State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

May 9, 2016

Honorable Alberta Darling
Co-Chair
Joint Committee on Finance
Room 317 East
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Darling:

Thank you for your April 29, 2016, letter regarding implementation of Family Care/IRIS 2.0. I appreciate the opportunity to share more information about the Department's plans to transition to the new program.

Please find attached several documents in response to your questions. The Department worked with the Office of the Commissioner of Insurance on these responses. OCI developed the responses to questions 11, 13, and 14.

Please contact me if you have any questions about these materials.

Sincerely,

Kitty Rhoades
Secretary

Family Care/IRIS 2.0 Questions from Senator Darling

Transition

1. **What is the Department's plan and timeline for transition from the current programs to Family Care/IRIS 2.0?**

2. **Assuming the Centers for Medicare and Medicaid Services (CMS) approves the state's waiver request, approximately how much time would it take for the Department to develop proposed capitation rates, write a request for proposal (RFP) for consideration by potential bidders, review responses to the RFP, and write contracts for the successful bidders?**

   The following is a combined response for both Questions 1 and 2 above. Upon approval of the Family Care/IRIS 2.0 Concept Plan, the Department will begin work on multiple aspects of program implementation, detailed below. Many of the activities that must occur in order to implement Family Care/IRIS 2.0 can be carried out concurrently.

   Upon approval of the Concept Plan by the Joint Committee on Finance (JFC), the Department will begin drafting amendments to the Family Care waivers, developing the Request for Proposals (RFP), and writing contract language. Over the next six to nine months, the Department will detail the changes to the Family Care program as part of the development of long-term care waiver amendments. Throughout this time period, DHS will have regular communication with Centers for Medicare and Medicaid Services (CMS) to ensure a smooth process upon submission. At the same time, the Department must prepare amendments to the legacy waivers that detail how these waivers will be phased out. All waiver amendments will include a required public comment period prior to submission to CMS. The Department intends to hold the public comment period, as well as tribal consultation, in the last quarter of 2016, with waiver submissions to CMS in early 2017. CMS has 90 days to approve or disapprove the waiver amendments; however, there are procedures CMS may employ to extend the time period for review if it has additional questions.

   The Department will develop the RFP at the same time it is finalizing waiver amendment language. A typical RFP of this magnitude takes six months from the time the RFP is released publicly to the time of issuing the Letters of Intent to successful bidders. The Department anticipates that the RFP will be released approximately 30 days after submitting the waiver amendments to CMS. It is important to note that this RFP is different than a typical RFP, as bidders will be scored on quality and capacity to fulfil contractual obligations, and not on a cost proposal, since all contract rate payments must be actuarially sound based on contract requirements. The planned procurement timeframe allows the Department to score RFP responses at the same time CMS reviews the waiver amendments; however, contracts will not be executed until CMS approves the waivers.

   At the same time the RFP is being finalized, the Department will be developing language for the new contracts. The contract language is driven by both what is included in the final waiver and the RFP. Some contract language may need to be modified based on the response from CMS,

however the bulk of the contract can be developed as CMS reviews the amendments and bidders respond to the RFP.

Assuming CMS takes about 90 days to respond to the Department's waiver amendments, the Department anticipates finalizing the intent to certify letters with successful bidders in mid-2017. Successful bidders will then work to develop networks and meet requirements to begin serving members. All successful bidders must be certified by the Department prior to any Medicaid member enrolling with the Integrated Health Agency (IHA). The Department anticipates the certification process will take three to six months to complete.

During the certification period, the Department will begin training Aging and Disability Resource Center (ADRC) staff to assist members with enrollment counseling. It is also during this time period that the Department, in conjunction with local ADRCs, would begin member education and outreach. By this time, the Department and ADRCs will have more specific information, such as the make-up of each IHA's network, which is critical to consumers. Enrollment counseling, including ADRCs meeting individually with transitioning members, will begin four months prior to the transition date. It is anticipated that the first round of enrollment counseling would occur during the final quarter of 2017.

The Department assumes that it could have IHA contracts in place and begin the transition of members from Managed Care Organizations (MCO) to IHAs eight to nine months after CMS approval. This approximate timeline is contingent on multiple factors, including the actual timing of CMS approval, any further requirements or conditions established by CMS, the state procurement process, the volume of RFP responses, and the readiness of selected IHAs to begin operations. Final rate development would occur after CMS approval, as rates are dependent on the final requirements included in the waiver. DHS anticipates finalizing rates at the end of summer 2017.

The Department plans to take a phased approach to the transition of Family Care/IRIS 2.0 zones, and the transition process for each zone will occur over a period of several months. DHS has not yet finalized an order for transition, but anticipates that the order in which each zone transitions will be determined in mid-2017. The transition order may be impacted by which entities are selected as a result of the RFP process. It is anticipated that this transition would occur no sooner than calendar year 2018.

The approximate timeline and plan outlined above are dependent on several factors outside of the Department's control. This includes the timing of CMS approval, any further requirements or conditions established by CMS, the State procurement process, the volume of RFP responses, the readiness of selected IHAs to begin operations, and the pace at which ADRCs can complete enrollment counseling.

The timeline above represents the Department's current plan. Member health and safety is the most essential part of the transition. Prior to any transition, the Department will meet with ADRCs, MCOs, and IHAs to develop a successful timeline that ensures member health and safety. Throughout the transition process, DHS will maintain regular contact with ADRCs, MCOs, and IHAs to evaluate the transition process. Based on this regular communication, the Department may modify the timeline and plan by either slowing down or speeding up the

transition as appropriate to ensure a transition that introduces minimal disruption and ensures member health and safety.

3. What is the most likely start date integrated health agencies (IHAs) would begin offering Family Care/IRIS 2.0 in the remaining non-Family Care counties?

DHS plans that implementation of Family Care/IRIS 2.0 would occur by zone. Family Care/IRIS 2.0 will be implemented in non-Family Care counties at the time the program is implemented in the IHA zone within which the county is located. It is anticipated that this transition would occur no sooner than calendar year 2018.

4. How will the Department minimize disruption of services for enrollees during the transition?

The Department has multiple years of experience in transitioning current long-term care members to Family Care. It has ensured the transition of thousands of long-term care members from county-based legacy waiver programs to Family Care MCOs, most recently in seven northeast Wisconsin counties and is in the process of transitioning Rock County to Family Care/IRIS effective July 1, 2016. The Department has also successfully transitioned members from one MCO to another. In recent years, two MCOs have ended participation in Family Care, and the Department managed the transition of members to new MCOs with limited disruption in services.

To facilitate a seamless transition for members to Family Care/IRIS 2.0, the Department will take a multi-faceted approach, focusing on a number of areas, including IHA readiness; continuity of care through interagency coordination and information sharing; member communication, education, and empowerment; and Departmental oversight and monitoring of all phases of the transition.

Certification of IHA Readiness and Network Adequacy. One of the most important ways the Department will ensure a seamless transition for members is to ensure IHA operational readiness and network adequacy through the initial IHA certification process. Certification is a comprehensive process, and it is important to note that an IHA may not begin their role as a managed care entity until certified by the Department. Key certification requirements include, but are not limited to:

- A comprehensive provider network that meets all contractual obligations related to network adequacy, including:
    - Provider network has an adequate number of providers to meet member needs on a timely basis and reflects the specific needs and preferences of enrollees;
    - Provider network has an adequate number of providers available for weekends, evenings, and if applicable, 24 hour access;
    - Provider expertise and availability for all members;
    - Availability of culturally competent resources necessary to meet the diverse needs of enrollees within the service area;
    - Service providers must be geographically accessible to members and available on a timely basis;
    - Adequate living arrangement support to meet individual needs and desired outcomes of its enrollees residing in their own home or a residential services setting;
    - Adequate provider base to accommodate expansion;
- A self-directed services option, including a process for educating members about how to choose and engage in self-direction;

- Fully implemented operations, administrative, and staffing plans;
- A process for developing members' interdisciplinary care management teams;
- A comprehensive staff training plan;
- An approved member communications plan and 24-hour member support;
- A process for managing member enrollment and supporting ongoing eligibility, including functional screening and a well-developed plan for collaboration with ADRCs and Income Maintenance consortia;
- A model for person-centered case management, care planning, and care coordination that is focused on achieving positive outcomes;
- The ability to meet timeliness requirements, including ensuring that the IHA can meet a contractual obligation that the interdisciplinary team will contact each new member, in person or by phone, within three calendar days of enrollment and meet with the member in-person within ten calendar days of enrollment to complete an initial assessment and answer member questions;
- A process for complying with all requirements related to member rights;
- A fully developed grievance and appeals process, including member supports for engaging in this process; and
- A critical incident management system.

Continuity of Care through Interagency Coordination and Information Sharing. Throughout all phases of Family Care/IRIS 2.0 planning and transition, the Department will work closely with IHAs, MCOs, ADRCs, providers, and members to ensure that members are able to make the transition without disruption of services, and in a manner consistent with their care needs and choices.

In the past, to ensure continuity of care for members when legacy waiver counties have transitioned to the Family Care benefit, the Department has directed CIP/COP agencies to provide the incoming MCO with contact information for each member's long-term care waiver service providers. The MCO then focuses on working to incorporate those providers into their own service network. The Department is responsible for notifying CIP/COP members of the pending change.

To ensure continuity of care and minimal disruption to members, the Department will work to facilitate collaboration between IHAs, MCOs, ADRCs and other stakeholder entities, including:

- Counties and current MCOs will continue to serve current members during the transition;
- The Department will host meeting with MCOs, IHAs, County agencies, and ADRCs to discuss roles and responsibilities.
- Counties and current MCOs will provide IHAs with a list of providers currently serving their members;
- Counties and current MCOs will update functional screens for members and work with ADRCs and Income Maintenance agencies to ensure that every participant has uninterrupted functional and financial eligibility during the transition period;
- The Department will mail transition information to all members;
- Upon enrollment in an IHA, counties and current MCOs will provide applicable member records to the IHA, which detail the member's care plan, providers, risk indicators, court orders, protective placement, natural supports, self-directed services, restrictive measures, crisis plans, etc.;

- The IHA interdisciplinary teams will contact each new member, in person or by phone, within three calendar days of enrollment and meets with the member in-person within ten calendar days of enrollment to complete an initial assessment and answer member questions;
- IHAs will continue member's existing care plans until new member-centered plans can be established in collaboration with members;
- New IHAs will be expected to utilize existing supports to minimize disruption of services to members until the IHA works with the member to establish a new member-centered plan, which includes long-term care services, primary, acute, and behavioral health services.
- Counties and current MCOs will identify participants with high-risk care needs and work closely with the IHAs on transitioning those individuals;
- Counties and current MCOs will establish agreements with the IHA to clarify roles and responsibilities related to crisis collaboration; and
- The Department will facilitate IHAs to develop MOUs with counties for crisis planning and other coordination of services.

Member Communication, Education, and Empowerment. Another important means of ensuring a seamless transition for members is to provide members with clear and comprehensive information about Family Care/IRIS 2.0 so that they are empowered to make informed choices. Similar to other transitions of this magnitude, the Department will undertake a comprehensive member and stakeholder communication and education plan, which is described in greater detail in the response to Question 5. During the transition to Family Care/IRIS 2.0, the Department will ensure that a dedicated hotline is available to members.

One of the most important ways to provide individualized information and support to members is through the ADRC enrollment counseling process. Each member will have access to receive enrollment counseling at the time of the transition to Family Care/IRIS 2.0. This service helps to minimize service disruption for members by increasing accessibility of information and simplifying the process of selecting an IHA that the member feels best meets their overall health and long-term care needs and goals.

Independent ombudsmen are another key resource available to assist members in the process of transitioning to Family Care/IRIS 2.0. The Department will work to ensure that all members have access to independent ombudsman resources, which assist with the resolution of any issues that may arise.

Departmental Transition Process Management. Finally, a key component in ensuring a smooth transition of members to Family Care/IRIS 2.0 is Departmental involvement in monitoring each phase in the transition process, providing guidance, and clarifying expectations throughout, as necessary. For Family Care/IRIS 2.0, as with any other transition of this magnitude, the Department will designate oversight teams to concentrate on specific areas of the transition. These teams work with and closely monitor the transition activities of outgoing managed care providers, ADRCs, and of the new and continuing IHAs. To support the transition process, the Department also provides the ADRCs with information and assistance training and enrollment counseling training. The Department also hosts provider forums in order to share information and respond to questions related to the new Family Care/IRIS 2.0 model.

5. How will the Department ensure that enrollees are fully aware of the program changes and their options?

Member and Stakeholder Communications. Similar to prior transitions to managed care, the Department will implement a comprehensive member and stakeholder communication and education plan. When the Department implements a change that impacts member services, such as implementation of Family Care/IRIS 2.0, the Department is required to comply with all CMS member and public notification requirements. The comprehensive communication plan includes these Federal requirements but also goes beyond, covering all aspects of outreach to members, guardians, counties, service providers, and other stakeholders. The Department will undertake a wide range of outreach initiatives, which may include:

- Member educational materials and direct mailings that provide clear information on:
    - What will change and what will remain the same under Family Care/IRIS 2.0;
    - When Family Care/IRIS 2.0 will be implemented;
    - When enrollment counseling will be available for members to learn about new managed care options and choose an IHA;
    - What specific steps members should take to choose an IHA under Family Care/IRIS 2.0; and
    - Who the member can contact with questions about their benefits, the upcoming Family Care/IRIS 2.0 changes, and the enrollment counseling process.
- Public outreach meetings,
- Stakeholder outreach and education to help support members in the transition to Family Care/IRIS 2.0, and
- Family Care/IRIS 2.0 website updates, including webinars of key informational sessions and videos of certain public forums

ADRC Enrollment Counseling. From the Department's perspective, the most important and personalized component of communication on a member level occurs during enrollment counseling at the ADRC. ADRC enrollment counseling is a decision-support process whereby members are assisted in evaluating their managed care provider. The enrollment counseling process is individualized, with members offered access to an ADRC specialist who can assist them with weighing options based on the person's specific strengths, needs, and preferences. Each member will have access to receive enrollment counseling at the time of the transition to Family Care/IRIS 2.0.

To ensure that members receive clear and comprehensive information about their options under Family Care/IRIS 2.0, the Department will conduct comprehensive trainings for ADRC information and assistance specialists and supervisors. This training will focus on providing enrollment counseling to members, which incorporates information about the Family Care/IRIS 2.0 acute, primary, and behavioral health services, in addition to traditional long-term care services.

The Department is exploring ways to ensure that ADRCs can manage the additional workload associated with the transition to Family Care/IRIS 2.0 and ongoing while continuing to maintain the high level of service provided to their primary customer base. Strategies under consideration include:

- Hiring temporary staff;
- Exploring Department distribution of information to the greatest extent possible so that people can be prepared and generally informed prior to their counseling with the ADRC;

- Managing the workload across ADRCs;
- Ensuring that all necessary systems, provider networks, and procedures are in place prior to the start of enrollment counseling for Family Care/IRIS 2.0. This would ensure that ADRCs have sufficient time to meet with members; and
- Opening a toll-free hotline to triage calls based on whether an inquiry requires a conversation with the ADRC or is a more basic question that can be answered quickly.

6. Why will current members be required to disenroll and re-enroll if they wish to remain with a current managed care organization (MCO) under the new system?

At no time during the transition will eligible members be disenrolled from the Family Care program. It should be emphasized that implementation of Family Care/IRIS 2.0 is unrelated to member eligibility for long-term care services. There will be a new set of managed care provider options for continuing Family Care members at the time of Family Care/IRIS 2.0 implementation. It is important for members to be fully informed of their options and affirmatively choose the IHA in which they wish to enroll. Members will remain enrolled in their current MCO until they have selected and enrolled in a Family Care/IRIS 2.0 IHA. In zones where one or more existing MCOs continue operating as an IHA under Family Care/IRIS 2.0, ADRCs will offer streamlined enrollment counseling for those members who wish to remain with their current managed care provider.

7. Will current Family Care or IRIS enrollees be required to change their current residential care placements?

The Department remains committed to supporting member choice regarding the right to receive services where members live and the right to reside independently within the community with dignity and respect. It is important to note that Family Care/IRIS 2.0 will continue the same policies regarding residential care as under current Family Care 1.0 policy. The Department operates an outcomes-based model, in which a member's residential care placement offers the least-restrictive environment possible to meet the member's outcome goals, while supporting member health and safety. Even under current policy, there are times when it is determined that a member's residential setting no longer facilities the best outcomes. In these cases, the consumer is given a choice of residences within the IHA's network that does meet the member's outcome goals.

While member choice to receive services in the community does not always mean a member will be able to choose the *specific* residence in which they live, IHAs must contract with any residence that accepts the IHA's rate and satisfies any quality of care, utilization, or other criteria that the IHA requires of other providers it contracts with to provide the same service. Under Family Care/IRIS 2.0, if a member's residential care setting continues to meet care plan outcome goals and the residential care provider contracts with the IHA, the member may continue residing in that setting.

8. **If the Department were to eliminate the 'any willing provider' requirement three years after program implementation, what criteria will it use in deciding whether to retain the current 'any willing provider' requirement?**

Act 55 specifically requires that, for a minimum of three years after the date of implementation of Family Care/IRIS 2.0 in a zone, an IHA must contract for long-term care services with any long-term care service provider that agrees to accept the reimbursement rate that the IHA pays to similar providers for the same services and that satisfies any quality of care, utilization, or other criteria that the IHA requires of other providers with which it contracts to provide the same long-term care services.

The Department included the three year minimum requirement in the Family Care/IRIS 2.0 Concept Paper in compliance with Act 55 requirements, but would be responsive to additional Legislative guidance in regard to this requirement. During the initial years of Family Care/IRIS 2.0, the Department will gain experience regarding the impact of this requirement. The Department is willing to provide information to JFC, upon request, regarding the outcomes of this provision and recommendations for future IHA contracts.

Service Zones

9. **It is not clear from Milliman's actuarial analysis that establishing more than three zones would result in too much risk for the IHAs. Please provide the potential geographic boundaries of these three zones that the Department is most likely to propose to CMS.**

The Department used an independent actuarial firm, Millman, Inc., to assess risk and provide guidance on zone design. Milliman conducted an actuarial analysis of CY 2014 Family Care long-term care service expenditures and the CY 2014 Family Care capitation rate. Using these data, Milliman developed tables presenting the level of financial risk associated with various levels of enrollment. Milliman's actuarial analysis was one of several key components involved in the Department's regional design analysis, which resulted in the recommendation that three zones be established statewide. The full set of criteria used to determine the need for three Family Care/IRIS 2.0 zones includes:

- Each Family Care/IRIS zone must have three IHAs;
- Zones must be structured such that each IHA has sufficient enrollment to ensure that, based on normal variations, there is an 85 percent chance that annual expenditures are +/- 2.5% of actual State capitation payments, as determined by the actuarial analysis;
- An adjustment to account for uneven distribution of enrollment across the three IHAs in a zone;
- An adjustment to account for uneven distribution of three target groups of Medicaid long-term care members across the State: individuals with intellectual disabilities, physical disabilities and frail elders, such that zones have sufficient member populations to meet the actuarially sound benchmark risk threshold;
- Each Family Care/IRIS 2.0 zone must include a mix of urban and rural areas in order to ensure access to services, limit disruption to existing services, and provide incentives for IHAs to seek to operate in the zone;

- Current Family Care geographic services zones must be combined under the new model to minimize disruption to provider networks and facilitate member transitions;
- No county may be split between zones, and each county must be included in one and only one zone; and
- An IHA must serve all counties within their service zone.

Please refer to the supplemental materials included with this response, which provide information on several potential regional geographic designs that were developed based on the three-zone model, and which take into account all of the additional design requirements described above. These supplemental materials also provide additional detail on how the actuarial analysis was used to the Department's proposal for a three-zone model.

10. Further, explain why the Department chose the risk range associated with three zones, and compare this risk range with the estimated risk ranges of establishing four or five zones, with three IHAs serving each zone.

The Department recommends operating three Family Care/IRIS 2.0 IHA zones, each with a choice between three IHA managed care entities. As previously noted, the Department has established an actuarially sound target risk range for IHA cost variability, which specifies that zones must be structured so that each IHA has sufficient enrollment to ensure that there is an 85 percent chance that annual expenditures fall within +/- 2.5% of actual State capitation payments.

The Department has determined that this risk range and administrative structure represents the best means for the Department to comply with Federal requirements to offer members a choice of managed care entities, manage financial risk, and maintain program stability for members and providers, should any one IHA choose to leave the marketplace or should DHS choose to end its contract with one of the IHAs. The Department has determined that it would be infeasible to implement a four- or five-zone model without modifying the zone design criteria described in the response to Question 9.

Please refer to the supplemental materials included with this response for detailed information on the Department's analysis of the need for three geographic zones and three IHAs within each zone.

Current MCOs Participation in Family Care/IRIS 2.0

The Office of the Commissioner of Insurance (OCI) developed the responses to questions 11, 13, and 14.

11. What is the process and timeline for current MCOs to become health maintenance organizations (HMOs)?

There is no straight-line response to this question because the current MCOs have a number of paths to become licensed as an HMO. Specifically, the MCO could:

- Create an insurance company and transfer business and assets of the MCO to the insurer through merger or some other mechanism. Application packets for forming an HMO are available on the OCI website;
- Buy a license through the acquisition of an already licensed insurer. The MCO may buy a licensed insurer subject to OCI approval. This would still require the insurance entity to meet capital and surplus requirements, and the license would have to be in the specific line the insurer wishes to sell;
- Partner with an insurer. An MCO could partner with an existing licensed insurer. The MCO and the licensee, subject to OCI approval, could negotiate over a variety of terms. It could vary from the existing licensee providing all capital and surplus to the MCO to get licensed and everything in between. Service agreements would be subject to OCI approval. Insurers are allowed to transfer risk to providers if the agreement is not disapproved by OCI, however the ultimate responsibility would remain with the insurer; or
- Be acquired into an insurance holding company. The MCO's assets and business could be purchased by a for-profit insurer holding company that would provide the necessary capital for the entity to become a licensed insurer. An MCO could be purchased or merged into a not-for-profit insurer organized under Wis. Stat § Chapter 613.

In general, the stand-alone licensing process averages six to nine months, based on current volume and assuming the application being filed is complete and requires only minor follow-up, and the entity is well capitalized. The timeframe for OCI review of the application is heavily dependent on how long it takes the organization to respond to OCI requests for additional information. It should be noted that the requesting entity will have to perform a lot of work prior to sending in an application for licensure, which was not accounted for in the above estimate of six to nine months.

Second, as part of the application process, the applying entity has to demonstrate that they will be able to meet the financial requirements. This requires submitting five years of financial projections that project enrollment, premiums and other income, benefits, administrative and other costs, and projected point of break-even, in terms of income compared to disbursements and enrollment. The projections are to be supported by feasibility studies.

12. What communications has the Department had with current MCOs regarding the process of becoming an HMO?

The Department and OCI worked with its Family Care MCOs and many other organizations on legislation that would allow current Family Care long-term care districts to covert from a quasi-governmental entity to a non-stock, not-for-profit corporation under Wis. Stat. § Chapter 181 or a service insurance corporation under Wis. Stat. § Chapter 613. 2015 Wisconsin Act 215 provides a path for current MCOs to covert in preparation to become licensed as insurers by the OCI. At the time of this writing, the Department has received a formal request from only one MCO, My Choice Family Care, a Family Care MCO currently operating in Southeastern Wisconsin. The Department is in discussions with My Choice Family Care and is in process of reviewing submitted documentation, as required by 2015 Wisconsin Act 215, regarding their interest in establishing a service insurance corporation. It is the Department's goal to ensure that all entities undertaking such a change in status are doing so in full compliance with State and Federal law. The Department is committed to working with MCOs in accordance with 2015 Wisconsin Act 215.

While the Department can assist entities with the process of converting to a non-stock, not-for-profit corporation or a service insurance corporation, the process of becoming a licensed insurer is outside the scope of the Department. In order to initiate this process, entities must work with the OCI.

13. What steps would a current Family Care MCO need to take to become licensed as an HMO in order to bid to become an IHA, and how long would this process take?

As stated in the response to Question 11, this will vary significantly depending on which path the MCO uses to become a licensed HMO. If the MCO partners with a well-capitalized existing licensee, the process may move relatively quickly. If the MCO chooses to obtain a new HMO license, it will take time to gather all the necessary information to submit to OCI, and for OCI to complete its review.

14. What solvency requirements would these MCOs need to meet, and is it likely that the current MCOs could meet the solvency and other requirements before DHS awards the initial IHA contracts?

MCOs would be required to meet the solvency standard required for HMOs. As an insurer, the entity would be required to meet minimum capital and surplus requirements and report their financial condition to OCI using statutory accounting principles. Since the risk will vary from entity to entity, the specific requirements will vary based on the entity's projections of the risk. It is also important to note that MCOs currently use GAAP accounting rather that statutory accounting, which will result in changes to valuation of some assets, whether other assets are allowed to be admitted, and changes to the timing of admitting certain assets.

15. If a current MCO is not selected as an IHA, how could it participate in Family Care/IRIS 2.0?

A current MCO not selected as an IHA could continue participating in Family Care/IRIS 2.0 by entering into a sub-contracting agreement with an IHA to deliver long-term care services within a zone. These subcontracting arrangements would be similar to current practice for certain other State Medicaid managed care organizations. Specifically, some BadgerCare Plus HMOs currently choose to subcontract out all of their behavioral health services to a regional service provider. Subcontract agreements would be developed at the discretion of the IHA managed care entities.

16. Could any of the current MCOs serve significantly larger geographic areas than they currently serve?

It is certainly feasible that some MCOs could serve larger or different geographic areas than they currently serve, if they have the financial capacity to expand. It is notable that there is a wide variation in size and covered service area among existing Family Care MCOs, with some entities serving as few as 8 counties and others serving as many as 26 counties. One MCO will expand to serve 40 counties later this year, if certified.

Over the past several years, existing MCOs have continued to expand into new areas of the State, and many Wisconsin counties are now served by more than one MCO. For example, in 2014, one MCO went from serving five counties to serving 16 when it began serving Northwest Wisconsin. In 2015, two MCOs added seven additional counties in the Northeast. DHS is currently in the process

of introducing a second MCO in Southwest Wisconsin, which will bring the total number of counties served by that MCO to 40. With the expansion of Family Care to Rock County, a MCO that is not serving a contiguous county will be providing service, suggesting that MCOs believe they can provide service across that State. In fact, all of the State's MCOs have undertaken some type of service area expansion since the time of their initial tenure as a Family Care managed care entity. Below is a list of MCOs, including their initial and expanded service areas.

- **ContinuUs:** Began as a Family Care pilot in Richland County and now provides Family Care in 21 counties.
- **Community Care Connections of Wisconsin:** Began as a Family Care pilot in Portage County and now provides Family Care in 16 counties.
- **My Choice Family Care:** Began as a Family Care pilot in Milwaukee County and now provides Family Care in 8 counties.
- **Lakeland Care District:** Began as a Family Care pilot in Fond du Lac County and now provides Family Care in 13 counties.
- **Western Wisconsin Cares:** Began as a Family Care pilot in La Crosse County and now provides Family Care in 8 counties.
- **Care Wisconsin:** Began the Family Care Program in Columbia County and now provides Family Care in 26 counties. Also began the Partnership Program in Dane County and now provides Partnership in 7 counties.
- **Community Care, Inc.:** Began the Family Care program in Racine County and now provides Family Care in 14 counties. This entity also started the Partnership and PACE Programs in Milwaukee County and now provides Partnership in 9 counties and PACE in two counties.
- **iCare:** Began the Partnership Program in Milwaukee County and now provides Partnership in 4 counties.

17. How can we be assured that large companies will not shut out opportunities for smaller companies, including MCOs and smaller national companies, to operate IHAs?

All companies large and small will have the opportunity to compete via the RFP process to operate as IHAs. The Department will ensure through the competitive procurement process that the State selects IHA managed care entities that are best positioned to provide high quality services and fulfill all Family Care/IRIS contractual obligations. It is important to note that applicants do not bid on a contract rate through the RFP. Instead, the RFP focuses on the applicant's quality, capacity, financial stability, and experience. Applicants will need to demonstrate capacity to provide care management, long term care, acute, primary, and behavioral health services to elders and people with disabilities. As part of this demonstration, applicants will need to establish they have adequate provider networks, expertise at care plan development and monitoring, quality controls, fiscal and administrative capacity, and ability to comply with other state and federal requirements. Past experience in these areas will likely be a way to demonstrate such abilities and expertise.

After IHAs are selected, the Department sets per member contract rates through its actuarially sound rate setting process based on member population mix and acuity levels and without regard to the IHA's size. Applicants do not bid on a contract rate through the RFP process and therefore larger companies do not have a price advantage based on volume.

18. How frequently will the Department rebid the IHA contracts?

The time period for purchasing authority for procurements varies. DHS currently has a five year purchasing authority for Family Care; contracts with MCOs are renewed annually. This means that MCO contracts must be procured at minimum of every five years. It has not been decided what purchasing authority DHS will pursue for Family Care/IRIS 2.0 or how often IHA contracts will be renewed.

If a current MCO or any other bidder submits a proposal and does not meet the minimum mandatory requirements, their proposal would be rejected and they would need to wait for the next procurement cycle.

All proposals determined to meet the minimum mandatory requirements (i.e., that are not rejected) will be scored and ranked. DHS would initially enter into contract negotiations with the top three scorers for each IHA zone; however if those contract negotiations are unsuccessful, then DHS may enter into contract negotiations with the fourth top scorer and so on.

In the event that DHS contracts with an IHA that later stops serving Family Care/IRIS 2.0 members, DHS could choose to go back to the initial list of ranked, qualified proposers and select the next vendor on the list to replace the IHA that stopped serving IHA members. Depending upon specific circumstances at the time, DHS could also consider releasing another RFP under the existing purchasing authority.

Additionally, DHS plans that implementation of Family Care/IRIS 2.0 would occur by zone. The sequence in which zones will transition to Family Care/IRIS 2.0 has not yet been finalized.

Self-Directed Services

19. How will the Department ensure that IHAs use a consistent methodology in determining budget amounts?

The waiver requires that the budget methodology be applied consistently to each member choosing to self-direct. The Department will prescribe the budget methodology to be used in its contract with each IHA.

The Department will establish a standard methodology for setting self-directed supports budgets. This methodology will be detailed in the Department's waiver submission and will require CMS review and approval. In addition, the standard public and tribal comment period will apply before the waiver is submitted, so the Department will have an additional opportunity to receive feedback from the public and tribes regarding this methodology prior to submitting the waiver amendments to CMS for approval. Finally, the Department will conduct regular monitoring and quality reviews to ensure self-directed budgets are in compliance with both waiver requirements and Department contractual obligations.

20. Explain how current self-directed budgets are established and how they would be established under Family Care/IRIS 2.0.

A. <u>Current IRIS Policy</u>

Under current IRIS policy, both a preliminary and a final budget are developed, each serving a different purpose. The preliminary IRIS 'budget' is generated for IRIS members based upon the functional screen they receive at the Aging and Disability Resource Center (ADRC). The final IRIS budget is determined based upon the mix of services that are included the member's plan of care, which is also how budgets will be developed under Family Care/IRIS 2.0.

Preliminary IRIS Budget: The preliminary budget is calculated in two steps. This budget is created based on a different methodology and has a different purpose from the final IRIS budget. The preliminary budget provides a range within which we anticipate a member's IRIS budget costs will fall.

1. In Step 1, the historical average cost to serve people with similar long-term care needs is calculated. This calculation uses an algorithm similar to that used for setting the Family Care capitation rates, which is an acuity-based rate.

2. In Step 2, the initial acuity-based rate, or individualized budget amount (IBA), is grouped into one of three rate bands: high, medium, and low. This rate is then adjusted using a formula designed to ensure that the preliminary budget amount would be expected to cover at least 80% of costs for 80% of members within an assigned rate band. The preliminary budget adjustment model, originally developed in 2010, **is not intended to reflect a member's specific care needs**. Rather, it is a tool for estimating an individual's IRIS budget prior to development of the IRIS service plan, based on certain individual acuity factors relative to other IRIS members with similar acuity.

For example, if historical expenditures show that a person with an intellectual disability at a certain acuity level is expected to cost $1,000 per member per month, the $1,000 would be multiplied by 139% and the member's final preliminary budget would be adjusted to $1,390. This adjustment factor inflates the estimated amount needed to support the individual based on their acuity in two of the three rate bands.

The following table outlines the three rate bands and the associated adjustment factors.

PMPM Cost	Intellectual Disability	Physical Disability	Frail Elderly
LOW	$0 - 499.99	$0 - 499.99	$0 - 499.99
MEDIUM	$500 - $2,399.99	$500 - $1,199.99	$500 - $1,199.99
HIGH	$2,400 +	$1,200 +	$1,200 +

PMPM Cost	Intellectual Disability	Physical Disability	Frail Elderly
LOW	.76 * IBA	.79 * IBA	.74 * IBA

MEDIUM	1.39 * IBA	1.38 * IBA	1.52 * IBA
HIGH	1.93* IBA	2.13 * IBA	1.93 * IBA

Final IRIS Budget: When an IRIS member develops their service plan in collaboration with the IRIS consultant, their final IRIS budget is based on the specific services included in their plan. The IRIS consultant helps ensure that the plan includes services that are allowable under the program rules and that the service costs are reasonable, given where the member lives and other market conditions. If the actual need of the participant and costs associated with that need is larger than the preliminary budget, a budget adjustment process is undertaken.

B. Family Care/IRIS 2.0 Policy

For Family Care/IRIS 2.0, the Department will implement a CMS-approved standard budget methodology for setting self-directed support budgets, which will be set forth in IHA contracts. The current process of developing a 'preliminary budget' will be discontinued. Budgets under Family Care/IRIS 2.0 will be based upon each individual's unique member-centered plan and the services the member elects to self-direct. Under Family Care/IRIS 2.0, when a member enrolls in an IHA and then decides to self-direct some or all of their long term care waiver services, the member will choose an IRIS Specialist. IHAs must provide a choice of at least two IRIS Specialist agencies, one of which must be external to the IHA. The IRIS Specialist will be a member of the Interdisciplinary Care Team (IDT). The role of the IRIS Specialist will be to help the member develop and manage the self-directed portion of their plan. The self-direction budget will be based upon the unique mix of services in the member's plan of care, just as the actual final service budget is today. It is important to note that the Department has committed to continue with budget authority and employer authority for members who choose to self-direct. Members will continue to have authority to hire, manage, and direct their paid workers or care providers. Members will continue to manage and direct their own service budgets.

Savings Estimate

21. What actual program experience led DHS to conclude that primary and acute care costs for the Medicaid-only enrollees could be reduced by 7% compared to the current costs for these enrollees?

The 7% acuity savings were based only on the acute care costs of MA-only enrollees, which averaged $18,816 per year in CY 2014, and which indicate a high level of acute care services that should provide opportunities for savings from management and coordination of care. During past rate development for acute and primary managed care programs, actuaries have suggested that management can reduce fee-for-service acute care costs by 11% and that this reduction can be assumed when developing managed care rates for new populations. DHS took a more conservative approach in its cost savings estimate, reducing this 11% to 7% in order to account for the possibility of additional IHA administrative costs to cover the management of acute care services. Also, Departmental analysis of the SSI managed care program suggests that savings can be realized by management of acute care. Specifically, when comparing the average monthly costs of MA-only adult disabled persons who are not in long-term care programs to members who participate in SSI managed care, the average cost of the managed care group is more than 20% less than those in

fee-for-service. This finding supports the Department's assumption that acute and primary care costs will also be reduced under Family Care/IRIS 2.0.

22. What limits, if any, will be placed on IHAs' net revenue (profits)?

The Department does not set specific limits on an MCO's net revenue. The Department sets per member per month contract rates based on an actuarial analysis. The analysis predicts the expected monthly costs of providing covered services to an MCO's member population based on the health conditions of the population and their need for assistance with activities of daily living.

In the past, when MCOs began operations in a Family Care expansion area, DHS has entered risk-sharing agreements to reduce uncertainty for the MCO. These agreements involve establishing thresholds for the size of the annual surplus or loss the MCO may experience. If an MCO experiences a surplus in excess of the threshold, then a portion of the surplus will be recovered by the Department. If an MCO experiences a loss in excess of the threshold, then the Department will provide funding to cover a portion of that loss. These risk-sharing agreements are typically applied only during the early years of expanding a new long-term care program into a county. Here is an example of how an agreement could work, based on how some agreements were structured in the past:

- If an MCO's actual costs for the year is within a certain range of its revenues for that year (such as 2% above or below), then no additional action is taken.
- If the MCO's actual costs exceed it revenues for that year beyond a contractually established threshold (such as 2%), then the Department will provide additional funding to cover ***a portion of*** the loss.
- If the MCO's actual costs are less than its revenues for that year beyond a contractually established threshold (such as 2%), then the Department will recover funding equal to ***a portion of*** the MCO's annual surplus for that year.

Please note the above example is presented for illustrative purposes and does not necessarily suggest the exact risk-sharing agreement the Department may implement in the future. Any such agreements must be approved by CMS.

Once a program becomes established in a region and eligible members have been transitioned to the new program, the MCO's population case mix and service needs become more predictable and there is less need for risk-sharing agreements. As it does with MCOs, the Department will conduct robust oversight of IHA quality outcomes and contract compliance to ensure that the IHA is providing these services. If an IHA happens to be especially cost effective in delivering these required services, its lower cost experience will be incorporated into rates established in subsequent contract years.

Furthermore, the Department monitors MCO administrative costs on an ongoing basis, including as part of the annual rate-setting process. Under current policy, MCOs must file annual financial reports that have been audited by an independent accounting firm. MCOs also submit regular progress reports on interim financial results. These reports include detailed information on administrative costs and number of employees.

In establishing annual capitation rates, administrative costs are categorized as either fixed costs (e.g. salaries for human resources or business office staff) or variable costs (e.g. claims, fiscal, information, and quality management). This distinction allows for better cost estimation and adjusts for the number of members served by the MCO. For example, administrative costs associated with quality management activities go up as enrollment increases. For fixed cost administrative expenses for which there is not a specific per member cost (such as human resources or business office staff), the Department establishes a fixed price reimbursement based on total overall of enrollment. The nine components of administrative costs are:

- Administrative and Executive (fixed)
- Compliance (fixed)
- Human Resources (fixed)
- Marketing (fixed)
- Provider Management (fixed)
- Claims Management (variable)
- Fiscal Management (variable)
- Information Management (variable)
- Quality Management (variable)

Categories of costs that fall into the 'fixed' category are funded at three levels (small, medium and large enrollment) on a fixed price basis. For example, in CY 2016 one MCO in the 'small enrollment' category received $363,538 for human resources, while an MCO in the 'large enrollment' category was paid $460,482. In contrast, for the variable cost of claims management, all MCOs were paid $16.90 per member per month (PMPM), and costs varied according to the total number of members served.

The current Family Care rate model has regularly adjusted the reimbursement amounts for administrative costs. It is also notable that CMS is in the process of strengthening requirements for managed care rate setting. These new CMS regulations require that administrative costs be re-determined annually, which the Department has done for many years. A thorough description of the administrative cost component of Family Care capitation rates can be found in the 2016 Family Care Rate Report, starting on p. 15. This rate report is available on the Department's website at: https://www.dhs.wisconsin.gov/familycare/reports/fc-2016capitationrates.pdf.

The Department has developed a strong and reliable method for establishing actuarially sound annual capitation rates for managed long-term care entities, which has been very effective at managing administrative costs. For CY2016 rates, the implied administrative portion of the Family Care capitation payment for the program overall was 4.4% as paid out, which compares very favorably to administrative rates seen in other programs.

Looking at the program as a whole over the four-year period from 2012 through 2015, MCO net income as a percentage of total revenue (profits or losses) never exceeded 2.5% of paid capitation rates, and the average amount of revenue over this same period was only 1.48% of paid capitation rates, which underscores the reliability of the Department's current rate setting model. Based on the past level of accuracy we have achieved, the Department believes that Wisconsin has one of the best-performing managed long term care rate setting models in the United States.

Family Care Partnership Program

23. The Concept Paper indicates that the Department will continue to work with CMS to expand the Family Care Partnership program to more counties to increase consumer choice. If this occurs, the program would compete for enrollees with Family Care/IRIS 2.0. How would this competition affect the financial viability of the IHAs and the Family Care Partnership MCOs?

The Partnership program differs from Family Care in that it integrates all Medicaid and Medicare services under a managed care entity, including primary, acute, and long-term care. Approximately 81% of current enrollees are dually eligible for Medicare and Medicaid. As a result, most persons that join the Partnership program are losing some flexibility in the range of Medicare providers that can be utilized. For Medicare enrollees who are ineligible for Medicaid, there can be a significant financial incentive to join a Medicare managed care (Advantage) plan, due to inducements for broader benefit coverage or lower cost-sharing. However, for dual eligibles, Medicaid covers the Medicare cost-share and also provides coverage for dental, vision, and most other services, so there is limited financial incentive to join Partnership and give up the flexibility of choice among Medicare providers. This is likely the reason for a relatively low take-up rate for Partnership compared to Family Care, since Family Care still allows participants to be part of fee-for-service Medicare. It is notable that Federal regulations do not allow States to mandate managed care for Medicare services.

The Partnership program currently operates in 14 Wisconsin counties, including Milwaukee County. In SFY 2015, counties that operated Partnership contained 57% of all current community based long-term care members. However, the large majority of those members have traditionally chosen to receive their Medicare benefits through fee-for-service, which means they enroll in Family Care.

In the counties where Partnership is available, only 11.9% of community based long-term care members elect to enroll in the PACE and Partnership programs. This enrollment trend has been fairly stable over time and is likely to continue under Family Care/IRIS 2.0, an assumption that has informed the Department's planning, including the proposed three-zone model. Given the limited take-up rate for this program, the Department estimates that continuing to offer this benefit will introduce minimal disruption in the Family Care market; yet this program provides a niche benefit that is preferred by certain members, and from the State's perspective allows better management of all services. Continuing to offer the benefit also allows additional options that expand member choice in zones where the program operates.

24. Describe the timeline and process for expanding the Family Care Partnership program.

The timeline for expanding Partnership is longer than the transition to IHAs under Family Care/IRIS 2.0 because of additional CMS approvals needed for the Medicare components.

DHS will develop and issue an RFP to competitively procure new Partnership entities. The Department must then evaluate responses, select final applicants, and negotiate and execute contracts with those entities.

Once selected, the Partnership managed care entity must apply to CMS to become a Medicare Dual Eligible Special Needs Plan (D-SNP) and also must submit an executed State Partnership Medicaid

contract to CMS. The entity would need to submit these items to CMS approximately 10 months before it intends to begin providing Partnership services.

Pursuing Partnership expansion in parallel to Family Care/IRIS 2.0 expansion results in Partnership implementation and expansion no sooner than January 2019. This is because Partnership requires separate CMS approval for the Medicare services and this approval cannot occur until after the procurement and contracting process with the State is complete.

25. What are the limits and opportunities in terms of using Medicaid funding in Family Care/IRIS 2.0.

For Medicaid only members, which comprise fewer than 30% of long-term care participants, the Family Care/IRIS 2.0 IHA will cover all Medicaid services with the exception of prescription drugs, which will continue to be delivered as a fee-for-service benefit. For dual eligible individuals, IHAs will cover Medicaid long-term care services and any acute and primary care services that are not covered by Medicare. It is notable that, due to Federal restrictions on Medicare, the State cannot require dual eligibles to receive their Medicare services through managed care, so the Family Care 2.0 model is needed to maintain choice for dual eligibles regarding receipt of Medicare services.

It should be emphasized that the State must operate a non-Partnership option for long-term care members. Expanding Partnership requires an assurance that there will be the necessary Partnership Dual Eligible Special Needs Plan (D-SNP) in every county to which the State wants to expand the program. The D-SNP Medicare plan is a contract between CMS-Medicare and the managed care entity. The state can *influence* the availability of D-SNP Medicare plans but cannot *assure* the availability of such plans in any particular area because their availability is contingent on the decisions of private managed care entities and CMS.

The State can offer but cannot mandate that members enroll in a Partnership D-SNP plan, which requires members to be in a Medicare managed care plan. CMS has typically refused to require members to enroll in any form of Medicare managed care, and all existing Special Needs Plan (SNP) and Demonstration programs have some opt-out alternative. Thus, the State must offer an alternative to Partnership, in this case Family Care/IRIS 2.0, in order for individuals to be able to receive long-term care waiver services and receive Medicare through fee-for-service.