1999 DRAFTING REQUEST

Bill

Received: **09/8/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget-in 6-2288**

By/Representing: **Fossum**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact: **Lorraine Barniskis (DHFS)**

Alt. Drafters: **yacketa**
champra

Subject: **Health - long-term care**
Health - social services
Public Assistance - med. assist.

Extra Copies: **GMM**

Topic:

DOA:.....Fossum - Long-term care redesign

Instructions:

See Attached; same as 97-5277

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LRB-0030

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Subject: **Health - long-term care**
Health - social services

Extra Copies: **DHFS**

Topic:

DOA:.....Fossum - Long-term care redesign

Instructions:

See Attached; same as 97-5277

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1999 DRAFTING REQUEST

Bill

Received: **09/8/98**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Health and Family Services 267-5267**

By/Representing: **Lorraine Barniskis**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact: **DOA**

Alt. Drafters: **yacketa**

Subject: **Health - long-term care**
Health - social services

Extra Copies:

Topic:

Long-term care redesign

Instructions:

See Attached; same as 97-5277

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	kenneda						

FE Sent For:

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the statutes as though the amounts appropriated to the department under that appropriation for fiscal year 1998–99 were $12,600 less than the amounts in the schedule.

SECTION 9120. Nonstatutory provisions; governor.

(1) CHILD'S FIRST BOOK INITIATIVE. From the appropriation under section 20.525 (1) (a) of the statutes, the governor may expend not more than $45,000 in fiscal year 1998–99 for a child's first book initiative. The governor may contract with a state agency, as defined in section 20.001 of the statutes, to administer the initiative. The state agency contracted with shall acquire children's books and send those books to the parents of newborn children to encourage those parents to read to their children and thereby stimulate the intellectual development of those children.

SECTION 9122. Nonstatutory provisions; health and family services.

(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM. The department of health and family services shall apply to the federal government to establish a medicare rural hospital flexibility program, as authorized under 42 USC 1395i–4 (b).

(3) FAMILY CARE.

(a) By July 31, 1998, the department of health and family services shall submit final drafting instructions to the legislative reference bureau for proposed legislation to initiate establishing, on July 1, 2000, a new system under which long–term care is provided to elderly and adult disabled individuals. The drafting instructions for the system shall be for services to these individuals that include all of the following:

1. The establishment of a single consumer entry point for long–term care services for a county or tribal area, to provide information on aging, disability and services for long–term care and to perform functional and financial screening for and collect information about individuals.

2. A needs–oriented, individualized long–term care benefit that covers a full array of services and support items.

3. Simplified and uniform eligibility for a long–term care, publicly funded subsidy, based on functional ability and ability to pay.

4. A care management organization that provides services that are tailored to individual needs and preferences in a cost–effective manner, including the option for the consumer or the consumer's family to direct services.

5. Combined federal, state and local funding, within the limits of federal law, that is designated for each consumer and applies regardless of change of the consumer's service setting or his or her residence within the state.

6. Prepaid funding to counties or other entities for care management and delivery of services, based on average per person costs for consumers at various disability levels.

7. Coordination of long–term care with primary and acute health care services.

8. Meaningful involvement of consumers, family members and guardians in the design, implementation and ongoing policy direction of the long–term care system.

9. The right of a county or tribe to opt or decline the option to be the single entry point for long–term care services or a care management organization for the area of the county's or tribe's jurisdiction, if the county or tribe meets established performance standards.

(b) The department of health and family services shall in an expeditious manner, request any waivers of federal laws that would be necessary to effectively implement, on July 1, 2000, the long–term care system described in paragraph (a).

(c) In preparing drafting instructions for proposed legislation, as specified in paragraph (a), the department of health and family services shall take into consideration the recommendations of a steering committee that is appointed by the secretary of health and family services. The steering committee shall include long–term care consumers, family members of elderly and disabled adult individuals and leaders from state governmental, advocacy and long–term care service provider organizations.

(3t) RULES FOR EXPEDITING MEDICAL ASSISTANCE ELIGIBILITY DETERMINATIONS. Using the procedure under section 227.24 of the statutes, the department of health and family services shall promulgate rules required under section 49.45 (2) (a) 24. of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 49.45 (2) (a) 24. of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a) and (2) (b) of the statutes, the department need not provide evidence of the necessity of preservation of the public peace, health, safety or welfare in promulgating rules under this subsection.

(3ty) NEONATAL INTENSIVE CARE UNIT TRAINING GRANTS.

(a) In this subsection:

1. "Developmentally supportive and family–centered care" includes all of the following:

a. Caregiving that is individualized, flexible and responsive to each infant, based on continuous skillful monitoring of the infant's behavioral and physiologic responses.

b. Modifications to the caregiving environment to minimize infant stress and promote optimal infant adjustment to his or her neonatal intensive care unit experience.

c. Support of the developing parent or family and infant relationship throughout the infant's neonatal intensive care unit stay and after discharge, using strategies that focus on developing parental competence in infant

Lorraine Baniskis 7-5267 6/4/98 Long Term Care Redesign
Linda McCabe 6-0554
Chuck Wilhelm
Gretchen Fossum
Tina Yacker
Freddie Bone
Tom Hamilton

Lisa Kelly - another contact

June 17 ~~Wed~~ 2:30 at DHFS

Notes from meeting of 6/17/98

A. State Long-Term Council
- 3 year terms
  Begin October 1, 1999
- Staggering: 3 groups
  Initial term 3 yrs
  4 yrs
  5 years

St. Council to advise DHFS re # of CMO's + to recommend change

B. County LT Care Councils
# of Terms - Same as for State LT Council

If appointed bec. of Co Bd. membership, lose membership if not reelected - See other stat. language
Co Bd membership may be no more than 4 ~~[illegible]~~ Not more than 4 members may be co bd. members

In Co w/ Co. Exec. or CA, CE or CA appoints, subj. to Co Bd. approval

Grievance + Appeal Process - have work group w/ will determine

Implementation

In 46.27, amend reqmt. for cos to participate to state unless + until LT Care is in placement
See 46.271 – 46.278 for this language

Rules v. Contract

Areas Still in Disagreement

Role of Cos.
Can they be both RC + CMO; what is separation betw/ 2
Role of local LT Care Councils
Alternative Fee-for-Service (If eligible for LTC, is it a mandatory enrollment)

Chris Hendrickson - BCMH
Lisa Kelley - OSF
Lorraine Barriskis

DAK, TAY,

Long-Term Care Redesign - Questions for 6/17/98 mtg:

1. Use 46.28 for new section (currently "Revenue bonding for residential facilities") - 5 cross-refs
   Gives us 10 sections to work w/ (46.28 — 46.289)

Outline 2. Eligibility - entitlement

Entitlement: at higher? levels of functional disability
categor. eligible for Medicaid
confirmed APS needs

Eligible: at lower? levels of functional disability
not cat. eligible for Medicaid
no APS needs

What about people presently on COP who are eligible, but not entitled?

* What are levels of functional disability that are differences?

What are differences in appeal rights for eligibles vs. entitlees?

→ See p. 16 - consumer seeking approp. provider

Further questions on Oatline

Appeals Process
To director of Resource Center / CMO
To County LTC Council?

Questions to ask Lorraine Baumiskis 7-5267

9/98:

(?) ① (State) Council on L-T Care
How does it interact with BOALTC?

(?) ② Re tribal or county councils
ⓐ Is a multicounty council limited to 20 members?

✓ ⓑ Is a multicounty council limited to 4 co bd. members
7/17/98: not more than 40%

ⓒ language in 46.22 –

OK
✓ 1. Vacancies to be filled for residue?
✓ 2. Removal from office by 2/3 vote for cause on notice in writing + hearing?
✓ 3. Staggering language? – 3, 4, 5 years ok?
4. Elections language?
✓ * 5. Reimb. language

✓ ⓓ "Pool" language not useful bec. too vague
Co bd chair or CE to solicit names; consumer reps must both be picked from noms. given

✓ ⓔ Who is to train + support consumer representatives?
Co bd to provide training

DHFS

Department of Health and Family Services
1999-01 Biennial Budget Statutory Language Request
September 11, 1998

Title: Family Care Program Revenue Appropriation

Current Language

None exists.

Proposed Change

Create PR appropriation in program 06 – Division of Supportive Living for client cost-sharing revenue in the Family Care program.

Effect of the Change

Collections from Family Care participants will offset a portion of the cost of their care. This appropriation has been created in the B-2 system as 435(6)(g), a continuing PR state operations appropriation. Funds projected to be collected in this appropriation have been budgeted to offset the costs of the Family Care Program.

Rationale for the Change

The Department plans to implement a new long-term care program known as Family Care. In Family Care there will be a sliding cost-sharing requirement applied to participants. Participants will pay from 0 to 100% of the cost of their care plan, based on their ability to pay (i.e., their financial resources.)

This appropriation is being created to allow the State to collect and spend funds received from Family Care participants. Funds collected from Family Care participants will offset the cost of the Family Care program to the state and federal governments.

Desired Effective Date:	Upon passage.
Agency:	DHFS
Agency Contact:	Cindy Daggett
Phone:	266-5380

From Gretchen Fossum 9/21/98:
This request belongs to Family Care request, not as a separate budget request. Also, she feels it is incorrect programmatically.
DAK

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

(*) To do

July 31, 1998

To: Steve Miller, Director
Legislative Reference Bureau

From: Joe Leean, Secretary

Subject: Drafting Instructions for Family Care

Session law enacted as part of 1998 Act 237 requires this Department to submit final drafting instructions to the Legislative Reference Bureau for proposed legislation to redesign the state's long term care system. Attached is the Department's proposal, along with a chart that indicates what content we propose be in the legislation, along with what provisions we propose be handled through rules or contract requirements. Please note that this chart is not intended to suggest actual legislative language, but simply to suggest which topics should be addressed.

We have begun discussions with federal officials about what federal waivers will be needed to implement the proposed new system. As those discussions proceed, it is possible that further changes to our proposal will be needed.

Thank you.

cc: LTC Redesign Consolidated Steering Committee
Mark Bugher, DOA
Annette Cruz, Governor's Office
Bob Lang, LRB
Tilli de Boor, DOA
Debora Kennedy, LRB

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone (608) 266-9622

Legislative Drafting Request - Redesign of the Long Term Care System

NOTES:

- **These notes are intended to outline the topics to be addressed in legislation, rule or contract, not to suggest actual statutory language.**
- Topics are not necessarily sorted in the same way as they would be in the actual statutory language.
- All references are to the Department's proposal titled "Family Care: Redesigning Wisconsin's Long Term Care System" and dated 7/31/98

Topic	Statute	Rule (allow emergency rules throughout)	Contract
State LTC Council 15.197(5)	Composition: 25 members. At least 51% elderly people, people with physical disabilities, and people with developmental disabilities and their representatives; of these, at least 2/3 must be elderly people, people with physical disabilities, and people with developmental disabilities; up to 1/3 can be their family members, guardians, or other advocates; consumer representatives must be proportional among the three target groups. Balance of members are county and tribal representatives, service providers, representatives of Resource Centers and CMOs, state officials and other community leaders. (a) (b) (c) Appointment: Chair appointed by Governor; other members appointed by the Governor from pools of nominations solicited by the Secretary of DHFS from respective stakeholders (d) Terms: 3-year staggered; initial terms of 3, 4 and 5 years; members serve until replacement is appointed; not more than 2 consecutive terms 46.282(1) Responsibilities: (a) Assist the Department in developing broad policy issues related to long term care services and systems. (b) Assist the Department to develop, implement, coordinate and guide the state's LTC system, including review and recommendations on the Department's standard contract	• Criteria that the Department, the State LTC Council and local LTC Councils will use in determining the appropriate number of CMOs in an area and the appropriateness of particular organizations to serve as CMOs.	

Topic	Statute	Rule (allow emergency rules throughout)	Contract
	provisions for Resource Centers and CMOs, the new Family Care benefit (including per person rate structure), and, for as long as they are a part of the system, the Community Options Program, the Community Integration Program and other Medicaid Home and Community-Based Waiver Programs, and the Medicaid fee-for-service system.		
46.282(1)(c)	• Review, at the request of counties, tribes, local LTC Councils, or applicant organizations, Department decisions regarding how many CMOs should operate in a given geographic area, which organizations should receive CMO contracts from the Department, and whether specific contracts should be terminated. The Council will review disputed decisions in light of materials presented by the applicant organization, any affected CMO already operating in the same geographic area, any affected local LTC Council and the Department. The State LTC Council will review these cases within established guidelines and make recommendations to the Department. The final Department decision on the matter must include consideration of the Council's recommendations; if the Department's final decision does not agree with the Council's recommendations, it must explain in writing its reasons for not doing so.		
(d)	• Monitor patterns of complaints, grievances and appeals across the state to identify issues that need state level attention.		
(e)	• Monitor the number of people on waiting lists and the level of their functional needs.		
(f)	• Review patterns of utilization of various types of services by CMOs.		
(g)	• Monitor the statewide pattern of enrollments and disenrollments in CMOs.		

46.282 (1)(h)	• Review annual reports submitted by local LTC Councils and other information and report annually to the Governor and the Legislature on the status, significant achievements and problems in the statewide LTC system, including people served, costs, the number and service areas of Resource Centers and CMOs, waiting list information, and results of quality reviews. Make recommendations for system changes as indicated by these findings.		
County/Tribal LTC Council 46.281 (1) (f) 1. 46.282(3)(b)2. 46.27 (4) 46.282(2)(d)	• Creation: The Department will not sign any contract for a Resource Center or a Care Management Organization within a county, until the County LTC Council has developed a plan for the structure of the local LTC system. When the County LTC Council has been appointed, it may assume the responsibilities of the LTS Planning Committee; a separate LTS Planning Committee, with the membership specified in s. 46.27 is no longer required. County is required to provide training and support to consumer representatives to enable them to participate in deliberations of the Council and to pay for reasonable expenses associated with their participation in the Council. • Composition: An odd number of members, not to exceed 21 for a single-county Council, or 25 for a multi-county Council. At least 51% elderly people, people with physical disabilities, and people with developmental disabilities and their representatives; of these, at least two-thirds must be elderly people, people with physical disabilities, and people with developmental disabilities; up to one-third may be their family members, guardians, or other advocates; consumer representatives must be proportional among the three target groups. Balance of membership: up to 4 County Board supervisors or other elected officials (or 1 from each county in a multi-county Council of more than 4 counties), LTC service providers, county residents with recognized ability and demonstrated interest in LTC (similar to language for Human		• Requirements for local agencies, esp. CMOs to consult with Council and to attach Council's recommendations to its applications

Topic	Statute	Rule (allow emergency rules throughout)	Contract

	Service Boards, except don't exclude providers, as these provisions do). If tribal lands are located in the county, at least one member appointed by each affected tribe.
	• Appointment: by the County Board(s) or County Executive(s) if applicable — similar to process for Human Service Boards, 51 Boards, and Social Service Boards in current statutes. If tribal lands are located in the county, at least one member of the Council must be appointed by the elected governing body of the affected tribe. Consumer representatives are appointed from a pool of nominations submitted to the County Board or County Executive by consumers, family members, guardians, and local organizations representing older people and/or people with disabilities.
	• Terms: 3-year; staggered; initial terms of 3,4 and 5 years; members serve until replacement is appointed; not more than 2 consecutive terms
	• Responsibilities (initial and ongoing) See pp. 50-53 and Appendix 5 of proposal (include all).
	• Tribal planning:
	  • To be certified as a Resource Center or CMO, tribe or tribal organization must demonstrate that it has involved consumers, other tribal members, providers and other stakeholders, through a tribal LTC Council or through another process similar to that required of counties, in determining what roles the tribe or tribal organization would undertake, and in developing its application(s).
	  • Tribal LTC Councils or their equivalents must include representatives of counties within which tribal lands are located.		

Department	Secretary shall solicit, not later than 3 months after effective		• Specific

Topic	Statute	Rule (allow emergency rules throughout)	Contract
powers and duties	date of legislation, nominations to membership on the State LTC Council from elderly people, people with physical disabilities, people with developmental disabilities, their family members, guardians and other advocates, provider organizations, counties and tribes, and others with knowledge and interest in development and guidance of the state's LTC system. Department shall provide lists of nominations to the Governor. The Governor shall make all appointments to the Council from these lists, except for the Council chair. 46.281(1)(b) 2 • Department shall provide information to and seek recommendations from State LTC Council on all matters listed in the responsibilities of the Council (see above). Department shall provide training to consumer representatives to enable them to participate in the Council and shall pay reasonable expenses associated with their participation. 46.281(1)(a) 46.281(1)(c) • Department shall apply for necessary federal waivers to implement the Family Care benefit for Medicaid recipients • Department shall implement the new LTC system so that Resource Centers, Care Management Organizations, and the Family Care benefit are available in all parts of the state within 6 years after enactment of enabling legislation and receipt of necessary federal waivers. (Lay out rough timetable, as shown on pp.64-66 of proposal) 46.281(1)(d) 46.281(1)(d) • Authorization for Department to phase in implementation and to transfer funds within/between appropriations as the new system becomes available to a target group/geographic area. 20.435 ? • Prior to contracting with any organization to perform Resource Center or CMO functions, Department shall consult with County and Tribal LTC Councils. Department shall consider the recommendations of these councils in making its determination regarding how many contracts are awarded and to whom. 46.281(1)(b)	46.287(1) 46.287(2)	performance standards, requirements for QA/QI processes, etc. • Specifics of what Department is buying from external advocacy organizations; response time requirements, etc.

Topic	Statute	Rule (allow emergency rules throughout)	Contract
46.281 (1)(e)	Department shall certify that all organizations applying to operate a Resource Center or a CMO meet all requirements established by the Department.		
46.281 (1)(f)	Department shall contract with organizations to serve as Resource Centers and CMOs.		
	Department shall contract with one/more external organization(s), independent of any Resource Center or CMO, to provide advocacy to LTC clients.		
46.287	Department shall promulgate rules as required for implementation of the new system (specify topics where rules are needed).		
46.281(1)(g)	Department shall develop and implement per person monthly rate structure for the Family Care benefit and may develop risk-sharing arrangements in contracts with CMOs, in accordance with applicable state and federal laws and regulations.		
46.281(2)			
46.281(1)(h)	Department shall develop standards for management information systems.		
	(Grouped in a paragraph on quality):		
46.281(1)(i)1.	Department shall establish and enforce standards for Aging Resource Centers and Disability Resource Centers.		
2.	Department shall use performance expectations related to consumer-based outcomes in its contracts with CMOs and Resource Centers and as part of its overall quality assurance and improvement efforts		
3.	Department shall conduct ongoing evaluation of new system		
4.	Department shall require that QA & QI mechanisms are built into each component of the LTC system		
5.	Department shall assure external quality reviews of Resource Centers and CMOs		
6.	Department shall make accessible to the public information about the results of findings about the quality of specific organizations in the LTC system		

Topic	Statute	Rule (allow emergency rules throughout)	Contract
Aging and Disability Resource Centers 46.283 (1)(a)	• Who may serve in this capacity ✓ Counties & tribes have right of first selection (see proposal). (Note: this includes multi-county consortia, quasi-governmental "authority" created by county, multi-tribe consortia, county-tribal consortia, and private, multi-tribal organizations like GLITC) ✓ If county declines at any time, does not volunteer by three years after effective date of legislation or federal waiver approval, whichever is later, or cannot meet standards, Department may contract with private, not-for-profit organization that applies and meets standards. 46.283 (1)(b) ✓ If receipt of federal waivers requires it, the Department may contract with non-county agencies for certain functions to be provided through Resource Centers. 46.283 (1)(c) ✓ Must meet standards established by Department, including: Governing board separate from CMO; at least 25% elderly and/or people w/ disabilities and/or their families and guardians, representative of the client group(s) served by the Resource Center. (See appendix 5) 46.283(5)(a)+(b) ✓ The Department shall assure that, at minimum, all of the following are available through consumer contact with a Resource Center:: 46.283(2) (a) ✓ Information, referral and assistance at hours that are convenient for the public (b) ✓ 24-hour emergency screening and response (c) ✓ Prevention and intervention services (d) ✓ Benefits counseling and financial planning services (e) ✓ Determination of functional eligibility for the Family Care benefit (f) ✓ Determination of maximum client cost sharing amount under standards established by the Department		• Minimum geographic area for Resource Center (i.e., when we would allow less than full county) • Expertise, linkages, other items listed under "Requirements for Resource Centers" in proposal • Balance of functions from list in proposal • Compliance with civil rights requirements • Many other requirements

Topic	Statute	Rule (allow emergency rules throughout)	Contract
46.283 (2)(g)	• Assistance to eligible individuals regarding their choices of whether to enroll in a CMO, and if so, which available CMO would best meet their needs.		
(h)	• Assistance in enrollment in a CMO for individuals who choose to enroll.		
(i)	• Management of any necessary waiting lists for Family Care for people who are eligible at the intermediate level and neither Medicaid-eligible nor confirmed as having a need for adult protective services.		
(j)	• Assessment of risk for each person who is on a waiting list for Family Care; develop, with the person, an interim plan of care and assist the person to arrange for services.		
(k)	• Transition services to families whose children with disabilities are about to enter the adult service system.		
(l)	• If a county agency, adult protective services and elder abuse services		
(m)	• If a county agency, certification of eligibility for SSI-E, Medicaid and food stamps		
46.283(3)	• Requirements:		
(b)	• Must cover minimum geographic area, as defined by Department		
(c)	• Must submit all reports and data as required by the Department		
(d)	• Must develop and implement internal quality improvement and assurance processes that meet Department standards		
(e)	• Must cooperate with external quality assurance reviews		
46.283(4)(a)	• From the appropriation under ____, the Department shall contract with organizations that meet requirements under ____ and shall allocate funds for services to be provided through Resource Centers. s		
(b)	• County matching funds required on allocation for certain RC functions (work is underway to determine percentage and specific portion of funding that is matchable)		

Topic	Statute	Rule (allow emergency rules throughout)	Contract
Eligibility for Family Care; definition of benefit	• Define functional eligibility at two levels Require Department to promulgate rules for interpretation of definitions; allow emergency rules) • Any person receiving services through COP, or MA HCB Waiver as of the effective date of legislation is also eligible, regardless of whether he/she meets functional eligibility test. • Age (18+), primary disabling condition not mental illness, any other restrictions on eligibility • Access to Family Care is only through enrollment in a CMO • Financial eligibility and cost-sharing criteria • Define Family Care benefit (DHFS attorneys will help with this)	• Detail related to functional eligibility criteria at each level, including exclusions • Detail related to financial eligibility criteria • Detail on cost sharing	
Entitlement to public subsidy for LTC services	• Who is entitled to public subsidy for Family Care benefit (those at higher levels of functional disability plus those who meet intermediate level of care and are categorically eligible for Medicaid and/or have confirmed APS needs, and who meet financial test). • Persons who are eligible, but not entitled (those at lower levels of functional disability and neither categorically eligible for Medicaid or needing adult protective services) • Direction to Department regarding management of waiting lists for people eligible but not entitled (more detailed instructions to follow)	• Additional detail interpreting eligibility vs. entitlement.	
Care management	• Department is authorized to contract with CMOs, including county agencies, to manage care under a prepaid, per person monthly payment system • Counties/tribes have right of first selection to operate CMOs, without competition for first two years (see proposal). (Note: this includes multi-county consortia, quasi-governmental "authority" created by county, multi-tribe consortia, county-tribal consortia, and tribal organizations like GLITC)		• Detailed requirements for CMOs (including balance of list from pp. 38-40 of proposal) • Balance of functions from list in proposal

Topic	Statute	Rule (allow emergency rules throughout)	Contract

46.284(5)(a)
46.284(5)(b)
46.284(3)(a)
 	
46.284(2)6.
 	
46.284(2)7.
 	
46.284(2)9.
	• If county declines at any time, does not volunteer within four years after effective date of legislation or approval of federal waiver, whichever is later, or cannot meet standards, Department may contract with a non-county organization that applies and meets standards.
	• Requirements for CMOs:
	  • Requirements for composition of governing board and separation of it from Resource Center governing board (See Appendix 5) — Duties
	  • Must accept requested enrollment of any person eligible for public subsidy of Family Care benefit; must offer care management services to people who qualify functionally but are private pay
	  • Must retain any enrollee (i.e., no involuntary disenrollment except under exceptional circumstances; each requested involuntary disenrollment must be reviewed and approved by the Department)
	  • May not encourage any enrollee to voluntarily disenroll in order to access LTC services through the Medicaid fee-for-service system.
	  • Must demonstrate specific expertise in the needs of each group it will serve, including strong connections to that group's typical LTC service providers. If the CMO specializes in one group, it must demonstrate that it can meet the special needs of members whose needs cross target group definitions.
	  • Must demonstrate thorough knowledge of local LTC and other community resources, including LTC resources designed to serve consumers in the least restrictive environment possible.
	  • Must demonstrate thorough knowledge of methods for maximizing informal caregivers and community resources and integrating them into an overall plan of care.
			• Specific requirements and definitions for minimum services to be available in network; process requirements for personalizing care plans, etc.
			• Specifics of assessment, care plan and care monitoring processes
			• Specifics of rates to be paid
			• Specifics of required tools that must be used for assessment, care plan
			• Specifics of reporting requirements
			• Specifics of requirements for adequate consumer choice of providers to meet identified needs of enrollees
			• Specifics of consumer-directed care (who's

Topic	Statute	Rule (allow emergency rules throughout)	Contract
46.284(2)(b)2. 46.284(2)(a)10. 46.284(2)(b)3. 46.284(2)(b)4. 46.284(2)(b)5. 46.284(3)(b) 46.284(3)(c) contractual 46.284(2)(A)1. 46.284(3)(e)	• Must meet all state and federal requirements and performance standards, including case management standards. • Must cover minimum geographic area, as defined by Department • Must submit all reports and data as required by the Department • Must develop and implement internal quality improvement and assurance processes that meet Department standards • Must cooperate with external quality assurance reviews • Functions of CMO: • Conduct, for and with each enrollee, a comprehensive assessment, using standard format provided by the Department, that shall include face-to-face interview. • Develop, with enrollee, and his/her family/guardian as appropriate, a comprehensive care plan • Assessment must solicit, and care plan must address consumer preferences and values. • Have available the full range of LTC services required in its contract with the Department, and provide them in accordance with each enrollee's personal care plan • Have available a sufficient number of accessible providers to ensure that enrollees can choose from among a broad array of providers that meet the needs of its enrollees; develop plans for its provider network and review existing networks in consultation with Local LTC Council. • Must make available options for self/family directed care as specified in its contract with the Department		eligible, options that must be offered, etc.) • Specifics of geographic catchment areas. • Specifics of risk sharing arrangements • Many other requirements
Client rights, responsibilities, and protection of rights	• LTC client rights and responsibilities (Specifics of this are being worked on by a workgroup.) • Medicaid recipients retain all current rights, including right to grieve to state at any time.	**Note**: some of this probably goes in the "statute" column; workgroup will help with	• Specific requirements of Resource Centers and CMOs

Topic	Statute	Rule (allow emergency rules throughout)	Contract
	• Department shall establish rules for what actions may be appealed to the state (Specifics of this are being worked on by a workgroup.)	the "sort." • Details of complaint, grievance and appeal processes. (What is grievable for whom? Eligibility issues, entitlement issues, care plan issues, etc. Notice, due process, other process issues at each level. • Details of what types of complaints, grievances or appeals may come to the state for formal review, when in the process, what kind of review, etc. • Details of what types of appeals may go to judicial review • Note: these need to be sorted by questions of eligibility, entitlement, and service provision/denial once found eligible/entitled. Also, need to determine what in current statutes needs to be	regarding their internal grievance, complaint and appeal processes and requirements for passing on to next level • Specific requirements for internal advocacy

Topic	Statute	Rule (allow emergency rules throughout)	Contract
		updated to make a more cohesive system.	
Require pre-admission screening and provision of information to current residents by Resource Center	• Require functional screen for all new long term admissions to NHs, CBRFs, other licensed/certified residential LTC facilities; assessment and care plan also required for all new long term admissions of people who are currently financially eligible for public payment for LTC costs or who are likely to be eligible within 1 year. (See proposal.) • Short-term admissions exempted (for under 90 days for post-acute, rehabilitation, terminal care, etc. - same as current exemptions for COP assessments, plus see pp. 7-8 of proposal) • Define penalties for licensed/certified facilities (NHs, CBRFs, AFHs and RCACs eligible for public funding) that do not comply with requirements related to admission of persons without required referral to a Resource Center . (Update current requirements related to COP assessments; further instructions to follow.) • Require Continuing Care Retirement Facilities that are regulated by OCI and Residential Care Apartment Complexes that are registered with DHFS (but not certified) to provide information about Resource Center services and the Family Care benefit to new admissions prior to admission. • Require Resource Centers to provide information about Resource Center services, the availability of functional screen, assessment and care plan, and the Family Care benefit to all current residents of LTC residential facilities within 6 months of local availability of these services. • Direct Department to promulgate rules in this area (see next column for topics to be covered (may be additions)	• Define processes that Resource Centers, CMOs and facilities must follow to assure timely screens, assessments and care plans • Define in more detail who must have screen, assessment and/or care plan and when. • Cost sharing requirements for assessments and care plans for private pay individuals	• Specific Resource Center requirements for timely responses to requests from hospitals, LTC facilities and others for functional screen. • Specific CMO requirements for timely response to requests from hospitals, LTC facilities, consumers and others for assessment and care plan. • Detailed Resource Center requirements for providing information, within specified time period to residents of LTC facilities about services of Resource Center

Topic	Statute	Rule (allow emergency rules throughout)	Contract
			and the Family Care benefit
Adult Protective Services	• From the appropriation under ___, Department shall allocate funds to each county for provision of adult protective services (define - see p. ___ of proposal). • County match requirements (further instructions to follow)		• Detailed requirements for provision of adult protective services (through state/county contract)
Appropriations	• Create new appropriation(s) for LTC and authorize the Department to transfer funds between appropriations as necessary (further instructions to follow)		
Transition	• Allow the Department to waive any COP, Medicaid Waiver or Medicaid fee-for-service statutory provision or regulation for counties for up to 5 years, provided that (a) such waivers are in compliance with federal law and are consistent with the program's intent; and (b) the waivers are deemed necessary for the effective implementation of Family Care.		
Replaced by instructions 9/12/98:	• Reduce the maximum allowed county-specific COP carryover from 10% of its allocation to 5% or $_____, whichever is greater; remove limitation that carried-over funds must be spent within the following calendar year; authorize carried-over funds to be used for either spending for client services or investment in a risk reserve for Family Care. • Remove the $500,000 limit on the COP High Cost Fund (allowed carryover of unspent funds under s.46.27 (7)(g)) to allow use of the fund for planning and implementation of the new LTC system. • "Sunset" requirements for COP assessments for new NH and CBRF admissions at the point where screens through Resource Centers are available in a county to take their place. • Direct the Department to propose, within six months of enactment of this legislation, a plan for how it will reorganize		

Topic	Statute	Rule (allow emergency rules throughout)	Contract
	itself to effectively implement and manage the LTC system. Note: This whole area of the transition to the new system across the state, as well as within a county needs more work. Workgroup being formed to make recommendations.		
Other amendments to current statutes	• Amend existing statutes regarding various LTC programs as necessary (e.g., cross references, program requirements for programs that will no longer exist as free-standing programs when the new program is fully phased in, etc.) • Current law requires RCACs to be certified to receive MA Waiver funding; expand this to include Family Care funding. • Authorize counties, or multi-county consortia, to create special-purpose quasi-governmental corporations to operate CMOs (similar in structure to housing authorities). Specify that employees of these authorities retain any rights to public pension funds, county benefits. • Authorize counties to create cash reserves for CMO risk reserve fund. • Authorize counties to contract with providers using prepaid or postpaid contracts which provide a fixed payment for each person served by the provider in return for a defined set of expected outcomes determined by the county, provided that the county has in place a system approved by the department to monitor and assess the outcomes of such contracts. • Authorize counties to enter into a joint venture with a private or public organization, provided the articles of incorporation, governance system, risk-sharing agreement, and general structure of the joint venture are approved by the Department and the county board of supervisors. (Act 268 provides a beginning of what is needed; broaden to other types of county agencies and for LTC services, not just mental health.) • Create new category for CMOs under Office of the Commissioner of Insurance regulatory requirements. (Specifics are being negotiated through a work group that includes OCI.)		

replaced by later instructions

Topic	Statute	Rule (allow emergency rules throughout)	Contract
	• Will need changes to allowable cost statutes (e.g., 46.036) for CMOs and possibly Resource Centers (details being negotiated through a work group) • Note: This is the beginning of what will be a long list; additional instructions will follow; LRB will undoubtedly have many questions in this area.		

Redesigning Wisconsin's Long Term Care System

Many people need help taking care of themselves because of frailty or a developmental or physical disability. Long term care includes many different services, like personal care, housekeeping or nursing. Long term care is provided in people's homes, in nursing homes, in small and large residential care facilities or group homes, and in the workplace.

Most long term care is actually provided by family members, and people pay directly for a lot of care. Yet the government in Wisconsin still spends more than a billion dollars a year paying for care that people themselves cannot afford.

To help determine how to improve long term care, the state Department of Health and Family Services has spent more than two years gathering information not only from people affected by the current system, but also their relatives and service providers, as well as experts and taxpayers.

A new plan called Family Care is now proposed for consideration by citizens and their elected representatives.

Goals

Keep it simple...

- Fewer rules and more focus on giving people the kind of help they need.
- "One-stop shopping" to learn about available services and housing, costs and government benefits.
- Well-publicized Aging and Disability Resource Centers to give information and advice and help people sign up for programs.
- A Care Management Organization arranges and pays for all services.

Make it affordable...

- Promote prevention and timely intervention to reduce the need for care.
- Give the right help to the right people in the right places at the right time to reduce unnecessary cost.
- Help people make plans and decisions about how to stay (or become) more independent.

Give people better choices...

- Make a variety of kinds of help available so people can choose what suits them.
- Make it possible for more people to live in their own homes or in other places where they and their families can continue to do as much as they are able.
- Welcome families, friends and neighbors, as well as paid caregivers, to the care team.

Serve the public...

- Everyone can use the local Resource Centers and Care Managers, whether or not government payment is needed.
- Everyone who is not poor pays what they can toward the cost of care.
- Taxpayers support services for people based on their level of disability and need for financial help.
- People with disabilities who want to work are enabled to do so by getting the supports they need, while paying what they can for health and long term care.

People define quality...

- People who use services are involved in decision-making.
- People who use services report on the quality of care and information they get.
- Quality is measured by comparing how well different people thrive with the care they receive.
- Privacy and self-determination are required in service delivery and protection of information.
- Safety and rights are protected.

Old and new tools for success:

- The flexible services currently available in Wisconsin's Community Options Program continue to be available.
- High quality nursing homes, residential facilities, apartments and community and day service providers continue to be supported.
- Care coordination and service management designed to address individual preferences and goals are required in every service setting.
- New Aging and Disability Resource Centers are organized by county and tribal governments to offer good information to the public and quick access to care.
- People who choose to sign up for the new program provide information for an inventory of how much assistance they need.
- Government programs are simplified in one funding stream with common rules and purposes for elderly people and other adults with disabilities.
- Funds are channeled through local Care Management Organizations in a monthly payment for each person based on a level of need.
- Current Medicaid services continue for people who don't qualify for or don't choose the new long term care program.
- People who sign up get help designing a plan for care, and get help obtaining services from qualified providers who meet the person's needs and provide satisfactory service.
- People who are able and willing to manage their own services are supported to do so.

Services and benefits...

Many funding sources are combined to support the widest range of choices. A monthly payment from the state, combined with the person's cost-share, can be used for any needed services.

Community Options...Brought into home or neighborhood.

Residential Options...Provided by licensed or certified Community Based Residential Facilities and Residential Care Apartment Complexes.

Nursing Home Options...Provided by licensed Nursing Facilities.

Sunset COP Assessment: Issues

Questions: (NO)

Does this ~~eliminate~~ assessments under COP entirely? They are crucial, at present, for determining eligibility for COP, ~~=~~ What about DD people?

How to determine when a nc is available? (Important, bec. of penalty.) Secy to send notice to co. + to n. hs. in area = (Yes) + cbrfs

Also affects 46.277 - CIP - Keep

Affect COP C-BRF staff
NH penalties, etc

Kennedy, Debora

From: Lorraine Barniskis [BARNILO@dhfs.state.wi.us]
Sent: Monday, November 30, 1998 5:53 PM
To: InfoTech.EMX.FOSSUG@dhfs.state.wi.us; Kennedy, Debora
Cc: ALLENJB@dhfs.state.wi.us; BOVEFE@dhfs.state.wi.us; InfoTech.EMX.gpotarac@dhfs.state.wi.us; KIESOJA@dhfs.state.wi.us; LEWISKA@dhfs.state.wi.us; WILHECA@dhfs.state.wi.us
Subject: Follow up instructions


kndy1130.doc

Here's more detail on two pieces:
- Clarification about roles of State LTC Council and the existing Board on Aging and Long Term Care; and
- Preadmission screening requirements.

I'll send hard copy to those of you outside our LAN, in case the attachment doesn't travel well via electronic means.

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF SUPPORTIVE LIVING
1 WEST WILSON STREET
P.O. BOX 7851
MADISON WI 53707-7851

Date: November 30, 1998

To: Debora Kennedy - LRB
Gretchen Fossum - DOA

From: Lorraine Barniskis - DHFS

Re: Further Information on Family Care Legislation

We have developed more detail in several areas of the Family Care legislation, as outlined below. Please let me know if you have questions. I plan to get you additional information in other areas by the end of this week, including some of the transitional issues.

1. Overlap between requested language to establish the State LTC Council and existing language related to the Board on Aging and Long-Term Care (BOALTC).
In conversations with the Director and other staff of BOALTC, we have agreed that the State LTC Council will have broad planning and oversight responsibilities for the state's LTC system, while the BOALTC will focus on its current primary mission of providing advocacy and ombudsman services for residents of LTC facilities. To clarify this intent, we suggest the following changes to the section 16.009 of the current statutes. BOALTC's director has reviewed and agreed to these changes.

From Gretchen Fossum 12/3/98: DO Not Draft

- In s.16.009 (1) (em), add a definition for residential care apartment complex, so that the list of types of residential LTC facilities will include this relatively new type of facility.

- Amend the following parts of s.16.009 (2) to clarify that the Ombudsman's role is focused on issues related to residential facilities:

(b) 1. Investigate complaints from any person concerning improper conditions or treatment of aged or disabled persons who receive care in a long-term care facility or concerning noncompliance with or improper administration of federal statutes or regulations or state statutes or rules related to long-term care facilities for the aged or disabled.

**** Note

(b) 2. Serve as mediator or advocate to resolve any problem or dispute relating to long-term care facilities for the aged or disabled.

(d) Promote public education, planning and voluntary acts to resolve problems and improve conditions involving long-term care facilities for the aged or disabled.

~~(em) Monitor, evaluate and make recommendations concerning long-term community support services received by clients of the long-term support community options program under s. 46.27.~~

(h) Conduct statewide hearings on issues of concern to aged or disabled persons who are receiving or who may receive care in a long-term care facility.

(I) Report annually to the governor and the chief clerk of each house of the legislature for distribution to the appropriate standing committees under s. 13.172 (3). The report shall set forth the scope of the programs for providing residential long-term care for the aged or disabled developed in the state, findings regarding the state's activities ~~in the field of~~ related to long-term care facilities for the aged and disabled, recommendations for a more effective and efficient total program and the actions taken by the agencies of the state to carry out the board's recommendations.

2. Specific requirements for pre-admission screening for residential care.
Please note that the following requested provisions differ somewhat from our original instructions. As we have discussed this area further and gained some experience through the Aging and Disability Resource Center Pilots, we have refined what we believe will work. If you need further detail, I can provide you with a copy of the report of a workgroup that has developed specific process requirements for a variety of situations in which pre-admission screening will apply.

- Require every nursing home (including ICF-MR), Community Based Residential Facility (CBRF), Adult Family Home (AFH) and Residential Care Apartment Complex (RCAC) to inform prospective residents about the services of the Aging and Disability Resource Center, the Family Care benefit, and the right to request a functional and financial eligibility screen for the new benefit, within timeframes established by the Department under rule.
- Require hospitals, prior to discharge of a patient who is elderly or who has a physical or developmental disability and whose disability or condition requires long term care that is expected to last at least 90 days, to refer such individuals to the Aging and Disability Resource Center. Require the Department to specify these requirements in rule.
- Require nursing homes (including ICFs-MR), CBRFs, AFHs and RCACs to refer any person seeking admission who is elderly or who has a physical or developmental disability and whose disability or condition is expected to last at least 90 days, to the Aging and Disability Resource Center within the timeframes established by the Department under rule. The following admissions are exempt from this requirement:
  - A person who has had a functional screen for Family Care within the previous 6 months.
  - A person who enters the facility for respite care.
  - An individual who is enrolled in a Care Management Organization for the Family Care benefit.
- Require the Department to establish by rule penalties for failure to comply with these requirements and authorize it to impose penalties. Specify that the penalty for nursing homes is a Class C violation.

- Sunset current requirements for a Community Options Program assessment prior to admission to a nursing home or CBRF (along with respective penalties), effective when a local Aging and Disability Resource Center is available to provide a functional screen under Family Care.
- **For current residents**: Require Aging and Disability Resource Centers to provide information about its services, including the availability of the functional screen, assessment and care plan, and the Family Care benefit to all current residents of NHs, CBRFs, AFHs and RCACs in its area within six months of local availability of the Family Care benefit in its area. Require that they provide a screen to any current resident requesting one and assist anyone they find eligible to enroll in a CMO for the Family Care benefit if the person chooses to enroll.

cc: George Potaracke - BOALTC
John Kiesow - DHFS/SO
Kevin Lewis - DHFS/SO
Chuck Wilhelm - DHFS/OSF
Fredi Bove - DHFS/OSF
Joyce Allen - DHFS/OSF

Don't forget co. depts. authorize to be CMO or RC

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF SUPPORTIVE LIVING

1 WEST WILSON STREET
P.O. BOX 7851
MADISON WI 53707-7851

From G.F. 12/10/98: This may be drafted DAK

Date: December 8, 1998

To: Gretchen Fossum - DOA/Budget

From: Lorraine Barniskis - DHFS/DSL/BALTCR

Re: Additional Information for Family Care Legislation

As requested, here are additional details regarding some of the items in our original drafting request.

Risk Management

You asked for clarification on several items related to management of financial risk in the new LTC system. We are sending a separate memo on the issue of regulation by the Office of the Commissioner of Insurance, which suggests language that has been agreed to by OCI staff. Key OCI staff are out of town today, but a response from them has been promised by Wednesday, Dec. 9.

With respect to the other items mentioned in the original list of risk-related issues that need to be addressed in the legislation, here is some clarification. The new subsection dealing with funding and risk-sharing (s.46.284 (4)) should include the following concepts:

- The funds for capitated payments include state and federal Medicaid funds and state GPR.
- Notwithstanding allowable cost policy requirements or any other provisions of s.46.036, care management organizations, including those operated by county departments under s. 46.215, 46.22, 46.23, 51.42 or 51.437, may be funded by the department and may expend funds consistent with this section.
- If a care management organization's family care expenditures exceed payments received under family care, the department is authorized to share in that loss, within the limits established under its contract with the care management organization.
- If a care management organization's family care payments exceed its family care expenditures, it may retain a portion of these savings and may be required to return a portion to the department, as specified in the contract.
- Authorize the department, through its contracts with care management organizations, to impose solvency protections that it deems reasonable and that are necessary to retain federal financial participation. These protections may include requirements that a risk reserve be segregated from other funds of the organization or its parent organization (including the county) and that interest or other gains accruing from the fund must remain in the fund.

- Authorize counties to establish risk reserves and to place the reserve in a separate account to be used only for Family Care.
- Clarify that CMOs are responsible for subcontracting, including determining whether or not a limit is placed on the subcontractor's profits. The Department's role is to review subcontracts and rates to protect consumer access and CMO financial viability.
- Authorize CMO, including county CMOs, to subcapitate payments to providers. Require the Department to obtain annually an independent of each CMO.
- If the CMO ceases participation in family care, the risk reserve, minus any contribution of non-Family Care funds, shall revert to the state to be used for payment of providers with outstanding bills and for the continuation of services to enrolled Family Care participants.

Eligibility issue

In our proposal, a person is assured of family care services if they meet functional eligibility criteria at the intermediate level and are "in need of adult protective services." We would like to clarify the underlined criterion as follows:

The entitlement applies to a" person with a substantiated need for adult protective services." A person in need of adult protective services is a person who has a physical or mental condition which:

(1) substantially impairs the ability of the person to adequately care for his or her needs, including, but not limited to the need for food, shelter, clothing, personal care, health care, money management, safety, mobility or communication; and

(2) is experiencing, or is at risk of experiencing, abuse, financial exploitation, neglect, or self-neglect. "At risk" means that there is reasonable cause to believe that abuse, financial exploitation, neglect, or self-neglect will occur.

Statement of rights

You requested that we pare down and reformat the materials we sent earlier on consumer rights. Our revised request is attached (*Attachment 1*).

Federal Waivers:

Please include language directing the Department to obtain necessary federal waivers to implement the new LTC system for Medicaid recipients. Please use the waiver directive for W-2 as a model, rather than the language s.49.665. The phrasing of the latter provision allows the Department to implement Badger Care only if a waiver is consistent with all of the state statutory provisions for that program, precluding us from implementing the program partially in the absence of such a waiver.

Transitional Provisions:

The following provides more detailed information on some of the transitional items that were included in our original instructions submitted on July 31, 1998 and/or our proposal of the same date.

- Amend s. 46.27 (7) (g) to remove the cap on the amount of COP funds and broaden authorized uses, enabling the Department to fund start-up costs of Aging and Disability Resource Centers and Care Management Organizations with any available funds from this source, as follows:

(g) The department may carry forward to the next state fiscal year ~~up to $500,000 of~~ funds allocated under this subsection and not encumbered by counties by December 31 or carried forward under par. (fm). The department may transfer moneys within s. 20.435 (7) (bd) to accomplish this purpose. An allocation under this paragraph shall not affect a county's base allocation for the program. The department may allocate these transferred moneys during the next fiscal year to counties for planning and implementation of aging and disability resource centers under s. 46.283 or care management organizations under 46.284, and for the improvement or expansion of long-term community support services for clients whose cost of care significantly exceeds the average cost of care provided under this section, including any of the following:

1. Specialized training for providers of services under this section.
2. Start-up costs for developing needed services.
3. Home modifications.
4. Purchase of medical equipment or other specially adapted equipment.

Rationale:
While on-going benefits of higher quality and cost-effectiveness are expected under the redesigned LTC system, counties will first need to make substantial one-time investments in the infrastructure needed to support the new system. The suggested amendment would allow any underspending in the Community Options Program to be used to offset these costs.

- Several amendments to s. 46.27 of the statutes are requested to authorize counties, with Department oversight, to use county underspending in COP to begin a risk reserve in anticipation of operating a CMO. Suggested amendments are as follows:

Amend s. 46.27 (2) to add:
46.27 (2) (k). Review and approve or disapprove the terms of escrow accounts created under sub. (7) (fm) and approve or disapprove disbursements for staff or administrative costs from the escrow accounts.

Amend s. 46.27 (7) (fm) as follows:
46.27 (fm) 1. The department shall, at the request of a county, carry forward up to 10% of the amount allocated under this subsection to the county for a calendar year if up to 10% of the amount so allocated has not been spent or encumbered by the county by December 31 of that year, for use by the county in the following calendar year. This amount shall be reduced by the amount of funds remaining in the county's risk reserve escrow account under subd. 2. at the end of the calendar year. The department may transfer funds within

s. 20.435 (7) (bd) to accomplish this purpose. An allocation under this paragraph does not affect a county's base allocation under this subsection and shall lapse to the general fund unless expended within the calendar year to which the funds are carried forward. A county may not expend funds carried forward under this paragraph for administrative or staff costs, except administrative or staff costs that are associated with implementation of the waiver under sub. (11) and approved by the department.

GAF note: the original drafting instructions (page 14) reduced the maximum carryover from 10% to 5%. The department has decided to leave the carryover at 10%.

2. The county may expend funds allocated under this section and not needed for services under sub. (7) or sub. (11) to create and maintain a Community Options risk reserve. The annual amount of such expenditure may not exceed 10% of the county's allocation made under this section, or a maximum of $750,000, whichever is greater. The total amount of the risk reserve, including interest or other gains accruing from investment of the funds, may not exceed 15% of the county's most recent allocation under this section. The risk reserve must be an interest-bearing escrow account established with an accredited financial institution licensed in the State of Wisconsin under ch. 220 and the terms of the escrow must be approved by the department. The county may disburse funds from the risk reserve at any time only for the purpose of defraying non-institutional long-term care costs under the program. A county may not expend risk reserve funds for staff or administrative costs unless such expenditures are approved by the department. In a form specified by the department, the county shall annually submit a record of its risk reserve status, including all revenues and disbursements. If a county contracts with the department to operate a care management organization under s. 46.284, any funds in a risk reserve created under this paragraph may be used to meet contracting requirements under that contract. If the county creates a long-term care authority under s. xx.xx to operate a care management organization, funds may be transferred to the long-term care authority by resolution of the county board.

Rationale:
In addition to providing counties with an additional management tool to assist in program budgeting for the Community Options Program, this provision will enable them to prepare for assumption of risk-based care management contracts for the new Family Care benefit.

- Amend s. 46.27 (4) and/or create language in the new s. 46.282 (3) to allow a local LTC Council created under s. 46.282 (2) to assume the duties of the county long-term support planning committee under s. 46.27 (4).

Rationale:
This will clarify that the county need not support both the new LTC Council and the existing LTS Planning Committee. The former may oversee the Community Options Program and Home and Community-Based Waiver Programs.

- Please hold other changes to current statutes governing the Community Options Program, the Medicaid Home and Community-Based Waiver Programs, and county responsibilities under Chapter 51 for now. Eventually several of these statutes will need to be updated to account for the transfer of responsibility for providing LTC services from the county to the new LTC system. However, only a few Resource Centers and Care Management Organizations will be operational during the 1999-2001 biennium. So long as we have the requested authority to waive program requirements for COP and the Waivers, we would strongly prefer to wait until next biennium to propose these statutory changes.

GAF note: I infromed Lorraine that DHFS must identify precisely, by number, which statutes are to be waived.

- We have found it necessary to change the proposed phase-in schedule for the new system. The revised schedule is provided in *Attachment 3.*

12/8/98- Attachment 1

Revised statement of rights for Family Care legislation:

46.286

(1) In this subsection, "person" means any individual who is at least age 65, or any individual who has a physical disability or a developmental disability and who has any contact with an aging and disability resource center under s. 46.283 or a care management organization under s.46.284. "Eligible person" means a person who has been determined to meet functional eligibility criteria for long-term care under s.46.28x and financial eligibility for the family care benefit under s. 46.28x. "Enrollee" means a person who is enrolled in a care management organization under s. 46.284.

(a) Each person shall have the right:

(i) To full and accurate information, provided in an understandable and culturally appropriate manner, that will enable the person to make informed choices about possible receipt of long-term care services through either the family care benefit or other long term care service systems.

(ii) To receive a prompt determination of whether he or she meets eligibility criteria under s. 46.28x for the family care benefit.

(iii) To accuracy and privacy of information about the person that is collected by an Aging and Disability Resource Center, a care management organization or any contractor of either of these organizations.

(iv) To full access to any information about the person that is maintained by an Aging and Disability Resource Center, a care management organization or any contractor of either of these organizations.

(v) To be treated with dignity, respect, fairness and to be free from discrimination.

(vi) To assistance in understanding the person's rights and in resolving any dispute that the person may have related to his or her contact with an aging and disability resource center or a care management organization.

(vii) To fair and equitable due process procedures for resolving complaints or disputes.

(viii) To be free from reprisal or the overt or implied threat of reprisal for exercising the right to register complaints or grievances or participating in due process procedures.

(b) Each eligible person shall have the right to choose whether to enroll in a care management organization for receipt of the family care benefit, and to disenroll for any reason.

(c) Each enrollee shall have the right:

(i) To participate fully in planning and evaluating the treatment and services he or she receives.

46.286

(ii) To have a plan of care developed that is tailored to meet his or her unique needs and circumstances as discovered through an individualized assessment.

(iii) To receive services and supports from qualified providers that are prompt, adequate and appropriate for meeting the enrollee's individual needs, that as much as possible preserve the enrollee's health, safety and well being, and keep the enrollee free from abuse and neglect.

46.281 (1)(K)

(2) The department shall promulgate rules to implement these rights and shall include in each contract with an aging and disability resource center and with a care management organization requirements for protections of these rights.

12/8-98 - Attachment 3

Revised Phase-in Schedule

	Resource Centers		CMOs		
	Increment (% of State Population)	Cumulative	Planning and Development Stage Increment (% of State Population)	Fully Implemented CMOs Increment (% of State Population)	Cumulative
July 1- Dec. 31, 1999	15% (9 pilots)	15%	15% (5 pilots)		
Jan. 1 - June 31, 2000	5%	20%	5%	15% (5 pilots)	15%
July 1 - Dec. 31, 2000	10%	30%	10%	5%	20%
Jan. 1 - June 31, 2001	15%	45%	15%	10%	30%
July 1 - Dec. 31, 2001	15%	60%	15%	15%	45%
Jan. 1 - June 31, 2002	10%	70%	10%	15%	60%
July 1 - Dec. 31, 2002	10%	80%	10%	10%	70%
Jan. 1 - June 31, 2003	10%	90%	10%	10%	80%
July 1 - Dec. 31, 2003	10%	100%	10%	10%	90%
Jan. 1 - July 1, 2004				10%	100%

From G. Fossum 12/11/98: The department shall implement RCs and CMOs statewide by December 31, 2004.