Wisconsin BPDD
Wisconsin Board for People with Developmental Disabilities

2017-19 Biennial Budget requests

Prioritize real jobs in the community for people with disabilities

Integrated community employment supports are more cost effective[1]. People working in integrated community employment earn higher wages, resulting in more financial independence and the ability to be less reliant on Medicaid funded services[2]. DHS's 2014 report on sustainability of Medicaid funded long term care programs stated that community integrated employment is more cost-effective than facility-based employment and that a shift to this type of employment is necessary for fiscal sustainability in state programs[3].

Employment Recommendations

- Establish a pay for performance system that rewards community employment outcomes and fading or elimination of public employment supports[4].
- Establish a statewide policy priority requires every transition age student with a developmental disability exits high school with a community integrated job[5].
- Expand eligibility to private sector businesses and businesses owned by people with disabilities to compete for State Use program contracts, require State Use Contractors to pay employees at least minimum wage, ensure employees funded with State Use Contract dollars are being hired in community job settings.

Prioritize independent living with supports

Independent community supported living is the best practice and uses family and community resources to reduce bypass more expensive and restrictive Medicaid funded residential services. Community Supported Living can cost Medicaid 35% less than a CBRF placement[6]. 28% of people in Wisconsin's long term care programs (Family Care, IRIS) live in a Medicaid funded residential setting

[1] DHS' 2013 Long-Term Care report cites the cost of integrated employment support at $8.01 per hour worked, compared with a cost of $10.45 per hour worked in facility-based employment.
[2] According to DHS data, people in integrated employment earn more than three times more per hour than their facility based counterparts ($8.28 per hour versus $2.43 per hour).
[3] https://www.dhs.wisconsin.gov/publications/p0/p00590.pdf
[4] Service codes in long-term care can be changed to pay for hours an individual works, rather than hours of service provided. This incentivizes obtaining more hours of employment for a LTC participant, finding a good job match that minimizes the need for support, and rewards fading of job coaching over time because the agency is still paid for the hours a person works regardless of services delivered. This model has already been successfully implemented in Wisconsin by one Wisconsin MCO.
[5] Dane County has had this policy for 30 years, and has the leading integrated employment rate (75%) for people with developmental disabilities in long term care in the nation. Nearly every high school graduate with developmental disabilities in the last 5 years is in paid employment. Nearly 900 local employers have hired people with developmental disabilities. The employment provider network has expanded and focused almost exclusively on integrated jobs. People with disabilities working in community jobs pump more than $3.6 million in earnings back into local economy. Wages earned now nearly offset local costs of providing employment supports.
6 Community Supported Living Within Family Care: Community Care of Central Wisconsin's Experience; Strenn, Norby and Harkins; October, 2013 paper published by the Wisconsin Board for People with Developmental Disabilities. In Dane County, families have established community supported living residences that save Medicaid 70% compared to the cost of an adult family home placement.

(Community Based Residential Facility (CBRF), Adult Family Home (AFH), or Residential Care Apartment Complex). Residential Services account for 52% of Family Care expenditures[7]

Housing Recommendations

- Establish Community Supported Living[8] as the first and preferred option for Medicaid reimbursable residential supports.

- Allow use of administrative Medicaid funds to be used for housing-related activities like assisting with housing applications, developing a housing support plan, or providing tenant support services[9].

- Require MCOs to routinely check and match LTC recipients with available affordable housing and Section 811 rental housing vouchers.

Connect families so they can solve real world problems while reducing service system involvement

Family Networks seek out cost effective community-based solutions and resources, personal resources, and unpaid supports, in lieu of more costly Medicaid funded services. Family Networks can increase community employment[10], independent living[11], and facilitate transportation[12], fill in the gaps caused by significant workforce shortages in rural and underserved areas with limited access to qualified service providers, and can plan and prepare for a time when family caregivers may no longer be able to provide the same level of care and succession of caregiving[13].

Family Network Recommendations

- Establish two three year pilot programs—one in Family Care and one in IRIS—that provides dedicated staffing, technical assistance, training and coaching, requires outcomes reporting, and

7 https://www.dhs.wisconsin.gov/publications/p0/p00318-2013.pdf

[8] Community Supported Living is defined as a partnership between any person needing support to live in their own home and an entity providing individualized assistance.

[9] CMS encourages the use of Medicaid funds for these purposes. California, New York, and Tennessee -- are addressing the housing needs of dually eligible beneficiaries who use LTC. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[10] In one project, 85% of people with disabilities gained an average of 15 hours per week of employment, and reduced the support provided by Medicaid by 7000 hours per year. If these 11 individuals were not working part-time in the community, it would cost Medicaid $616,000 for 7000 hours in a sheltered workshop and $1,155,000 for 7000 hours of adult day services per year.

[11] One Family Network decided to focus on achieving independent living for their family members with disabilities. 20 individuals now live independently for 70% lower than if they were in an adult family home placement. If these 20 individuals were placed in Adult Family Homes the cost of supporting them would be $480,000 to $1,340,000 per year. Another group of five families is saving Medicaid 30% annually because they are sharing responsibility for hiring, training and scheduling shared staff and thus avoiding the overhead costs of a residential agency ($24 per hour residential agency versus $16 hour non-agency). In another example, Medicaid will save an estimated $27 million over the course of 9 individuals' lifespan because 9 families developed a clear succession plan to ensure their children can live in the community and avoid potentially decades of high cost, restrictive residential placement.

[12] Nine families assessed they collectively need more than 1500 rides per year for employment and community activities; by carpooling they have reduced the number of Medicaid rides by 150.

[13] When families transition caregiving to another family member or have ensured that their loved one can live and work independently in the community with supports, Medicaid may avoid residential and other costs that might have been incurred for decades.

recommendations to DHS on how to scale and replicate family networks in the long term care system.[14]

- Develop an incentive structure within Family Care outside the capitated rate for continuous outcome improvement initiatives, and include replication of the Living Our Visions (LovDane) model as an eligible continuous outcome improvement project.

- Create an incentive structure that rewards families for community integration efforts that result in reportable outcomes (specifically integrated employment, transportation to employment, community integrated living, community connections, etc.)

Stabilize the community based direct care workforce so people can stay out of expensive institutions

People with disabilities rely on direct care worker assistance in order to remain independent, employed, and in the community. If the community-based workforce is insufficient, people with disabilities may be forced into institutional settings, which will dramatically increase the Medicaid budget.

Community Based Workforce Recommendations

- Establish a statewide contract with a proven interface (MySupport) that enables long term care participants and available workers to find each other, hire and schedule workers, expand the available worker pool for workers not affiliated with a provider agency, and helps provider agencies to improve administrative efficiency[15].

- Reimburse workers for transportation costs associated with commuting to client homes.[16].

[14] Data elements should include number of families receiving one on one conversation specifically about participating in a Family Network; Number of families expressing interest being connected to Family Networks; Number of families referred to dedicated Family Network staff; Number of family networks and number of families within each network; Types of Activities Family Networks are engaged in (e.g. connecting to other families, connecting to community activities, securing community employment, securing community independent living, supported decision making and self-direction, futures planning, transportation solutions etc.); Engagement of participants whose families are in Family Networks in community employment (hours, wages, employment supports used), community supported living, community engagement, quality of life measures, supported decision-making and self-direction as compared to participants whose families are not participating in Family Networks; The level of family engagement in networks and types of activities families are engaged in; issues identified by families including participation; quantify the participant's existing support system and how many/amount of services are being paid by family, other caregivers, other entities, services available from public or private funding sources.

[15] Applications have been developed that match participants and workers by via profile information (care needed, geography, availability), enable participants to self-direct and hire workers that fit their needs and personality, enable personal care agencies and workers to track hours to prevent incurring overtime expenses, and enable provider agencies and managed care organizations to reduce administrative overhead while tracking workflow and billable Medicaid expenses. My Support (http://www.mysupport.com/) is an example of a platform currently operating in California, New Jersey, Iowa, and preparing to launch in Delaware and Maryland. My Support can be used as an the CMS suggested open registry of workers for public use, and Medicaid administrative match can be used by states to implement the My Support system and pay for ongoing operating costs (CMS Guidance, Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce August, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib080316.pdf)

[16] These costs should at minimum include gas, millage, and public transit system fares. Currently, the workforce is only reimbursed for travel time and not mileage. Travel time reimbursement often does not cover the cost of gas and wear and tear on the vehicle.

Keep people with co-occurring I/DD and mental illness in the community and out of mental health institutions

50% of Family Care members with IDD have co-occurring mental health conditions, and require specialized behavioral support. In 2015 Community TIES consultants provided active behavior support services 16% of the adult I/DD population served by Dane County (231 people).Every day these complex individuals are living in the community saves Medicaid 39-60%.

Mental Health Recommendations

- Use the same reimbursement rate for institutional and Home and Community Based (HCBS) services[17].
- Establish one or more county pilot projects between Waisman Community TIES, an MCO, a county CLTS program, and county mental health department.
- Develop an incentive structure within Family Care outside the capitated rate for continuous outcome improvement initiatives, and include replication of the Community TIES model as an eligible continuous outcome improvement project.

Ensure people with disabilities can get where they need to go on their schedule

A Wisconsin survey of more than 500 people with developmental disabilities finds, a lack of transportation affects people with disabilities' ability to get to work (70%), effects getting to medical appointments (66%), limits the ability to participate in their communities (86%), limits ability to shop and support local businesses (75%), and impacts people's ability to see their family (53%).

Transportation recommendations

- Increase funding for public transit systems and expand public transit options (routes, new systems).
- Explore Uber/Lyft drivers and other shared-ride systems as acceptable Medicaid payees to expand ride options and numbers of vehicles available that can be accessed by people with disabilities.
- Pass shared-ride legislation that assures accessibility, requires background checks for drivers, Leaves opportunity to partner with or contract with private companies that already operate wheelchair accessible vans or encourage people who own accessible vans to sign up as

[17] The average per capita cost of institutional services typically is considerably higher than that of HCBS. When a state establishes the same acuity-adjusted Per Member Per Month (PMPM) payment rate for institutional and HCBS services, MCOs have strong incentives to avoid institutional placements and to transition Nursing Facility and other institutional residents to HCBS settings. http://www.ncd.gov/publications/2013/20130315/,

drivers, prohibits charging people with disabilities additional fees or higher fares, prohibits discrimination against people with mobility equipment or who use service animals.

- Allow health care facilities to coordinate and schedule their own NEMT rides in conjunction with the medical and other treatment appointments they schedule.

- Implement “Pay for Performance” billing for all NEMT rides. BPDD recommends no payment be made if a ride does not show, and a sliding scale penalty be imposed that reduces payment the later the ride is, with no payment due if the ride results in a patient missing a scheduled appointment.