the population that would be sufficient to support three IHAs per zone, minimizing the risk of financial instability for the IHAs and therefore offering greater stability and continuity for Family Care/IRIS 2.0 members and

providers. Based on the actuarial analysis, dividing the state into three zones helps to ensure that each IHA can manage the financial risk as it provides acute, primary, behavioral health, and long-term care services. Creating more than three zones would increase the risk for IHA and program financial instability, thereby posing an increased risk for members and providers.

DHS also considered the following factors:

- Regardless of the size of the zone, IHAs will be required to serve all counties within a given zone. While zones will need to be large for financial stability, within a given zone IHAs will be required meet all certified network requirements, including having a sufficient number and type of providers that are distributed across the IHA zone.
- Members may receive services from providers that are outside of the member's IHA zone so long as the provider is within an IHA's network or in accordance with out-of-network policy.
- Each zone will have at least three IHAs.
- IHAs will be able to submit proposals for one or more zones.
- Adequate population base is necessary to mitigate financial risk.
- A mix of urban and rural areas in each zone will help to ensure sufficient IHA participation in all zones, as well as an adequate network of providers for all covered benefits with reasonable time and distance access.
- Developing zones by combining current Family Care regions will minimize disruption in the transitions.
- The remaining non-Family Care counties (Adams, Dane, Florence, Forest, Oneida, Taylor, and Vilas) will transition to Family Care/IRIS 2.0 when it is implemented in the zone in which they are located.

Final decisions about the order in which the zones will transition to Family Care/IRIS 2.0 have not yet been determined.

Ensuring Adequate Provider Networks

Family Care/IRIS 2.0 seeks to improve coordination between the multiple services and providers that support members' medical and long-term care needs.

Family Care/IRIS 2.0 will continue the provider network requirements under current managed long-term care programs with the IHAs. The existing DHS certification of provider networks requires MCOs demonstrate the following:

- Sufficient number, mix, and geographic distribution of providers of all services in the benefit package based on the location of providers and members and distance, travel time, and means of transportation ordinarily used by program participants.
- Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid fee-for-service members, if the provider serves only Medicaid members.
- Benefit package services that are necessary to support outcomes or that are medically necessary are available 24 hours a day, seven days a week.
- Members have access to prevention and wellness services.

- Cultural competence in the development of member care plans and the availability of service providers.
- Availability of specialized expertise.
- Physical accessibility of services.

Family Care/IRIS 2.0 will continue to require IHAs to have their provider networks annually certified by DHS to ensure access standards are met. DHS will also continue to monitor member grievances and appeals as another mechanism for identifying any issues with provider network adequacy.

Family Care/IRIS 2.0 will include network adequacy standards for medical services. These standards will be guided by the existing requirements in Medicaid managed care programs that govern time and distance for specific services and require the documentation of the number and type of providers, whether providers are accepting new patients, and the geographic location of providers in relation to program members.

Continuous Open Enrollment

Under Family Care/IRIS 2.0, there will be continuous open enrollment. This means that, at any time, an individual may make Family Care/IRIS 2.0 enrollment decisions, such as joining a program, switching a program, or changing IHAs.

Several factors were considered in deciding to maintain continuous open enrollment:

- Only a small number of Family Care and Partnership enrollees choose to switch programs. In 2015, of the 43,541 people enrolled in Family Care and Partnership, only 533 enrollees, or 1.2 percent, requested to switch to another program or MCO to meet their long-term care needs.
- Allowing individuals the ability to change IHAs at any time gives IHAs an incentive to retain members by providing high-quality services.
- Establishing time-limited open enrollment periods increases administrative complexity by requiring special open-enrollment periods.
- In order to ensure cost-effective care, it is important to allow newly eligible individuals who meet the functional eligibility criteria to enroll in an IHA immediately. Immediate enrollment will help prevent individuals from entering higher-cost placements that Medicaid will then have to fund.

DHS does not intend to automatically enroll Family Care and IRIS members into an IHA at the time of initial transition to Family Care/IRIS 2.0. DHS intends to work with ADRCs to assist Family Care and IRIS members actively choose an IHA.

In addition, there will be no auto enrollment for Medicare services. Wisconsin does not have the authority to enroll Medicare members in Medicare Advantage and will not do so. Medicare members will not be required to enroll in managed care for non-long-term care services. Individuals who are dually eligible for Medicaid and Medicare have the right to choose to obtain their Medicare benefits through fee-for-service Medicare or through a managed Medicare program.

Aging and Disability Resource Centers (ADRCs)

Aging and Disability Resource Centers (ADRCs) will continue to have an integral role in the long-term care system. ADRCs serve as a single point of entry into long-term care services and programs. ADRCs help people obtain information, evaluate their options, and make informed decisions about the programs, services, and supports that can best meet their needs. ADRCs help people plan for their future, maximize their personal resources, prevent the need for expensive care, and help to prevent or delay the need to access services through publicly funded programs. All of this helps to ensure a sustainable long-term care system.

ADRCs will continue to have a prominent role in Family Care/IRIS 2.0. ADRCs will continue to be locally based. Family Care/IRIS 2.0 will not change the number or location of ADRCs or the functions of the ADRCs.

Some functions specific to Family Care/IRIS 2.0 include:

- Perform the initial functional eligibility screen.
- Provide unbiased enrollment counseling.
- Inform people of their appeal rights.
- Assist individuals in choosing an IHA or a Partnership MCO.
- Assist individuals in determining if they want to self-direct long-term care services and from whom.
- Help the member decide whether to select an IRIS specialist employed by the IHA or an IRIS specialist that is external to the IHA (i.e., not employed by or affiliated with the IHA).
- Assist individuals with processing enrollment.
- Serve as a resource for members even after they have enrolled in a program.

Payments to IHAs

DHS proposes a prospective risk-based capitation strategy for IHAs that will enable members to receive the benefits that they need and encourage quality outcomes. Having three IHAs and three zones will mitigate the financial volatility of IHAs and ensure stability for the long-term care system. Based on the actuarial analysis, three zoness with three IHAs will maximize the financial stability of the IHAs. While financial results will vary, the actuarial model projects that in any given year, 85 percent of the time, profits are not expected to be greater than 2.5 percent and losses are not expected to be greater than 2.5 percent. If profits and losses are not within these margins, DHS will review the rate setting process to assess the variance. A prospective risk-based capitation is similar to how DHS operates other Medicaid managed care programs, such as BadgerCare Plus.

- DHS will utilize its contracted actuary to analyze program costs for prior years. Capitation rates will be set annually based on past program costs and will meet all federal requirements relative to actuarial soundness.
- If an IHA fails to meet contract standards and performance requirements, the Department will have authority to assess fines and liquidated damages to ensure compliance.
- Capitation rates for members self-directing services will be developed to preserve budget authority for members and to guarantee both full and partial self-direction of long-term care services.

- This rate setting method will incentivize IHAs to provide high-quality cost-effective care.
- IHAs will be held accountable for ensuring high-quality care through pay-for-performance requirements, which align reimbursement with member-care outcomes. DHS may withhold a percentage of the capitated payment to be paid based on performance.
- DHS will employ rigorous financial audits and other financial oversight strategies to ensure that IHAs are not experiencing significant profits or losses.
- IHAs will be required to report detailed encounter data to DHS. This data will allow DHS to audit both IHAs and providers to address utilization, quality, and cost.

This payment model encourages IHAs to invest in home and community-based long-term care services for members to prevent or avoid use of more costly services.

Quality Measures

DHS will implement a multi-faceted approach to ensure quality within Family Care/IRIS 2.0. DHS will use outcome measures that allow comparison not only among IHAs in Wisconsin, but also allow comparison across other states. Elements of the quality plan will include:

- Consumer Outcomes
  - Required reporting on a variety of health care performance measures including prevention and treatment using Healthcare Effectiveness Data and Information Set (HEDIS®).
  - Required reporting using National Core Indicators™(NCI) to assess outcomes of services provided to individuals addressing key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.
  - Required reporting of institutional admissions and relocations.
  - Required reporting of settings in which program participants are living and changes in type of settings.
  - Required reporting of potentially preventable medical services resulting from the quality of long-term care services.

- Consumer Satisfaction
  - Independent evaluations to assess consumer feedback.
  - Mechanisms for members to file appeals and grievances and DHS monitoring of appeals and grievances.
  - IHA and MCO scorecards that will be made available to the public.
  - Access to independent external ombudsman services for all members and for all services.

- Contract Compliance
  - DHS oversight of IHAs, including the quality of care management practice, access to quality providers, and mechanisms to ensure that members receive services that are timely and high-quality.
  - Annual quality reviews and care management reviews conducted by a contracted external quality review organization.

- Statutory requirements for licensed insurers regulated and monitored by OCI.
- Required reporting to DHS any serious incidents, members changing programs, or members changing IHAs, which DHS will monitor.
- DHS-conducted audits of direct service providers.
- Ongoing fiscal oversight.
- An accreditation incentive program that may include substitution of accreditation for certain contract requirements, financial incentives, or consideration during the procurement process.
- If an IHA fails to meet contract standards and performance requirements, the Department will have authority to assess fines and liquidated damages to ensure compliance.
- If financial penalties are not sufficient, the Department will have the authority to terminate the contract.

Contracting With Any Willing and Qualified Provider

DHS will require IHAs to adhere to Act 55 requirements to contract with any willing and qualified provider of long-term care services, which preserves the current provision in MCO contracts regarding any willing provider. As required by Act 55, this provision will be in place for a minimum of three years. DHS will assess the need to extend the "any willing and qualified provider" requirement beyond the initial three-year period after Family Care/IRIS 2.0 has been fully implemented and operational in all zones for at least two years.

- The IHA must allow any provider of long-term care services to serve as a contracted provider if:
  - The provider agrees to be reimbursed at the IHA's contract rate negotiated with similar providers for the same care, services, and supplies; and
  - The facility or organization meets all guidelines established by the IHA related to quality of care, utilization, and other criteria applicable to facilities or organizations under contract for the same care, services, and supplies.
- If the IHA declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.
- In establishing provider and management subcontracts, the IHA shall seek to maximize the use of available resources and to control costs.

Considerations for Tribes and Tribal Members

DHS is committed to implementing Family Care/IRIS 2.0 in a manner that acknowledges and respects the culture and sovereignty of Wisconsin tribes. Under Family Care/IRIS 2.0, tribes can continue to be service providers under contract with IHAs. IHAs will be motivated to contract with tribal service providers as one way to achieve tribal cultural sensitivity.

While Family Care/IRIS 2.0 will be phased in statewide, DHS remains committed to having a tribal options. DHS continues to work with Tribal Nations and CMS to realize this goal.

Next Steps

A final implementation timeline for Family Care/IRIS 2.0 is dependent upon approval of the Concept Paper by the Joint Committee on Finance and upon federal approval. The next steps in the implementation process are shown below.

- Approval of the Concept Paper by the Joint Committee on Finance
- Development of formal waiver and/or state plan authority documents to submit to CMS
- Required public notice and comment period prior to submission
- Submission to and approval from CMS
- Release of RFPs to select the IHAs that will provide Family Care/IRIS 2.0
- IHA selection and DHS readiness review
- A phased enrollment of members in IHAs and a phased approach to implementing Family Care/IRIS 2.0 one zone at a time over several months.

Addendum 1 – Family Care/IRIS 2.0 Benefit Chart

Benefits	Can be Self-Directed
Long-term Care Benefits	
Adaptive Aids	✓
Adult Day Care	✓
Adult Family Home 1-2 bed	✓
Adult Family Home 3-4 bed	✓
Assistive Technology/Communication Aids	✓
Care Management Services	
Community Based Residential Facility (CBRF)	
Consultative Clinical and Therapeutic Services	✓
Consumer Education and Training Services	✓
Counseling and Therapeutic Services (includes customized goods and services)	✓
Customized Goods and Services	✓
Daily Living Skills Training	✓
Day Habilitation Services	✓
Durable Medical Equipment	
Medical Supplies	
Environmental Accessibility Adaptations	✓
Financial Management Services	✓
Fiscal Employment Agent Services [1]	
Home Health	
Housing Counseling	✓
IRIS Specialist Services (formerly known as ICA services)[1]	
Meals: Home Delivered	✓
Nursing (includes Respiratory Care, Intermittent, Community and Private Duty)	✓
Nursing Home (including ICF-IID)	
Personal Care	✓
Personal Emergency Response System (PERS)	✓
Prevocational Services	✓
Relocation Services	✓
Residential Care Apartment Complexes (RCAC)	✓
Respite Care	✓
Self-directed Personal Care Services	✓
Specialized Equipment and Supplies	✓
Support Broker	✓
Supported Employment (Individual and Small Group)	✓
Supportive Home Care (includes Live-in caregiver)	✓
Training Services for Unpaid Caregivers	✓
Transportation Non-emergency Medical	
Transportation Specialized – Community	✓

[1]Required for members who self-direct care.

Benefits	Can be Self-Directed
Vocational Futures Planning and Support (VFPS)	✓
Acute and Primary Benefits	
Ambulance	
Ambulatory Prenatal	
Ambulatory Surgical Center	
Anesthesiology	
Audiology	
Blood	
Chiropractic	
Dental	
Diagnostic Testing	
Dialysis	
Drugs[2]	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	
Family Planning	
Hospice	
Hospital	
Laboratory and X-ray	
Nurse Midwife	
Occupational Therapy	
Physical Therapy	
Physician	
Podiatry	
Prenatal Care Coordination	
Private Duty Nursing	
Respiratory Care for Ventilator-assisted Recipients	
Rural Health Clinic	
School-based	
Speech/Language Pathology	
Vision	
Behavioral Health Services	
Behavioral Health Inpatient	
Behavioral Health Outpatient	
Behavioral Health Day Treatment	
Community Support Program (CSP)	
Comprehensive Community Services (CCS)	
Community Recovery Services (CRS)	
Crisis Intervention[3]	
Peer Support	

[2] Fee for service

[3] Crisis intervention will be a benefit in Family Care/IRIS 2.0 but it is yet to be determined whether this will remain a fee-for-service benefit.