

Transitioning from Medicaid Waiver Programs to Managed Long-Term Care¹

Note: See Managed LTC Expansion Information Bulletin #6 for information concerning residency issues in transition to managed care.

Purpose

As counties and planning consortia prepare for the transition to managed long-term care in their area, it is important that all partners involved, Aging and Disability Resource Centers (ADRCs), Managed Care Organizations (MCOs), county Home and Community-Based waiver programs, Income Maintenance agencies, and DHS work together to ensure that the transition to managed care is as seamless as possible for consumers, and that the programmatic transition for all partners is as smooth as possible. This information bulletin is intended to provide direction to counties and planning consortia on DHS requirements and procedures for enrolling adults currently receiving Medicaid waiver services (COP, CIP 1A/1B, BIW, or Children's Waivers), or waiting for services, into Family Care, Family Care Partnership (Partnership), or PACE. IRIS (the self-directed supports waiver) is a fee for service alternative that is available wherever the managed care programs exist. This document does not describe how enrollment into IRIS occurs. Information regarding implementation of IRIS is available at <http://dhs.wisconsin.gov/LTCare/Generalinfo/iris.htm>.

Submission and Approval of Transition Plans

Transition plans may be developed on a regional basis, for all the counties in a planning consortia area as a whole, or on a county-by-county basis only. The decision about the basic planning approach is up to the counties and planning consortia they are associated with.

Initial Transition Plan

- Three months (90 days) prior to the anticipated first date of enrollment in managed long-term care in that county, the county or regional planning consortia must submit an Initial Transition Plan spreadsheet to DHS. This initial plan must clearly indicate the total number of waiver participants, the total number of individuals on the wait list, and how they will be transitioned into the managed care program(s), consistent with information in the remainder of this document. For this initial plan, information about the average waiver costs of individuals transitioning in any given month is not necessary.
- The Initial Transition Plan must be developed collaboratively by the LTS programs, the ADRC, the Income Maintenance agency and the MCO(s). Information about the entities that collaborated on development of the Initial Transition Plan should be included when the Initial Transition Plan is submitted.

¹ Publicly funded long-term care includes IRIS and managed care (Family Care, Family Care Partnership and PACE).

- The content of written notices to current and potential consumers (those on the wait list) must be approved by DHS, and may be submitted with the Initial Transition Plan. Sample notices can be found at <http://dhs.wisconsin.gov/managedltc/transition>. (Note: Although the samples are on DHS letterhead, the county may use their own letterhead if preferred.)

Final Transition Plan

- Two months (60 days) prior to the anticipated first date of enrollment in managed long-term care in that county, the county must submit a Final Transition Plan spreadsheet to DHS. The Final Transition Plan must include the average wavier costs of waiver participants transitioning in any given month. The Department will review the plan and work collaboratively with the local agencies to come to agreement on an approved Final Transition Plan, with the goal of having that final plan in place 45 days prior to the first date of enrollment in managed care in that county.

Templates and instructions for completing the Initial Transition Plan and Final Transition Plan are available at <http://dhs.wisconsin.gov/managedltc/transition>. These plans should be submitted electronically to DHSfcexpansion@wisconsin.gov.

Eligibility

- In order to enroll in managed long-term care (MLTC), individuals must be adult residents of the county, functionally eligible, and financially eligible for Medicaid. Individuals are, generally, functionally eligible for IRIS or managed long-term care (Family Care, Partnership or PACE) if they have a long-term care need and are either a frail elder or an individual with a physical or developmental disability. To be eligible for Partnership and PACE, people need to be at a nursing home level of care. Family Care includes a non-nursing home level of care benefit for people who do not qualify for the nursing home level of care benefit.
- Non-Medicaid Family Care will **not** be available in managed care expansion areas. All Family Care enrollees must be eligible for Medicaid.
- The Family Care statute states that people who are receiving community-based or nursing home long-term care services when the Family Care benefit first becomes available in the county, and who do not meet functional eligibility requirements, will have a “grandfather” level of functional eligibility. However, it is anticipated that most or all of these individuals will be able to meet the Family Care non-nursing home level of care eligibility criteria.
 - If the county or planning consortia identifies an individual who is currently being served under a home and community-based waiver, and that person does not meet nursing home or non-nursing home level of care on the functional screen, please contact Nancy Rusch at 608-266-9303 or Nancy.Rusch@wisconsin.gov or Lindsey Arnold at 608-261-3677 or Lindsey.Arnold@wisconsin.gov for technical assistance.

- A number of informational memoranda about eligibility and enrollment issues in Family Care have been issued by DHS and can be found at <http://dhs.wisconsin.gov/LTCare/ProgramOps>.

Conversion of Current Waiver Participants to MLTC, and Others Who Can Enroll Immediately, Without Going on the Wait List

- Conversion of current waiver participants to MLTC or IRIS should be completed within six months (12 months in Milwaukee County for adults with disabilities, ages 18-59) of the beginning of enrollment in that county.
- Waiver participants in each county should also be enrolled into MLTC proportionately from each target group/waiver program with an even distribution of average waiver costs each month. This ensures that sufficient funding is available to eliminate waiver wait lists within three years, and helps manage the programmatic transition for the counties.
- Individuals in an ICF-MR or NH where the stay is intended to be long term and Medicaid is paying for the institutional care do not need to be placed on the wait list, but can be offered enrollment into an MCO or IRIS by their ADRC. Institutional relocations should occur as much as possible.
- When a county converts from fee-for-service COP/CIP waivers to managed care/IRIS, it may be serving some waiver participants outside of the county, and there may be other participants placed within the county by other county programs or MCOs. See Managed LTC Expansion Information Bulletin #6 for information about when individuals should be included in the county's transition plan.
- Waiver participants, or people enrolled in Family Care, Partnership, PACE, or IRIS who voluntarily (as defined in DHS Numbered Memo 2007-01, which defines residency, directed placement and voluntary concepts related to resident moves) move from other Wisconsin counties to the MCO service area, can enroll immediately. These individuals are not to be considered new applicants and they do not need to be placed on the wait list, but the ADRC can enroll the person directly into an MCO or IRIS (depending on his/her choice). Individuals do not need to have been enrolled for at least six months in their prior county in order to enroll into the MCO or IRIS. See Managed LTC Expansion Information Bulletin #6 (<http://dhs.wisconsin.gov/managedltc/grantees/infoseries.htm>) for information regarding how to handle individuals who move to, or are placed in, another county.
- Children who have been served by the children's waiver or the CIP waiver, who turn 18 and are eligible, **MUST** enroll in an available managed long-term care program or IRIS to continue receiving waiver services. They can enroll effective the first day of the month in which he/she turns 18, without going on a waiting list.

Wait List Management – ADRC Responsibility

- Enrollment of wait list individuals should occur at a rate no faster than 1/36 of the wait list per month for 36 months after the initial date of MLTC and IRIS in that county. This refers to people on the wait list at the beginning of the enrollment process. New people are placed on the wait list in accord with the State wait list policy. There is one waiting list in each county – it contains **both** the names of people who have been waiting during the county’s waiver operation and anyone who applies for enrollment in Family Care, Partnership, PACE or IRIS prior to the start date of entitlement in that county.
- By statute, Family Care/IRIS becomes an entitlement to eligible people 36 months after the benefit becomes available in that county. Entitlement begins after the 36th month, regardless of the number of people on the waiting list. Several months before entitlement begins in any county, the planning partners should assess the expected number of enrollments when entitlement begins, and plan for the smooth enrollment of those people. This may require specific capacity building on the part of the affected MCO(s) or IRIS program.
- Eligible people in counties where Family Care became available before January 2008, have an entitlement to Family Care services. For example, Family Care started in Richland County in 2001. On July 1, 2008, Richland County formed a public partnership between eight counties in southwest Wisconsin: Crawford, Grant, Green, Iowa, Juneau, Lafayette and Sauk. There is no wait list in Richland County, but the wait lists will remain in the other counties for 36 months after Family Care started there.
- As people leave publicly funded long-term care (IRIS or managed LTC) through disenrollment, loss of eligibility or death, the same number of additional wait list people may be enrolled.
- New non-institutional applicants will be placed on the wait list in accordance with State policy. It is anticipated the wait list will continue to exist for 36 months from the initial date that managed LTC and IRIS became available in the area.
- The ADRC will manage the wait list. ADRC wait list policies may have local priorities related to the order in which people from the wait list are served. *EXAMPLES include, but are not limited to:* Individuals who are at high risk of institutionalization, a person with a terminal condition, a person who is self abusive or neglectful, an individual who is court ordered to receive services, or a child who is required to leave the school system where the absence of school services may cause a crisis for the family or child.

Selection and Notification – All waiver participants and those on the wait list are notified of impending change to managed care and implementation dates.

- DHS must approve any written notifications to be sent to current waiver participants and individuals on the wait list about the transition to managed care and IRIS. Sample notices can

be found at <http://dhs.wisconsin.gov/managedltc/transition>. (Note: Although the samples are on DHS letterhead, the county may use their own letterhead if preferred.)

- Individuals should have a period of both functional and financial eligibility after their enrollment date. They should have at least 30 days of financial eligibility (as it pertains to IM eligibility on file in CARES) and 60 days of functional eligibility after their enrollment date so that the care management teams have time to determine what supports the individual may need in the recertification process and arrange for those supports.
- As stated above, waiver recipients should also be enrolled into managed long-term care/IRIS proportionately from each primary target group with an even distribution of average waiver costs each month. Meeting this plan ensures that sufficient funding is available to eliminate waiver wait lists within three years.
- Functional eligibility for MLTC is determined by the **date eligibility is calculated** in the LTC Functional Screen application. This is a change from the waiver program, which uses screen completion date.
- Waiver participants and individuals on the wait list choosing long-term care are offered the option of whichever programs are available in their service area, including Family Care, Partnership, PACE and IRIS; these offers are extended by the entity responsible for options and enrollment counseling. The MCO has no role in the wait list or waiver participant's decision about which program to choose.
- For Partnership and PACE, an enrollee who is eligible for Medicare must meet all enrollment requirements for participation in that program's Medicare component.
- Prior to the initiative to expand MLTC and IRIS statewide, Partnership programs completed an assessment and care plan before the consumer made his/her final enrollment decision. Partnership programs will need to change their process to conform with the process in Family Care in which the ADRC helps the applicant choose a program, an MCO (if applicable), and an enrollment date, and the assessment and care plan are completed after enrollment.
- As managed care expansion rolls out, the Department will no longer grant requests from Partnership organizations to not enroll someone who is living in assisted living/substitute care or in a nursing home, when that person does not wish to relocate. In expansion areas, people living in assisted living/substitute care or nursing homes and ICFs-MR will have the option of enrolling in any of the managed long-term care programs available in the service area.
- For waiver participants transitioning to a managed long-term care program through the centralized enrollment process, enrollment dates must be on the first of the month. This will lessen confusion for fee-for-service Medicaid providers, reduce administrative work for the waiver agency and for the new MCO, and in general facilitate the transition from fee-for-service Medicaid to managed care. First of the month enrollments may also reduce potential

misunderstandings by enrollees. For waiver participants transitioning to IRIS, enrollment dates are encouraged to be the first of the month for similar reasons.

- The county should be sensitive to requests by waiver participants to delay their enrollment until later in the transition process, as long as it is within the six-month transition period, and there is a good reason to consider a later enrollment date. For instance, counties may decide to delay an enrollment date because the individual's current providers do not yet have contracts in place with the MCO.
- DHS must approve materials that will be provided to current participants about the transition to managed care/IRIS.
- Current waiver participants should receive the necessary counseling about program requirements and service options available in their service delivery area.
- Determining who will provide enrollment counseling to waiver participants about publicly funded long-term care is a local decision. For example, a county could decide that the LTS agency that manages the COP and CIP programs, rather than the ADRC staff, will do enrollment counseling for current waiver participants.
- If the LTS agency is doing enrollment counseling for current waiver participants, the county must identify any potential conflicts of interest that may arise and have a plan for mitigating that conflict of interest. For example, a care manager may know he or she will be performing care management for a particular MCO, and if people will have a choice of MCOs, that may pose a conflict when counseling clients about which MCO and/or program to enroll in.
- Anyone providing enrollment counseling whether to waiver participants, wait listed or new individuals, must read Resource Centered Info Bulletin #09-01 (located at <http://dhs.wisconsin.gov/LTCare/Generalinfo/rcs.htm>) and watch the webcast on enrollment counseling. Staff are strongly encouraged to attend the on-site training on this topic. Supervisors are encouraged to review and discuss these training materials with their staff before staff begin providing enrollment counseling. Preparation can also include mentoring and shadowing.
- The ADRC will do enrollment counseling for those on the wait list and for new applicants.
- As part of enrollment counseling, people should be made aware that enrollment will be delayed if the MCO(s) does not meet certification requirements by the projected start date.
- MCOs are advised to make available to the enrollment counseling agencies information about their program, provider network and program or provider limitations as soon as possible so the information can be included in enrollment counseling.
- In Milwaukee County, applicants age 60 years old and older will need to speak with an independent enrollment consultant until the MCO and Aging Resource Center are operated by separate county departments.

MCO Capacity

- MCOs are responsible for providing needed services from the first day of enrollment, whether they are former waiver services or health-related services formerly funded by Medicaid fee-for-service.
- It is expected that contracted MCOs will have capacity to continuously enroll all individuals referred by the ADRCs in its service area. Just the same, during the 36-month phase in process, the MCO must maintain effective communication with the ADRC about the capacity of the MCO to accept enrollments.

Enrollment

- Beginning July 1, 2009 a standardized enrollment form (DHS F-00046) will be required for enrollment in Family Care, Partnership and PACE. The form, or other forms in use by ADRCs, may be used prior to that date. Enrollment and disenrollment forms are available at <http://dhs.wisconsin.gov/managedltc/transition>.
- DHS will perform centralized enrollments for current Medicaid waiver participants, as well as wait list individuals who are already receiving Medicaid “card services.” This will allow current waiver participants and some wait list individuals, identified by the waiver program and/or ADRC, to be enrolled in Family Care, Partnership or PACE, centrally by DHS.
- By the first of the month before enrollment is scheduled to begin, the managed care expansion county’s waiver agency and/or ADRC, as appropriate, must:
 1. Select, in accordance with the approved transition plan, the current waiver participants to be enrolled effective the first day of the next month;
 2. Select, in accordance with the established selection criteria, Medicaid eligible wait list individuals to be enrolled effective the first day of the next month;
 3. Conduct appropriate enrollment counseling and obtain signed enrollment forms; and
 4. Enter data for individuals into the Program Participation System (PPS). The entries into PPS will be submitted to DHS for central enrollment processing. These entries will not go through the regular enrollment process via the local Economic Support Agencies. Information about the PPS system is available at <http://dhs.wisconsin.gov/lc/Geralinfo/pps.htm>. This process replaces submission of the centralized enrollment spreadsheet to DHS.
 - The centralized enrollment spreadsheet should only be used in rare circumstances. *(For example, if there is an urgent situation where someone should be enrolled on the first of the current month, but they were not submitted via PPS, the needed information can be sent in using the spreadsheet. DHS will process these late submissions manually.)* If the managed care expansion county’s waiver agency and/or

ADRC is unable to submit an individual via PPS, please contact Sara Edmonds at sara.edmonds@wisconsin.gov for further guidance. If it is decided that the use of the spreadsheet will be necessary, a template and instructions for completing the spreadsheet are available at <http://dhs.wisconsin.gov/managedltc/transition>.

- Centralized enrollments will only be done for people already receiving Medicaid (i.e., Medicaid home and community-based waiver participants, or individuals on the waiver wait list who are receiving non-waiver Medicaid). Individuals should have a period of both functional and financial eligibility after their enrollment date. They should have at least 30 days of financial eligibility (as it pertains to IM eligibility on file in CARES) and 60 days of functional eligibility after their enrollment date so that the care management teams have time to determine what supports the individual may need in the recertification process and arrange for those supports.
- Individuals on the wait list who are not receiving Medicaid must have their Medicaid eligibility determined by the county Income Maintenance agency. Such individuals in each respective county should be encouraged to apply for Medicaid through their county's Income Maintenance agency no later than 30 days prior to the desired enrollment date. (If the planned enrollment date is 1/1/08, the Medicaid application should be filed by 12/1/07.)
- Unlike enrollment in the current home and community-based waivers, Family Care, Partnership and PACE enrollment may not be backdated.
- DHS will continue to accept centralized enrollments for waiver participants and wait list individuals, as noted above, until the end of the 36-month transition period for waiver participants and wait list individuals. Individuals enrolling in IRIS are not enrolled centrally. They are referred for enrollment via PPS (for information about IRIS and PPS go to <http://dhs.wisconsin.gov/LTCare/Generalinfo/iris.htm>). For details on processing IRIS enrollments, refer to the "Introduction to Implementing IRIS" webcast and PowerPoint located at <http://dhs.wisconsin.gov/LTCare/Generalinfo/Webcast/adrcwebcastIRIS.htm>.

Functional Screen Transfers

- When an individual, who has an existing LTC Functional Screen, whether they are currently on a waiver or a waiting list, decides to enroll in the MCO, the agency that owns the screen (i.e., the county waiver agency or ADRC) must transfer the screen to the MCO. There is a 'Transfer' function built into the LTC Functional Screen application. The DHS SOS help desk has instructions on how to transfer a screen. Contact the help desk at 608/266-9198 to request a copy of the instructions.
- The ADRC will continue to have access to all screens transferred to the MCO without the need for release of information forms. ADRCs need to contact Hollister Chase at 608/261-8877 or hollister.chase@wisconsin.gov to request "super rights" to MCO screens.
- ADRC staff are bound by strict confidentiality requirements, as well as requirements related to protected health information. This means that ADRCs will only access an individual's

screen at the time they are actively working with the individual on a specific ADRC-required business function. When accessing a screen, ADRC staff will only view the minimum amount of the individual's screen necessary to accomplish the intended purpose. ADRCs are to access the LTC FS only for consumers residing in the county(ies) they serve.

- If existing county waiver agency screener becomes a screener at an ADRC or with the new MCO, then that screener will have to have their profile changed in the functional screen. The DHS SOS help desk has instructions on how to change a screener's profile. Contact the help desk at 608/266-9198 to request a copy of the screener update instructions.

DHS Technical Assistance

- As new counties and consortia continue to transition to managed LTC, DHS will arrange regular conference calls with ADRCs, current waiver programs, MCOs and Income Maintenance agencies to answer questions and provide technical assistance related to transition and enrollment plans and their implementation. Staff in the Office for Resource Center Development will arrange these calls; contact Janice Smith (Janice.Smith@wisconsin.gov) for more information.