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.

From G. Fossum: use 20.435(7) ✓

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.

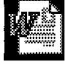
Desired Effective Date: Upon passage.
Agency: DHFS
Agency Contact: Cindy Daggett
Phone: 266-5380

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

Kennedy, Debora

(*) Not agreed to or need to discuss

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Friday, December 04, 1998 11:13 AM
To: Kennedy, Debora
Subject: FW: Comments on first preliminary LTC draft



1drftcmt.doc

Debora:

Here are Lorraine's comments etc.

FYI: The corporation section of the Secretary of State is now housed in the Department of Financial Institutions. GLITC is a corporation registered in the state. Was formed in 1965.

Gretchen

> -----Original Message-----
> From: Barniskis, Lorraine
> Sent: Thursday, December 03, 1998 6:08 PM
> To: Fossum, Gretchen
> Cc: Wilhelm, Charles; Bove, Fredi-Ellen; Allen, Joyce
> Subject: Comments on first preliminary LTC draft
>
> Gretchen,
>
> Here are our comments on the preliminary draft. Please let me know if you
> have
> questions or concerns. Thanks
>
> Lorraine
> <<1drftcmt.doc>>

Date: December 3, 1998

To: Gretchen Fossum - DOA/Budget

From: Lorraine Barniskis - DHFS/DSL/BALTCR

Re: Comments on November 25, 1998 Draft of Family Care Legislation

Reference(s)	**Comments**
p. 1, lines 3-4 p. 2, lines 9-11 and note following	It was our intent that the Governor would appoint a person of his choosing to be the chairperson of the state LTC Council, whether or not the person was on the list of nominees solicited by the Department. It's fine to have him appoint this person for a 3-year term.
p. 1, line 8 through p. 2, line 8	We would like to have 25 members on the council, in order to have room for all the key stakeholders. I suggest the following changes: (b) *Membership*. The council consists of ~~23~~ <u>25</u> members, at least ~~12~~ <u>13</u> of (~~which~~ <u>whom?)</u> are persons who are aged 65 or older or who have physical or developmental disabilities or their immediate family members or other representatives. <u>The proportions of these 13 members are representative of the numbers of older persons, persons with physical disabilities and persons with developmental disabilities receiving long-term care services in the state.</u> Of those ~~12~~ <u>13</u> members, at least 9 are ~~equally proportional among~~ persons who are aged 65 or older, persons who have physical disabilities and persons who have developmental disabilities, and up to ~~3~~ <u>4</u> may be immediate family members of or guardians or other advocates for these persons. The remaining membership consists of representatives of counties ~~or~~ <u>and</u> of federally recognized American Indian tribes or bands; providers of long-term care services; representatives of <u>aging and disability</u> resource centers under s. 46.283 ~~or~~ <u>and</u> care management organizations under s. 46.284; state officials; or community leaders. *NOTES*: If "family members" in this context is part of a group of people who may include advocates, guardians and other representatives, do we need the modifier "immediate"? I don't think we want to require, as the original draft does, that 3 members of the council be people with developmental disabilities. I also wouldn't want to preclude their membership, but I think we want to allow for family members and guardians to represent their interests. For this reason, I'm also suggesting that proportionality apply to the whole group of consumers and their representatives. I changed the "or" to "and" in a couple of places because we definitely want both counties and tribes, and both resource centers and CMOs represented. If the original language accomplishes this, ignore my

Reference(s)	Comments
	suggestions here.
p. 2, lines 16-17	We would like to define "family care benefit" as "financial assistance for long term care and supports for persons meeting functional and financial criteria and enrolled in a care management organization"
p. 2, note following line 20	Yes, "at least 65" is correct.
p. 3, following line 6	Need to add here or elsewhere, requirement that the department train and support consumer members of the state council and that these members be compensated for reasonable expenses. (Similar to language for county boards and local councils.) Also need to add a requirement that the department provide to the state LTC council copies of reports from local LTC councils and other information needed by council members to perform their duties.
p. 3, line 23	I suggest deleting the phrase "under waivers of federal medical assistance laws." This would include the waiver programs not specified in the previous two lines, as well as programs that provide these services.
p. 4, lines 1-7	I suggest the following edits: (c) At the request of a county, tribe, local long-term care council, care management organization or ~~applying~~ organization applying for a contract to operate a care management organization, review, under guidelines established by the council, a preliminary decision of the department concerning... Also, see general comments below.
p. 4, lines 10-11	The phrase "and the levels of their functional needs" comes straight from our proposal, but upon further reflection, we don't know exactly how we would gather or provide that information. Please delete it.
p. 4, note following line 13	Since this is such a flexible benefit, I suggest not adding the modifier "long-term" to "services."
p.4, line 14	I suggest adding the phrase "care management organization" before "enrollments."
p. 4, line 22	Even though I shortened it to "Resource Centers" for ease of reading in a long proposal, I suggest using the full phrase "Aging and Disability Resource Centers" in the statutory language.
p. 6, lines 6-15 and p.6, line 16 through p.7, line 5	Again, cutting back on the number of overall members really curtails the ability to include all major stakeholders when over half the membership must be consumers and their representatives. We would like to be as flexible as possible in allowing counties to determine the size they want. Does it really matter if the percentage requirements result in a fraction, since they are modified by "at least"? If you round down, you don't meet the requirement; so you have to round up. If you agree, please go back to

Reference(s)	Comments
	our original proposal: For the single-county council: An uneven number of members, up to 21 For the multi-county: An uneven number of members, up to 25 If you think this is a problem, we propose the following alternative: For the single-county council: 21 members, at least 11 of whom are consumers/family, etc. Of these, at least 8 are elderly/disabled people; up to 3 family members, etc. For the multi-county: 25 members, at least 13 of whom are consumers/family, etc. Of these, at least 9 are elderly/disabled; up to 4 family members, etc. For both: Please change proportionality language similar to that suggested for the state council.
p. 6, lines 3-4	We want to enable Great Lakes Inter-Tribal Council to apply to operate an Aging and Disability Resource Center and/or a CMO and need to add a reference to such an organization. Do you have a standard description for them, or do you need us to draft one? Again, please insert "aging or disability" before "resource center."
p. 7, lines 6-10	Does it work to describe a tribal LTC council by only referring to the membership requirements for a county LTC council? The latter specifically includes, for example, county supervisors and other residents of "the county." We could refer to subd. 1 for the consumer representation requirements, but be more specific about other members being associated with the tribe or tribal organization? Wouldn't the analogous requirement be that the membership include up to 3 members of the governing board/council of the tribe/band/organization?
p. 8, lines 1-2	A note that these, also result in fractions. See my note above related to Council membership.
p. 8, lines 6-9	In the last sentence of this paragraph, shouldn't the county board be responsible for training for all members of its local council (including those appointed by a tribe), and a tribe or tribal organization be responsible for training all the members of a council that is advising it (including the county representatives)?
p. 8, note following line 15	Except for the note above, I think these are fine additions.

Reference(s)	Comments
p. 9, note following line 9	The criteria, to the extent they're developed so far, are on p. 49 of the 7/31/98 proposal. These are pretty sketchy, so I suggest that we just refer to criteria established by the Department, in consultation with the state LTC Council.
p. 9, lines 10-14	Do we need to strengthen this to require that the council provide review and recommendations, upon the request of any organization wishing to apply to operate an aging and disability resource center or care management organization. (The organization is required to attach these recommendations to its application, so shouldn't the council be required to provide them if asked? Within a given time frame - say 60 days?) Please see suggestions related to p. 11, lines 11-15 about the content of these comments; maybe you could just cross reference instead of repeating.
p. 9, lines 15-19	In line 15, please change "the" to "any" to allow for the possibility of more than one CMO in an area. In line 19, add "the care management organization and" before "the department." Please add (here or in a new subd.) something like the following: Review initial plans and existing provider networks of any care management organization in the area to assist them in developing a network of service providers that includes a sufficient number of accessible, convenient and desirable services.
p. 10, lines 6 and 23	Please change the phrase "elderly and disabled persons" to "older persons and persons with physical or developmental disabilities."
p. 10, line 8	Suggest adding "policies for" before the word "older." As drafted, it could be interpreted to mean planning for individual people, which was not our intent.
p. 10, line 12	Please change the last part of this sentence to read: "... between the aging and disability resource center and the care management organizations..."
p. 10, line 17	I assume this is just an error.
p. 10, lines 18-19	I suggest the following changes: 12. Identify potential new sources of community resources and funding for ~~the aging or disability resource center and for care management organizations~~ needed services for older persons and persons with physical or developmental disabilities.

Reference(s)	Comments
p. 11, lines 4-5 and note following	I agree with Debora's comments. How about if we change this to the option for them to provide informal complaint mediation, as requested by consumers seeking or receiving services from the aging and disability resource center or the care management organization? Could they do this without statutory authority? Could they have a formal role in grievance mediation/resolution without statutory authority?
p. 11, lines 8-9	Please delete the reference to "nonprofit" and the statutory definition of that term. Any organization, whether for-profit, nonprofit, governmental or quasi-governmental, may apply for and receive a contract to operate a CMO. (Resource Centers, however, may not be for-profit organizations.)
p. 11, lines 11-15	Please change the last sentence of this paragraph to read: An initial or renewal application for certification as a care ~~maintenance~~ management organization shall include the comments and recommendations of the appropriate local long-term care council or councils regarding the ~~optimal number of care mainteance organizations to operate in a given area and which organizations should serve as care maintenance organizations in that area~~ organization and its application. These comments shall include the council's observations about the qualifications and expertise of the organization; the extent to which it meets the requirements under s. 46.284 (2)(a); the extent of its linkages with local service providers, volunteer agencies and community institutions; and, if the organization is in operation, the past experience of consumers of its services.
p. 11, note following line 15	Sorry, this is evolving. An organization that is awarded a contract must be certified; an organization must have a contract in order to operate. Certification is granted if an organization meets standards. We will actually contract with a certified organization only under certain circumstances; e.g., the population of an area will support the inclusion of that CMO, the local council approves, etc. For example, we might receive more applications than could be supported in an area; in that case, we might certify all of those that qualify and request assistance from the local council in deciding among them. This is being negotiated (see general comments below).
p. 11, line 16 through p. 12, line 2 and note following	Does the term "counties" include multi-county organizations, county-tribal organizations and quasi-governmental corporations? If not, we need to come back to this. The phase-in will be county by county, so I suggest changing the first sentence to read: (b) ~~The~~ Within each county, the department shall award the initial contract~~s~~ to operate a care ~~maintenance~~ management organization to ~~counties that~~ the county or to a quasi-governmental organization established by the county under s. 46.28x if the county elects to operate a

Reference(s)	Comments
	care ~~maintenance~~ management organization and meets performance standards established by the department by rule and contract requirements. Instead of tying the exclusivity to the contract itself, as the last sentence of this paragraph does, would it be more straightforward to do something like this: During the first two years in which the county has a contract under which it accepts a per person per month payment for each enrollee, the department may not contract with another organization to operate a care management organization in the county unless one or more of the following apply: 1. The county and the local long-term council agree in writing that one or more additional care management organizations are needed or desirable; 2. The county does not elect to serve all target groups or cannot meet standards for all groups and a care management organization is needed to serve those groups not served by the county organization; 3. An American Indian tribe or band or a tribal organization [*however you define GLITC*] elects to operate a care management organization within the area and meets department standards.
see note 46.284 after (2)	PACE and Partnership references are provided below. In one sense, they're not CMOs, since they integrate acute/primary health services with LTC, include Medicare funding, and operate under specific federal authorizations. Would it be more clear to include a definition of care management organization under the new s. 46.28 and specify that that term does not include: PACE: An organization that has a contract with the department to operate a program of all inclusive care for the elderly (PACE) authorized under subtitle I, sec. 4801, title XVIII of the Social Security Act (42 U.S.C. 1395); Partnership: An organization that has a contract with the department to operate a project under the Wisconsin partnership program under a dual federal waiver that includes both Medicare and Medicaid funds.
p. 13, line 9	Please add, at the end of this sentence, ", including primary and acute health care services."

Reference(s)	Comments
p. 13, line 14 through p. 14, line 10	Sorry, this also is evolving. Since the proposal was written, we have gotten further information from HCFA and are negotiating with stakeholders about how to deal with conflict of interest issues between certain RC and CMO functions. I am guessing that we will end up offering counties that wish to operate both a RC and a CMO two choices: (1) They create a quasi-governmental organization to operate either the RC or the CMO (with the other directly under county board/exec. supervision); or (2) we will contract with an independent organization to perform functional screens and provide choice counseling. In either case, the need for all these specific requirements for separate governing boards and their composition will go away. We do, however, want to retain the requirement that at least 25% of the governing board of each CMO be consumers or their representatives, and that of these, at least two-thirds are older people or people with a physical or developmental disability, representative of the age/disability of people enrolled in the organization (not necessarily actual enrollees, as in the current draft). (Again, do we need the modifier "immediate" for "family member"?) If the CMO is a private organization, we don't want to dictate what its board looks like except that it have strong consumer representation (as above) and that it is reflective of the ethnic and economic diversity of the community it serves. If the CMO is a county organization, do we need statutory authority for the county board/executive to appoint members and/or for county supervisors to serve as members? If not, we could omit further detail on that as well. (Unless the CMO is spun off as a quasi-governmental agency, I assume an existing county department would serve as the CMO, under its current governance.)
p. 14, lines 11-12 and lines 15-16	At the end of each of these sentences, please add "or by contract requirements."
p. 14, line 14	Please add the phrase "or information" after the word "reports." This will make it clear that we have the authority to request raw (unanalyzed, non-aggregated) data or other information.
p. 12 ff.	Lots of references to "care *maintenance* organizations" - can we use a search function to change to "management" throughout the document?
p. 14, line 18 through p.16, line 5	In view of likely changes related to governing board requirements, I think this is too much detail for the statutes. I suggest we come back to this after decisions are made on major issues.

Reference(s)	Comments
p. 16, lines 8-9	I suggest changing the first sentence to read: "...eligible for ~~a public subsidy for a~~ the family care benefit" This would be consistent with the suggestion above for how to define "family care benefit." In the second sentence, please change the last word from "rule" to "contract." Alternatively, delete this sentence. Until we have more experience with "real life," we want blanket authority to prohibit any involuntary disenrollments unless they have been specifically approved by the department. So, we would spell out some parameters in the contract about when we would even consider a request from a CMO to disenroll, and review/approve each such request individually. After we have more experience, we will be able to develop general rule language that provides enough protections for consumers.
p. 16, lines 15-16	Please add a requirement that the comprehensive assessment include a face-to-face interview with the enrollee.
p. 16, lines 17-18	Please change to read: (c) With the enrollee, and the enrollee's family or guardian if appropriate, develop a comprehensive care plan that reflects the enrollee's values and preferences~~, if appropriate~~.
p. 16, after line 18	Please add something like the following: (d) Arrange for and monitor services provided by the care management organization or its subcontractors. (e) Develop, within guidelines established by the department, mechanisms through which an enrollee may arrange for, manage, and monitor services and supports directly or with the assistance of another person chosen by the enrollee. This mechanism must provide the enrollee with a fixed budget, based on the enrollee's level of need, to purchase any services or support consistent with the enrollee's needs and the purposes of Family Care. Enrollees who choose this option must be able to purchase services or supports from any qualified provider, regardless of whether the care management organization contracts with that provider. The CMO must monitor the use of the fixed budget and the ongoing health and safety of any enrollee who chooses this option, and provide a level of support tailored to meet the unique need for assistance of each enrollee who chooses this option. (f) Provide, on a fee-for-service basis, case management services to persons who meet the functional criteria for Family Care, but do not qualify financially for a public subsidy.
p. 19	In the nonstatutory provisions, we need to remember to include a provision directing the Secretary to solicit nominations for the state LTC Council within 3 months of enactment of the legislation.

General comments:

We are in the process of negotiating with major stakeholders on several issues. As a result, we may need further changes in the following areas:

- The role of the local LTC Council (which in turn *may* necessitate some changes in the role of the state council and the department in the certification/contracting process).
- Grandfathering in current clients of long term care services/programs.
- Resolution of conflict of interest issues and implications for structural requirements for how CMOs and Resource Centers are governed.

Please convey my thanks to Debora. It's exciting to see this come together as actual legislation after all the work that so many people have put into it.

cc: Fredi Bove - DHFS/OSF
Chuck Wilhelm - DHFS/OSF
Joyce Allen - DHFS/OSF/CDSD

Kennedy, Debora

From: Lorraine Barniskis [BARNILO@dhfs.state.wi.us]
Sent: Friday, December 04, 1998 12:26 PM
To: Kennedy, Debora
Subject: Possible changes to Family Care legislation

Rich-Text-Format

See attached for possible changes. This is a draft, which is the only format I have in electronic form - but Joe signed something quite like this and discussed it with a group of advocates and county reps yesterday. They are supposed to get back to us next week. Please note that I'm not suggesting you draft from this memo yet, but I did want you to be aware of the areas where things might need to change in order to get the support we need.

The other possible, and really major change is that this legislation may not include people with developmental disabilities at all. They are so scared that they may want us to do only the existing CMO pilots for this biennium, so they can wait and see how this plays out before they commit to statewide coverage. Shortsighted, if you ask me - but there you are.

I'll be working this weekend and you may certainly call me at home if I can be helpful. 233-7207.

(on Dept. letterhead)

DRAFT
for discussion only
11/30/98

Date: November 25, 1998

To: Tom Frazier, CWAG
Craig Thompson, WCA
Lynn Breedlove, WCA
Judy Fell, WCDD

From: Joe Leean, Secretary

Re: Family Care Issues

The Department offers the following information and proposals to the issues raised in your memo of November 12, 1998.

1. ***Adequate Funding***
   We are committed to developing budget projections in this and all other areas of the Family Care program that reflect as accurately as possible the resources needed to fund the program. We will be submitting updated cost model information to the Department of Administration by early January, including those changes that further refine the cost model for people with disabilities. They will review and refine what we have submitted, as will the Legislative Fiscal Bureau. As we collect additional information from the Aging and Disability Resource Center Pilots and the Care Management Organization Demonstrations, we will all have better information that can be used to continue to refine budget projections for each year of the phased-in implementation.

   One of the most difficult parts of the LTC cost model has been estimating the service needs, and therefore projected cost, for adults with developmental disabilities. The Department's database in this area, the Human Services Reporting System (HSRS), provides data on an aggregate basis only of services funded by Community Aids/county funds and provided to individuals with developmental disabilities. To derive an estimate in its cost model, the Department needed to make certain assumptions, particularly with respect to the amount of services provided to children versus adult with developmental disabilities. Recently, the Wisconsin Council on Developmental Disabilities (WCDD) staff provided us with additional data and proposed a methodology to refine the estimate of the amount of services provided to adults versus children. We appreciate receiving the WCDD material and are reviewing it.

   In testing the functional screen, we are deliberately oversampling people with developmental disabilities, including those with very high costs (e.g., Center

Residents) and those with moderate costs (e.g., some people who receive limited services funded by Community Aids or county funds). We will be testing the validity of the screen itself and the eligibility criteria for people with a developmental disability at various need levels from the most intensive to those who may have moderate needs. We will also tie service cost information to the results of these screens, to further develop cost model information, to inform the rate setting process, and to ascertain the various levels of functional needs for this group. We also plan to undertake a survey of a sample of counties to obtain more detailed information on the types and level of Community Aids/county-funded services provided by counties to individuals with developmental disabilities. By drawing on the information from WCDD and these special studies, we will be able to refine and increase the accuracy of our cost estimates for individuals with developmental disabilities. We also fully plan to reassess and adjust the cost model as needed in the 2001-03 biennial budget based on information from Resource Center pilots and CMO demonstrations during the 1999-2001 biennium.

2. ***Role of Counties and LTC Councils in Selecting CMOs***

Counties will have a two-year period to operate CMOs without competition from other entities. A gradual phase-in period is planned for all CMOs, similar to that being used for the CMO Demonstrations, with a year or more of planning, network development and case management of Medicaid card services. In response to concerns that have been raised by counties, we will not count the planning and development time toward the two-year exclusive period. Instead, the two year period will begin with the effective date of the CMO's contract under which it accepts a per person per month payment for the services it will manage. This means that a county will have at least three years without competition.

When open, competitive bidding for CMOs is in place (after the period when counties may operate without competition, or sooner if the county chooses not to be a CMO), the local LTC Council will decide whether there should be one CMO or more. If the Council decides that there should be only one, the state will make the determination through a fair and open "winner take all" process, with the input of the local Council, as described below. If the Council decides that there should be multiple CMOs, the Department will rate all applications as to how well they meet standards and other application criteria (including local support), certify those that meet at least minimum criteria, and forward the results to the local LTC Council. The Council must choose at least two from among the certified applicants.

The Department, working with LTC stakeholders and within previously established standards, will establish specific guidelines for the minimum number of potential enrollees for a CMO to be viable. Indirectly, these guidelines will indicate the maximum number of CMOs that could be sustained in a county. Where more than one CMO is feasible, the local LTC Council will forward to the Department its decision about whether more than one should be established. The Department must

assure that CMO(s) are available with sufficient capacity to serve all current and potential enrollees. If it finds, through empirical data, that additional CMO(s) are needed, it will ask the local LTC Council to identify additional CMO(s).

Local LTC Councils must review and make recommendations on all CMO applications, and these recommendations will be a formal part of the Department's review process. Review criteria for evaluation of applications to operate a CMO will include a numerical score related to the strength of local support, especially from the local LTC Council, for each applicant. If the county is not a competitor, consumer members of the local LTC Council will be solicited to serve on the formal review panel for applications. If the county is a competitor, other consumers will be a part of the panel.

3. ***Grandfather in Current LTC Recipients***

For three years, we have worked with stakeholders on a proposal to change the LTC system so that it can be more flexible, more responsive to people's needs, and more cost-effective. We want a system that relies less on an expensive medical model and more on natural family and community supports. We want a streamlined system that unifies and makes sense of the existing fragmented array of programs that limit people's choices about where and how to receive needed care. We cannot create an effective *new* system and simultaneously guarantee, without qualification, that *nothing* in the current system changes for anyone. However, we can agree to the following assurances.

All current COP-R, CIP, COP-W, and Alzheimer's Family and Caregiver Support Program (AFCSP) clients and all current nursing facility and ICF-MR residents will be assured Family Care services. All current Community Aids and county funded clients who are long term care clients will be assured of services through the Family Care Program. Counties will be required to assure that all their current clients are offered access to the new program at the time of transition.

Self/family directed care options will be available to all Family Care participants, including those transferring from other programs, and this option will include the ability to purchase services outside the CMO's network. All consumers, including those who do not choose the self/family directed care option, will have free choice of personal care attendants and other regular in-home workers. Requirements for breadth of other provider choices are detailed in the Department's proposal, including oversight by the local LTC Council, Department monitoring of contract requirements, and rights for consumers to appeal.

Draft?

No current COP-R, CIP, or COP-W participant will be required to move from his or her current living arrangement in order to receive services, although he/she may choose to do so. Current COP-R, CIP and COP-W clients already participate in a care managed system and have a service package based on a comprehensive assessment

Draft?

and care plan. CMOs will therefore be required to keep these clients' existing COP/Waiver funded services in place as the CMOs assume care management, unless individuals request changes or their needs change. However, we will expect CMOs to work with consumers and their families to develop comprehensive care plans under the new system that meet their needs, values and preferences in a cost-effective way.

Some COP/Waiver clients may also be receiving services funded under the current Medicaid fee-for-service system. As these Medicaid "card" services are brought into the per person monthly payment, CMOs will review these services with clients to assure that they are cost-effective, flexible enough to meet clients' needs, and, for those not choosing self-directed care, that providers are in the CMO's network. So long as services are necessary and appropriate to meet assessed need, federal rules will require that CMOs provide Medicaid services at the same level that they would be provided in the fee-for-service system.

Strong grievance and appeal processes will be in place. No change in a care plan that is not agreed to by a consumer may be implemented until the grievance and appeal process is exhausted. Consumers may request a state fair hearing without first exhausting local grievance mechanisms: (1) if services are denied, reduced or terminated; (2) if the service plan offered by the CMO is unacceptable to the consumer because it (a) requires the consumer to live in a place they do not want to live; (b) restricts the consumer's choice of qualified personal care workers who will meet the CMO's price; or (c) the CMO otherwise requires the consumer to accept services or treatments that are insufficient to meet the consumer's needs, are unnecessarily restrictive, or are unwanted. Consumers will also have a right to a state fair hearing for any other grievance about the type, amount or quality of service or service provider, after the grievance has first been reviewed by the DHFS contract-monitoring unit for the Resource Center or CMO.

The Family Care proposal is built on consumer choice, including the choice of whether to enroll in a Care Management Organization. Strong residential pre-admission screening processes will be in place. In addition, each applicant for nursing home or other residential services who is eligible for public subsidy or who is likely to become eligible within one year will be provided an assessment and care plan, so that people will be well informed about their choices prior to making a decision. Resource Centers will be required to offer information about Family Care to all current nursing home and ICF-MR residents within a specified time frame after the new program is available in a county. Residents will have the opportunity to receive an assessment and service/care plan and to enroll in Family Care if they choose. Consideration of further restriction of access to LTC services should be delayed until the new system is better established.

4. *Advocacy*

The Department is committed to having a strong and adequately funded internal and external advocacy component in Family Care. The redesigned system will need checks and balances to assure that consumers' needs are met. The independent advocacy program needs to provide active support and assistance to individuals seeking help from the Family Care Program. The external advocacy component would help long term care consumers, potential consumers or their families obtain needed services and supports and assist them in protecting their rights under all applicable federal and state laws and regulations. In addition, it will be important to help assure that the services consumers receive are of good quality and meet consumers needs. The organization(s) providing external advocacy services will need to be truly independent without any conflicts of interest with Resource Centers, Care Management Organizations or the Department. They will need to have a Board that has a strong consumer leadership and a staff knowledgeable about Family Care and the target groups who will be receiving services.

The cost projections for the advocacy component will be reviewed and we will support additional resources to make sure that the system is adequately funded. We are looking forward to receiving the report from the Advocacy Workgroup that will provide more specific recommendations on an Advocacy Plan for Family Care including a recommended funding level. A re-estimate of the cost of advocacy services will be included in our submission of an updated cost model to DOA by early January.

5. ***Leadership by State Staff Who Know Community Services***

It is premature for the Department to reorganize itself prior to passage of the Family Care legislation. However, we have requested that the legislation direct us to submit specific plans for reorganization within six months of enactment of the legislation. We will assure that the organization responsible for implementation and management of the new system will have staff experienced in managing flexible home and community care, understanding of the needs of Family Care's target populations, and committed to services and systems that are responsive to consumers' preferences and values.

In addition, we must assure that the Department has capability to perform other important functions such as contract monitoring, quality assurance and improvement, evaluation, utilization monitoring and budget development. We view Family Care as a Department-wide program; consequently, many Divisions and Offices of this Department will share in the responsibility of making it work.

6. ***Resolving Conflicts of Interest***

The proposal must be changed to meet federal requirements for separation of certain functions in order to avoid conflicts of interest. Within the parameters of federal requirements, we propose that counties have choices about how to address these

problems: (1) a county could create a quasi-governmental organization to operate either the CMO or the Resource Center; or (2) the state will contract with an independent organization to conduct the functional/financial screen and to provide counseling to clients about their LTC options, including enrollment in Family Care.

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Friday, November 27, 1998 2:07 PM
To: Kennedy, Debora
Subject: FW: Family Care statutory language

hhalic.doc

50.49 (6m)

Debora:

The attached document is a stat language change for Family Care that was not included in the department's July request.

The "gut" of the request is that the CMO would not have to be licensed as a Home Health Agency even if it directly provides home health services. If the CMO choses to contract with an outside vendor to provide these services then that outside vendor would have to be licensed as a Home Health Agency.

If you have any questions, please contact me at 266-2288.

> -----Original Message-----
> From: Barniskis, Lorraine
> Sent: Friday, November 20, 1998 6:31 PM
> To: Fossum, Gretchen
> Cc: Wilhelm, Charles; Bove, Fredi-Ellen; Allen, Joyce
> Subject: Family Care statutory language
>
> Gretchen, I sent hard copy via snail mail just after the LTC Executive
> Team
> discussed this late this afternoon. This is what my phone message was
> about.
> Thanks
> <<hhalic.doc>>

Date: November 20, 1998

To: Gretchen Fossum - DOA

From: Fredi Bove - DHFS/OSF

Re: Additional statutory language change for Family Care

Since our statutory language request for Family Care was submitted on July 31, 1998, an additional issue has arisen. We would like to add language as follows:

50.49 (6m)

Language requested:
In the description of Care Management Organizations (CMOs), please clarify that CMOs are not required to be licensed as Home Health Agencies (HHAs), whether or not staff of the organization provide services that are similar to those provided by HHAs. Similar language should be included for PACE/Partnership Programs, and for Medicaid Prepaid Health Programs and Managed Care Programs.

Rationale:
Home Health Agencies primarily provide the limited services of skilled nursing, therapies, and home health. They must have policies established by a professional group including at least one physician and at least one registered nurse to govern services, and provide for supervision of these services by a physician or a registered nurse. CMOs will be managed care organizations, whose mission is fundamentally different from that of a HHA. Primary goals of the LTC Redesign effort have been to demedicalize the provision of LTC services for people with long term disabilities and to create a flexible LTC benefit that is tailored to an individual and managed by professional care managers, who may be social workers or nurses.

The mission of a CMO is much broader than that of a HHA; it will be responsible for the management of all LTC services, of which home health will be a part for some enrollees. To obtain necessary federal waivers, the state and CMOs will have to develop and implement a comprehensive plan for quality assurance and quality improvement. These quality standards will meet or exceed those required of HHAs under licensing standards, but will be more geared to outcomes for clients, rather than process requirements.

cc: Debora Kennedy - LRB
Chuck Wilhelm - OSF
Lorraine Barniskis - DSL/BALTCR
Joyce Allen - OSF/CDSD

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Wednesday, December 23, 1998 2:40 PM
To: Kennedy, Debora
Subject: FW: Family Care eligibility language

eligent2.doc

Debora:

Attached are the department's changes to the Family Care draft regarding eligibility for the Family Care Benefit.

In addition, a decision has been made, with DHFS concurrance, to make the following changes to the State Long-Term Care Council:

1. On page 1, line 8: change the created s. 15.197(5)(b) to read "The council consists of 25 members appointed by the Governor. Everything else on (b) should be deleted.

2. On page 2 delete lines 10 through 14.

3. On page 13 delete lines 18 through 20. – **** NOTE

4. On page 44 delete lines 2 through 11.

> -----Original Message-----
> From: Barniskis, Lorraine
> Sent: Tuesday, December 22, 1998 11:23 AM
> To: Fossum, Gretchen
> Cc: Wilhelm, Charles; Rowin, Mary; Malofsky, Shelley; Lewis, Kevin;
> Hamilton, Thomas; Gebhart, Neil; Bove, Fredi-Ellen; Allen, Joyce
> Subject: Family Care eligibility language
>
> Attached are our suggested revisions to the draft eligibility and
> entitlement
> language for the family care benefit. Our Office of Legal Counsel has not
> had a
> chance to review this latest draft, so it may still need some tinkering.
> Since
> so many people are out for the holidays, I wanted to get you what we have
> so
> far. Thanks.
> <<eligent2.doc>>

SECTION 28. 46.285 of the statutes is created to read:

46.285 Family care benefit. (1) ELIGIBILITY. A person is eligible for, but not entitled to, the family care benefit if the person is at least 18 years of age and meets all of the following criteria:

(a) Functional eligibility. A person is functionally eligible if, due to a disabling condition other than mental illness, substance abuse, or developmental disability, any of the following applies, as determined by the department or its designee:

1. The person's functional capacity is at either of the following levels:

a. Comprehensive level. A person's functional capacity is at the comprehensive level if the person has a long–term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance or supervision

b. Intermediate level. A person's functional capacity is at the intermediate level if the person has a condition that is expected to last at least 90 days or result in death within one year of the date of application, and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

2. The person was a resident in a nursing home or was receiving long-term care services funded under any of the following on the date that the family care benefit became available in the person's county of residence:

a. Long-term support community options program under s. 46.27 (7) or (11).

b. Community integration program under s. 46.275, 46.277 or 46.278.

c. Alzheimer's family caregiver support program under s. 46.87.

d. Community aids under s. 46.40.

e. County funding.

(b) Financial eligibility. A person is financially eligible if either of the following, as determined by the department or its designee, applies:

1. The projected cost of the person's care plan, as calculated by the department or its designee, exceeds his or her gross monthly income, deductions and allowances permitted by rule by the department, plus 1/12 of his or her available assets.

2. He or she is eligible for medical assistance under s. 49.472, 49.46 (1) (a) 4 or 6m, 49.47 (4) (a) 3 or 4, 46.27 (11), 46.275, 46.277 or 46.278 or any program of assistance operated under a waiver granted under 42 USC 1396n (c).

Note: 49.472 is the new eligibility under the Pathways program (to be created by this budget).

(2) COST SHARING. (a) Persons determined to be financially eligible under sub. (1) (b) shall be required to contribute toward the cost of their care an amount calculated by the department or its designee, after subtracting from gross income the deductions and allowances permitted by the department by rule.

(b) Funds received under par. (a) shall be used to pay for long-term care services.

(3) DIVESTMENT. (a) The department or its designee shall require all persons applying for the family care benefit to and, annually, all persons receiving the benefit to provide a declaration of assets, on a form prescribed by the department. The declaration shall include any assets that the person applying for or receiving the services, or his or her spouse has transferred to another for less than fair market value at any time within the 36-month period, or with respect to payments from a trust or portions of a trust that would be treated as assets transferred by an individual under s. 49.454 (2) (c) or (3) (b), within the 60-month period, immediately before the date of the declaration.

(b) In determining financial eligibility under sub. (1) (a) and in calculating the amount under par. (a), the department or its designee shall include as the assets for any person, except those persons who are eligible for medical assistance under s. 49.46, 49.468 or 49.47, any portion of assets that the person or the person's spouse has transferred to another as specified in par. (a), unless one of the following applies:

1. The transferred asset has no current value.

2. The department or its designee determines that undue hardship would result to the person or to his or her family from a denial of financial eligibility or from including all or a portion of a transferred asset in the calculation of the amount of cost sharing required.

(4) ENTITLEMENT. A person is entitled to and may receive the family care benefit through enrollment in a care management organization if he or she is financially eligible, participates in cost sharing, if applicable, and meets any of the following criteria:

(a) Is functionally eligible at the comprehensive level.

(b) Is functionally eligible at the intermediate level and is financially eligible under sub. (1) (b) 2.

(c) Is functionally eligible at the intermediate level and determined by an agency under s. 46.90 (2) or s. 55.05(1) to be in need of protective services or placement under ch. 55. The need for protective services or placement shall be established in accordance with applicable provisions under s. 55.05 and s. 55.06.

(d) Is functionally eligible under sub. (1) (a) 2.

Notes: We do want the same ***spousal impoverishment*** *protections and* ***estate recovery*** *provisions to apply to Family Care that currently apply to COP-Waiver*

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

Memorandum

DATE

FROM Director
Office of Strategic Planning

SUBJECT Request for Approval of Waivers under Section 402 of the Social Security Amendments of 1967 (42 U.S.C. § 1395b-1) and Medicaid waivers and matching authority under 1115(a)(1) for the "Wisconsin Partnership Program": A Dual Eligible Demonstration --**DECISION**

TO Administrator
THRU: OCOS _____

ISSUE

The State of Wisconsin Department of Health and Family Services submitted a request for Medicare and Medicaid demonstration waivers in February 1996 to establish a "Partnership" model of care for dually entitled nursing home certifiable beneficiaries who are either under age 65 with physical disabilities or frail elders. A variation to the PACE model, two PACE providers and two Centers for Independent Living will sponsor a model that will integrate all covered benefits for Medicare and Medicaid dual eligible and Medicaid-only beneficiaries enrolled in this full risk capitation model. Partnership plans will rely on nurse practicitioners and other multi-disciplinary team members to provide continuity and coordination with physicians who elect to participate. Partnership plans will rely less on adult day care as thé locus for service delivery than does PACE. The model is proposed as a fully voluntary enrollment model for 1,200 beneficiaries with 300 per site over five years.

Prior to commencing demonstration enrollment activities, the State must demonstrate to HCFA its operational and programmatic readiness to effectively treat Medicare and Medicaid beneficiaries within the demonstration model. This will require compliance with the attached terms and conditions cited in Tab A . HCFA will schedule a readiness

review upon obtaining waiver approval.

ACTION

This memorandum requests your concurrence in approving the Social Security Act Titles XVIII and XIX demonstration waivers required for implementation of this project by four community-based organizations in the State of Wisconsin. Due to the demonstration's policy significance, service to more than 300 beneficiaries, and fiscal impact greater than $1,000,000 approval for this demonstration is required from the Assistant Secretary for Management and Budget.

BACKGROUND

On February 19, 1996, the State of Wisconsin submitted a waiver-only application, entitled "The Wisconsin Partnership Program" (WPP), for Medicare waivers under section 1395(b)(1) of the Social Security Act and Medicaid waivers and matching authority under 1115(a)(1) and 1115(a)(2).

The Health Care Financing Administration (HCFA), in conjunction with other components within the Department of Health and Human Services (DHHS), has conducted a review of the WPP proposal. Based on these reviews, a list of questions and concerns was submitted to the State in July 1996. The State submitted a response to HCFA in January 1997 for review. The questions and responses are included at Tab B. Follow-up discussions involving HCFA, representatives from the DHHS, OMB and the State have proceeded since March 1997 on payment, budget neutrality and plan risk sharing arrangements. A draft of the Wisconsin Partnership Protocol has been submitted to HCFA for preliminary review. It will be examined in detail as part of the demonstration readiness assessment review.

DESCRIPTION OF THE WISCONSIN PARTNERSHIP PROGRAM

The Wisconsin Partnership Program (Partnership) is a fully capitated managed care model for frail elderly and people with physical disabilities. Enrollment is to be voluntary (one month lock-in) for both Medicare and Medicaid programs. Partnership plans use a multi-disciplinary team to manage care in a "partnership" that includes the participant, a nurse practitioner, the participant's own primary care physician, and a social worker or independent living coordinator. The Partnership model incorporates many elements of the Program for All Inclusive Care for the Elderly (PACE) demonstration. However, it eliminates required day center attendance and utilizes an open physician panel rather than a closed-panel model. Services are to be provided directly in the participant's home whenever possible. The open panel is believed to be more attractive to beneficiaries who may otherwise need to switch physicians.

Sites serving frail elderly beneficiaries are Elder Care of Dane County, in Madison, and the Community Care Organization of Milwaukee. Both organizations operate fully at

risk PACE plans. The sites serving beneficiaries with physical disabilities are Community Living Access (CLA) in Madison and the Center for Independent Living of Western Wisconsin (CILWW) in Eau Claire. These latter sites are expected to be the first in the nation to demonstrate fully integrated Medicare and Medicaid services under capitated arrangements for dual eligible beneficiaries with physical disabilities.

Partnership sites are already providing Medicaid services under a Pre-paid Health Plan (PHP) contract with the Wisconsin Medicaid agency. Partnership enrollment in these plans for December, 1997 was 59 for Milwaukee and 122 for Dane County. HCFA approved Elder Care Dane County as a PACE site on February 10, 1998. It initiated PACE services on May 1.

The Disability Partnership sites are sponsored by Federally funded and certified Centers of Independent Living, (funded under the Rehabilitation Act), to provide community-based services for people with physical disabilities. The Madison site has a Medicaid enrollment of 57 as of December, 1997. The Eau Claire site, to be implemented after the three other Partnership sites, has a Medicaid enrollment of 46 individuals.

ELIGIBILITY

The target populations for this demonstration are frail elderly and/or disabled individuals who are Medicaid-eligible or dually eligible for Medicaid and Medicare, and who meet Medicaid level of care criteria for nursing home admission. The model for Elderly will serve frail elderly people (age 55 and over). The model for People with Disabilities will serve younger (age 18-64) people who have a physical disability as their primary disabling condition (which excludes AIDS, mental illness, alcohol and other drug abuse, and a cognitive disability as the primary disabling condition, although people with these disabilities as a secondary diagnosis may be served in the program).

Both Medicaid-Only and Dual Eligible Beneficiaries who meet nursing home certifiable and financial eligibility criteria may choose Partnership enrollment. Wisconsin's "Community Options Program (COP)" 1915c Home and Community-Based Waiver serves elderly and disabled people and has established financial eligibility rules for community waiver participants. Since 1989, Wisconsin has also had demonstration waivers for the Program of All-Inclusive Care for the Elderly (PACE).

All COP, PACE, and Partnership waiver participants must be certified by the Wisconsin Bureau of Quality Assurance as meeting the skilled, intermediate-level one, or intermediate nursing home level of care requirement. This process is the same as is required for nursing home admission under Wisconsin Medicaid state plan rules.

Wisconsin's PACE program, like other States with PACE, applies community wavier rules for financial eligibility upon admission to the program. If the PACE participant is later placed in an institutional setting, the participant remains enrolled but the regular

Medicaid state plan financial eligibility rules are applied. The Partnership demonstration will utilize the same procedures as PACE.

BENEFITS

- Wisconsin Partnership organizations will provide or arrange for the provision of all services required under Medicare Parts A and B, Medicaid, and Wisconsin's Home and Community-Based Waiver (i.e., 1915c waiver). Additional benefits, as specified by plans, may be covered as they may finance through the capitation payments to Partnership plans.

- The Home and Community-Based Waiver Services include: adaptive aids, adult day care and day services treatment, communication aids, daily living skills training. non- emergency transportation, nutrition services, personal and supportive home care, respite care, and vocational services.

SERVICE DELIVERY SYSTEM

- Under this demonstration, HCFA and the Wisconsin Department of Health and Social Services, which is the State Medicaid Agency, will contract with community-based organizations (CBOs) to operate the Partnership Program. These organizations in turn subcontract with hospitals, clinics, and other providers to ensure a comprehensive network of acute and long-term care. Under the dual waivers, the contractors will be fully at risk for all long term and acute care. The capitated Medicare payments will be made directly to the contractors.

- The Partnership Program will be a managed care delivery system under a pre-paid capitated payment system. All Medicaid and Medicare covered services will be included in the capitation. Services such as communication aids, adaptive aids, personal care, etc. that are low cost ways to prevent institutionalization will also be provided.

- The Partnership uses a multi-disciplinary team to manage care in a partnership approach. The team includes the participant, a nurse practitioner, the participant's physician, and a social worker or independent living coordinator. Service delivery in the Partnership model is home-based and is designed to engage the consumer in care planning and decisions regarding their health care treatment and independent living goals.

PAYMENT

Similar payment methodologies will be used for both the Elderly and the Disability Partnership Plans:

- Medicare: Medicare rates for the Partnership model will use the same methodology in the PACE demonstration: the Average Adjusted Per Capita Cost (AAPCC) County ratebook for elderly and disabled beneficiaries, per the Balanced Budget Act of 1997, multiplied by the 2.39 adjuster for nursing home certifiable beneficiaries. Payment rates are based on a per member per month (PMPM) basis. A special term and condition is included with the award stating that this rate is subject to change based on additional research that indicates improved predictive accuracy as may be determined by the Secretary of the Department of Health and Human Services. Medicare capitated payments will be made directly to contractors.

- Medicaid: The Medicaid capitation rate for the frail elderly enrollees will be based on discounted fee-for-service costs used to capitate Medicaid services. The current rate will be determined using data from similar populations and trended based on actual yearly rate increases.

  The Medicaid capitation rate for enrollees with disabilities will be based on the current State Medicaid rates for persons with disabilities, developed by the actuarial firm of Milliman & Robertson. Historical nursing facility and total Medicaid costs in 1994 for persons with a primary diagnosis of physical disability, between the ages of 18 and 64, residing in a nursing facility in Dane County are used in the analysis. The same type of adjustments described in the Elderly Medicaid payment were made in developing the 1994 fee-for-service cost per eligible month. Trend factors based on actual rate increases for both nursing facilities and specific non-nursing home services in 1995 and 1996 were used to projects costs into 1996 to calculate the projected 1996 FFS cost per eligible month. The monthly capitation is 95 percent of this rate. Previously "carved out" services are to be included in the demonstration capitation rate.

- ESRD: Services for enrollees with End Stage Renal Disease will be provided under the same financing arrangements as are available to PACE providers. The plan receives the ESRD rate cells and may receive payment up to the Medicare fee-for-service limits, should costs exceed capitated payments.

RISK SHARING

A significant issue between HCFA and the State related to the availability of plan risk sharing as proposed by the State. The outcome is that Partnership sponsors will not participate in risk sharing with HCFA. Partnership sites will be required to meet the solvency requirements of PACE as are in place for PACE demonstration sites and as published in the PACE regulations. Partnership sites will purchase commercial reinsurance for some services and will maintain cash reserves per HCFA and State requirements.

BUDGET NEUTRALITY

Medicare budget neutrality is determined based on the calculation of the Medicare capitation payment for the Partnership model. The 5 percent discount from fee-for-service costs for the base year of Balanced Budget Act revised County ratebook for both frail elderly and beneficiaries with disabilities guarantees budget neutrality. With the exception of the risk adjuster, which may be changed based on the Department's decision, future payments are tied to changes in the capitation base as required under the BBA.

Medicaid budget neutrality for Wisconsin Partnership is based on Medicaid costs for both dual eligible and Medicaid only individuals for the years 1992 through 1996. Demonstration Counties are subject to budget neutrality terms and conditions. The State continues to develop data pertaining to Medicaid-only individuals for HCFA review prior to project implementation. However, the methodology described at **Tab C**, contains complete and comprehensive data for all dual eligible and Medicaid-only individuals combined for all years.

The State of Wisconsin will be subject to a limit on the amount of Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using the per capita cost method. Under this method,. Wisconsin will be at-risk for the Medicaid per capita cost of Medicaid recipients and dual eligibles. but not at-risk for the number of eligibles. By placing Wisconsin at-risk for the per capita costs of current program participants, HCFA assures that the demonstration Medicaid expenditures do not exceed the levels of spending that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates are calculated for each year of the demonstration, on a waiver year (WY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period.

Federal share of this estimate will represent the maximum amount of Federal Financial Participation (FFP) that the State may receive during the 5-year waiver period for the types of Medicaid expenditures included in the waiver for those eligible to enroll in Partnership demonstration counties. For each Federal fiscal year (FFY), the Federal share will be calculated using the Federal Medical Assistance Percentage (FMAP) rate for that year.

Each yearly budget estimate will be the sum of separate cost projections for each Medicaid eligibility group (MEG). The yearly cost projection for each MEG will be the product of the projected PMPM Medicaid cost for that MEG, times the actual number of eligible member/months as reported to HCFA by the State.

DEMONSTRATION OPERATIONS

Coordinated Program Operations, Monitoring and Compliance

Wisconsin and HCFA will coordinate oversight of Medicaid and Medicare standards within the Partnership Program. The Partnership Protocol will incorporate the requirements specified in these terms and conditions, all requirements of Section 1902 of the Social Security Act expressed in law not expressly waived by Partnership special terms and conditions, and all requirements of Section 1876 of the Social Security Act, or Medicare + Choice requirements that supersede Section 1876, expressed in law not expressly waived by the terms and conditions.

A special term and condition specifies that the Protocol include a description of Federal and State roles with respect to the demonstration operations, monitoring, and oversight as developed through HCFA and State collaboration. The site readiness review will also be utilized to finalize coordination and determine any necessary Protocol revisions.

Enrollment/Disenrollment

The State is limiting enrollment to 1,200 participants in the demonstration counties for the duration of the demonstration. Although is a potential eligible population of 35,000 nursing home certifiable dual eligible people in the State, the State believes that the Partnership model must be monitored, examined and refined before broader expansion is considered.

The State seeks to implement an enrollment and disenrollment system similar to that used in Minnesota's Senior Health Options demonstration. This system enables expedited enrollment compared to the process routinely used for Medicare risk contractors. This ability is important in meeting the demand for flexible enrollment that States require due to immediate changes in Medicaid eligibility status. The system will be designed to avoid some efficiencies in the Minnesota enrollment process and is expected to be more efficient than PACE enrollment for HCFA staff because of electronic submission of accretions and deletions by Partnership plans and fewer manual adjustments. The Office of Financial Management's Demonstration Support Branch has been working with OSP to implement this important aspect of the project.

Grievances and Appeals

Given the integration of the Medicare and Medicaid programs proposed under the Partnership demonstration, it is difficult to reconcile the grievances and appeals rights of beneficiaries guaranteed under both programs. The State's compliance with the Medicare requirements will be reviewed and approved per the Grievances and Appeals section of the protocol. While some processes may be approved in order to better coordinate Medicare and Medicaid processes, under no circumstance will appeal rights be truncated or time schedules for appeals processes be lengthened. The grievance and appeals procedures of Partnership plans will be reviewed in detail during on-site pre-operational readiness review.

Marketing/Membership Materials - Medicare Requirements

The State's and provider's compliance with the Medicare requirements will be reviewed as part of the HCFA Protocol review.

Quality Assurance

The State will oversee quality assurance (QA) for the Partnership Program, and will be accountable for QA in all of the Partnership providers and contractors. It will coordinate with HCFA on these activities. As required under applicable Federal laws and regulations, quality of care furnished under the Partnership will be subject to internal and external review. The internal and external review protocols that will be implemented must meet or exceed the review protocols that plans are currently subject to under HCFA's § 1876 review protocols and the Peer Review Organization (PROs). HCFA's oversight functions would continue to apply to the overall Partnership demonstration. With regard to internal review, the State will assure effectiveness and quality of care through monitoring of access, utilization practices, client information, as well as establishment of service standards in the contracts with CBOs. Medicare beneficiaries will continue to be able to appeal claims denials consistent with the time frames that are available per Section 1876 and have recourse to Federal judicial appeal.

Under the waiver demonstration, the Partnership Program will conduct research into the use of consumer-defined quality indicators to measure and improve the quality of service delivery to people who are elderly and people with disabilities.

EVALUATION

OSP has awarded a contract to the University of Minnesota for an evaluation of four states implementing dual eligible demonstration waivers, including Wisconsin. The evaluation is designed to allow for an assessment of the impact of each State demonstration, as well as an assessment of the overall impact of the three major features that each of the State demonstrations have in common:

- The use of a capitated payment strategy to expand services while reducing or controlling costs;
- The use of case management techniques and utilization management to better plan and coordinate care and improve outcomes; and
- The goal of responding to consumer preferences while encouraging the use of non-institutional care.

In addition, one of the universal themes to be developed is the difference between managing and integrating care. The former refers to the extent to which simply imposing caps changes the way resources are used. The latter addresses the extent to which better

results are achieved through closer coordination of care delivery.

The quasi-experimental design will compare three experimental groups (elderly in the community and in nursing homes, and people with physical disabilities) with a combination of comparison groups. Because of circumstances unique to each state, the evaluations of different states may require different combinations of the models. Data sources will include surveys of five populations (clients, family members/care givers, case managers, providers and special interest groups), case study interviews, and Medicare, Medicaid, project and encounter data.

HCFA RESOURCE REQUIREMENTS

Federal oversight of the Partnership demonstration will be administered by the Division of Health Systems Research in the Office of Strategic Planning (OSP). OSP will manage the service contract, coordinate the demonstration readiness review, lead monitoring and oversight activities and collaborate with the State on demonstration management tasks. OSP also administers the evaluation contract.

Operational assistance will be required from the Center for Health Plans and Providers for health plan qualification technical assistance, participation in demonstration readiness review, execution of the provider service contract, coordination with PACE sites, and technical assistance, as necessary, with the Group Health Plan for enrollment of Partnership enrollees.

Operational assistance also will be required from the Center for Medicaid and State Operations for participation in demonstration readiness review, execution of the provider service contracts, coordination with PACE sites and home and community-based waiver programs, as necessary.

The Office of Financial Management will perform enrollment and disenrollment functions, administer the payments to Partnership plans and conduct financial audits as may be required. It also will be represented during the demonstration readiness review.

The Office of Information Systems will provide technical assistance in permitting Partnership plan access to the Common Working File as is available to Medicare risk contractors.

The HCFA Regional Office in Chicago will be required to provide technical assistance in determining health plan qualifications, participate in the demonstration readiness review and participate in demonstration monitoring and oversight.

Other HCFA components will be requested for assistance as may be required.

ISSUES AND CONCERNS RAISED ABOUT PARTNERSHIP BY REVIEWERS

Relationship to PACE Providers

Reviewers have expressed concerns that Partnership demonstration providers must have clear and separate financial accountability from PACE contracts in the operation of separate contracts for Medicare and Medicaid covered benefits, especially because risk-sharing had been proposed between HCFA and the Partnership plans. Risk sharing has now been excluded from this demonstration.

Partnership staff will be housed within facilities used by PACE providers. Partnership will be charged for PACE services, such as adult day care, to assure financial accountability. The close relationship between PACE and Partnership needs to be examined by HCFA and the State to assess the financial record keeping system of the sponsors. Although it is not unusual for Medicare providers to operate more than one contract with HCFA, it is imperative that final Protocol approval and site readiness demonstrate that the sites do maintain adequate and separate financial reporting capabilities, especially so that solvency protection will be completely accountable.

Physician Partnership Arrangements

Under the demonstration, Partnership providers will sign an agreement or contract with physicians or physician organizations specifying the requirements for physician practice. Plans intend to reimburse physicians at the standard Medicare/Medicaid fee schedule, but may enhance the payment by reimbursing physicians for meeting with Partnership Project Director and for case management consultation with the Nurse Practitioner. Reviewers are concerned that difficulties in performing utilization management may lead to financial difficulty for the Partnership sponsors. The Partnership physician protocol has been prepared to address this concern. The Protocol must be approved by HCFA prior to implementation.

WAIVERS OF THE SOCIAL SECURITY ACT

MEDICAID WAIVERS

Under the authority of section 1115(a)(1) of the Social Security Act (SSA), waiver of the following provisions of the SSA (and its implementing regulations) are required for a 5 year period effective of the first day of enrollment into the Partnership Demonstration to enable the State to carry out the demonstration:

1. Uniformity Section 1902(a)(1)

   To allow the Partnership Program to be located in certain geographic areas of the

State.

2. Release of Information Section 1902(a)(7)

To allow the State to obtain information from providers and to release information to external researchers for purposes of evaluating the demonstration.

3. Comparability of Services Section 1902(a)(10)

To allow the differences in the amount and scope of benefits provided to recipients in the Partnership vs. fee-for-service.

4. SNF Level of Care Recertification Section 1902(a)(20)(B)

To allow the State to one-time lifetime determination in order to provide financial incentives to Partnership organizations to provide preventive care and reduce the utilization of hospital and specialist care.

5. Choice of Providers Section 1902(a)(23)

Permits maximum flexibility in matching Partnership participants with an appropriate primary physician in an HMO or PHP to the extent possible

6. Provider Reimbursement Section 1902(a)(13), 1902(a)(30)

To allow the State to make changes in Medicaid/Medicare fee schedules.

7. Special Income Limits Section 1902(a)(10(ii)(v) and (vi) and (VI)

To permit individuals at the special income level whose income is below 300% of the SSI benefit rate to be covered as set forth in 42 CFR 435.217 and/or 425.236, and to provide continuous care whether individuals reside in the community or in an institutional setting (the same as for PACE sites).

<u>§1115 Expenditures</u>

Under the authority section 1115(a)(2) of the SSA, expenditures made by the State for items identified below (which are not otherwise included as expenditures under Section 1903), are to be regarded as expenditures under the State's Title XIX plan.

- Expenditures for primary care organizations that are not federally-qualified HMOs, or federally-qualified community health centers, as currently required by 1903(m)(1)(A) and (2)(A)(I), 42 CFR 434.20 and 434.21 (exempt under 1903(m)(1)(A) and (2)(B)).

- Expenditures for entities that do not afford enrollees the disenrollment rights set

forth in 1903(m)(2)(A)(iv) and 42 CFR 434.27.

- Expenditure for comparable services to those offered in the State's Home and Community Based Waiver program.

- Expenditure for services to persons who would otherwise be eligible for services under the current home and community-based waiver but would lose such eligibility without application of spousal impoverishment provisions, so as not to be disadvantaged when enrolling in Partnership.

- Expenditures for the administrative costs of managing the full continuum of care of Medicaid eligible Partnership beneficiaries.

MEDICARE WAIVERS

- The authority and corresponding Medicare waiver authority to conduct this demonstration is section 402(a)(1) of Public Law 90-248 (U.S.C. 1395b-1) as amended by section 222(b)(1) of Public Law 92-603 (42 U.S.C. 1395b-1). Under this section, the Secretary is authorized to develop and engage in demonstrations "...to determine whether, and if so which, changes in method of payment or reimbursement...for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services..." Section 402(a)(1)(A) (Emphasis added).

- In order to demonstrate the Partnership model, changes in method of payment, service delivery design features and requirements that apply to risk contracts under section 1876 of the Social Security Act would be appropriately applied to Partnership under this demonstration project, including voluntary enrollment in health plans for periods of time specified under section 1876 (30 days in 1998). These requirements and the regulations implementing them will apply as terms and conditions of this demonstration, included at Tab A.

Under Section 402 of the Social Security Amendments of 1967 (42 U.S.C. §1395b-1), the State requests the following waivers in methods of payment and reimbursement necessary to implement this demonstration:

- Section 1813, 1814, 1833, cost, 1886, of the Social Security Act payment beneficiary 42 C.F.R. 409.80-409.87

  Waiver of the usual and reasonable reasonable charge, and DRG provisions, including copayments and deductibles.

42 C.F.R. 410.160 AND 161
42 C.F.R. 409.46
42 C.F.R. 412.2
42 C.F.R. 413.5-413.13

PROGRAM EXPENDITURE ESTIMATES

The State has estimated the following Federal Medicare and Medicaid expenditures with and without demonstration waivers for the 5 years of the demonstration:

The total Medicare and Medicaid projected 5-year demonstration costs are $231,094,848. Total projected program costs in absence of the waiver are $243,257,795. Projections indicate a net program savings of $12,162,947. Tables are included at Tab C which provide detail on these estimates.

In accordance with the waiver approval procedures established by HCFA and the Department, this cost estimate has been reviewed by the HCFA Office of Financial Management budget officer and his certification is attached (Tab **C**)

DISCUSSION

OSP recommends approval of the "Wisconsin Partnership Program" demonstration. The purpose of the demonstration is to test delivery systems which integrate long-term care and acute care services under combined Medicare and Medicaid capitation payments for both frail elderly and physically disabled dual eligible beneficiaries.

The State seeks to demonstrate an integrated service delivery system that increases options for consumers to select their physician and locations for services. Successful implementation of the proposed models may have national significance for further replication of open-panel physician models for delivering service to frail elderly and beneficiaries with disabilities. It will also provide results on the use of multi-disciplinary teams to provide or arrange services at convenient locations for beneficiaries.

It is necessary for HCFA to seek concurrence for waiver approval from the Assistant Secretary for Management and Budget (ASMB). A memorandum to notify ASMB of our plans to implement the demonstration is included for your signature **(Tab D)**.

RECOMMENDATION

I recommend that you approve the requested Social Security Act Title XVIII and XIX demonstration waivers for "The Wisconsin Partnership" demonstration, subject to the attached terms and conditions.

Barbara S. Cooper

DECISION

Approve _______ Disapprove _______ Date _______

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Monday, December 21, 1998 10:29 AM
To: Kennedy, Debora
Subject: Family Care Draft

2drftcmt2.doc

Debora:

Attached are Lorraine's comments on the second Family Care draft.

On page four of her comments is the request to increase the number of members of the Board on Aging and Long-Term Care. Rather than stipulating that 6 members are to be members with no interest in or affliation with any nursing, please amend s. 15.105 (10) to read as follows:

"All members shall be public members with no interest in or affliation with any long-term provider".

<<2drftcmt2.doc>> *** NOTE: Conflict w/current membership?

Date: December 20, 1998

To: Gretchen Fossum - DOA/Budget

From: Lorraine Barniskis - DHFS/DSL/BALTCR

Re: Comments on Second Draft of Family Care Legislation

Thanks for sending the second draft of the legislation for review. Our section by section comments and responses to the drafter's notes are provided in the following table. Additional instructions follow the table.

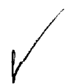
Reference	**Comments**
p. 2, lines 1-6	This still isn't quite right. The proportionality requirement should apply to all 13 members who are older people, people with a disability, their family members, guardians or other advocates. (The part about at least 9 of these members being actual older people or people with disabilities, with up to 4 being family members, etc. is fine.) We mean to have some flexibility here, while assuring that all target groups are well represented. For example, a daughter caring for an older person with Alzheimer's disease counts as a representative of "older people." If people with developmental disabilities remain covered by Family Care (and maybe even if they don't), an older parent of an adult with a developmental disability could count as either an older person or a representative of the DD target group. Does this work? "The age or disability represented by these 13 members shall correspond to the proportion of numbers of persons receiving long-term care in this state who are aged 65 or older or have physical or developmental disabilities."
p. 2, note following line 9	Rather than getting into a lengthy definition of "state official," I suggest we take out this term and "community leaders" and substitute something like "other individuals with recognized ability and demonstrated interest in long-term care." (Similar to the language used for local councils.)
Pages 2-4	We agree with the way the proposed amendments to s. 16.009 (2) have been drafted. These are good changes to our instructions.
pp. 4 - 9 (Sections 11, 12 and 17-21 of the bill on COP risk reserve)	Change 46.27 (7)(fr)1. to read: "A county may ~~expend, for a~~ <u>place in</u> a risk reserve funds that are allocated under par. (am) or (b) or sub. (11) c.3 and are not expended or encumbered for services under this subsection or sub. (11). <u>The county shall notify the department of the amount to be placed in a risk reserve, in accordance with department reporting requirements.</u> The county shall maintain the risk reserve in an interest-bearing escrow account with a financial institution, as defined in s.69.30(1)(b), if the department has approved the terms of the escrow."

Reference	Comments
	In 46.27 (7)(g), first sentence: Delete the phrase "or expended for a risk reserve under par. (fr)". SS. 20.435 (7)(bd), 46.27(7)(am) and (b) are OK as drafted. Explanation: Based on discussions with DHFS financial staff, the COP carryover provision will be implemented in the following way. Counties can choose to place unexpended COP funds in the risk reserve (up to the statutory limit). The county will be required to notify the Department of any such decision. Once the Department receives such notification, the Department will provide the funds to the county which will place the funds in the risk reserve. By the end of the calendar contract period, risk reserve funding is no longer in the Department, but has been transmitted to those counties that exercise this option. For this reason there is no need for the carryover provision for the risk reserve funds in s.46.27 (7)(g). Regarding the relationship of s.20.435 (5)(b) or (o) or (7)(im) to this risk reserve provision: Funding in these appropriations will be used to pay the per member per month payment (i.e., capitation payment) to the Care Management Organizations (CMOs.). Under the terms of the Department's contract with the CMOs, the CMOs will be allowed to place a portion of the payments received from the state in a risk reserve. This same practice is in place now with the Department's current managed care capitation-based MA programs, such as the AFDC HMO and PACE programs. Therefore, no additional statutory changes regarding the creation of a risk reserve are needed in s.20.435(5)(b) or (o) or (7)(im).
p. 10, lines 1-3; note on p. 31	I believe this definition should be tied to the contract under s. 46.284 (1), rather than to certification. An organization could be certified as meeting standards, but not get a contract and actually operate. We do not feel that it is clear from this definition and s. 46.284 (2) that PACE and Partnership are excluded and suggest that something like the following be added: "This term does not include: (a) An entity that contracts with the department to operate a program of all inclusive care for the elderly authorized under 42 USC 1395. to 1395eee (b) An entity that contracts with the department to operate a demonstration program known as the Wisconsin partnership program under the department's waiver of ss. 1813, 1814, 1833, 1886 and 1902 of the social security act." Both PACE and Partnership include primary and acute care services and integrate Medicare and Medicaid funding. Both are limited to people at

Reference	Comments
	nursing-home level of care. There is no federal authorizing statute for Partnership; it is a demonstration project under waivers from HCFA under their authority under ss. 222 and 1115 of the Social Security Act. I'm sending to you and to Debora hard copy of a document that explains the program and enumerates all the waivers we have for this program.
p. 10, note following line 10	Yes, "support items" is okay to use here.
p. 10, note following line 13	This term is used in several ways in the draft. I suggest something like this for the definition here: "Long-term care system means the organizations and programs providing Family Care or other publicly funded long-term care benefits or providing information about and access to those services." Then, the term will have to be replaced when it has a different meaning in the current draft. Notes are included in the following comments; I hope I caught them all.
p. 10, lines 16-17	See later notes regarding establishment of Resource Centers. I suggest replacing this definition with the following: "Resource center" means an entity that meets the standards for operation under s. 46.283 (3). We really mean by a Resource Center the place that a person can visit or call to get all the services listed in s. 46.283 (3). Given that it is possible that we will have to have more than one contract (e.g., if the county doesn't operate the Resource Center or if it does but we contract separately for screening and counseling), is the Resource Center really an "entity"? What else could we call it?
p. 11, lines 1-2 and note following	I apologize for not being clear in my earlier comments. When I used the shorthand term "consumer" relative to LTC Council members, I meant to include all older people and people with physical or developmental disabilities and their family members, guardians or other advocates who are members of the Council. They will all need this training in order to participate effectively. Thanks for pointing out that expenses are covered elsewhere; that's fine.
p. 11, lines 6-8	Please delete the last sentence of this paragraph. See attachment one for an overview of the changes in the process for deciding how many CMOs operate in a geographic area and what entity/entities operate them.

Reference	Comments
p. 11, note following line 14	The requests to HCFA would be to waive portions of s. 1902 of Title 19 of the Social Security Act related to statewideness, comparability and freedom of choice. Yes, I think "fund the long-term care system" in line 11 is too broad. I would take it out, leaving "...the use of federal moneys to provide the family care benefit..." We will be able to get some federal funds to support Resource Center functions, but don't need waivers to do so. In line 14, please change "long-term care system" to "operation of resource centers, care management organizations and the family care benefit."
p. 11, line 16	Please add "and the family care benefit"
p. 11, lines 18-21 and note following	See later notes regarding Resource Center provisions. I would change the portion of this subd. related to Resource Centers to read: "...and one or more entities for services specified under s. 46.283 (3).
p. 12, lines 1-3 and note following	Please delete this responsibility from DHFS purview. Instead, the Board on Aging and LTC will assume this responsibility. Amend s. 15.105 to read: There is created a board on aging and long-term care, attached to the department of administration under s. 15.03. The board shall consist of ~~7~~ 9 members appointed for staggered 5-year terms. Members shall have demonstrated a continuing interest in the problems of providing long-term care for the aged or disabled. At least ~~4~~ 6 members shall be public members with no interest in or affiliation with any nursing home. At least 5 members shall be persons aged 65 or older or persons with physical or developmental disabilities or their family members, guardians or other advocates. The changes to s. 16.009 (2) can stay as drafted; these relate to BOALTC's role as the ombudsman for residents of LTC facilities. Add to the general responsibilities of BOALTC: " *Long-term care advocacy.* The board shall contract with one or more organizations to provide advocacy services to potential or actual recipients of the family care benefit as defined under s. 46.28 (4) or their families or guardians. The board and contract organizations under this subsection shall assist these persons in protecting their rights under all applicable federal or state laws and regulations. An organization with which the board contracts for these services may not be a provider, nor an affliate thereof, of long-term care services, a resource center under s. 46.283 or a care management organization under s. 46.284. Advocacy services include, but are not limited to: information, technical assistance and training for consumers about how to obtain services or supports, advice and assistance in preparing and filing complaints, grievances and appeals, negotiation and mediation on behalf of

Reference	Comments
	individuals, and assuring the availability of, and consulting with legal backup for appropriate interpretation of law or regulation, and providing representation in administrative hearings and judicial proceedings."
p. 12, line 6 and following note	I suggest deleting this. Paragraph (i) seems to cover it.
p. 12, lines 8, 14 and 16	Please change the term "the long-term care system" to "resource centers and care management organizations"
p. 12, note following line 13	This provision is fine as drafted.
p. 12, lines 17-20 and note following	I suggest changing the phrase "the long-term care system" to "these organizations" — or just drop the phrase and move "external" ahead of "reviews." These reviews just have to be external to the organization being reviewed.
p. 13, line 17	Please change the term "the long-term care system" to "long-term care services"
p. 14, line 5	To avoid the possibility of any future misunderstanding, please add "non-binding" before the word "recommendations."
p. 14, lines 15-22	Please drop this paragraph. See Attachment 1.
p. 15, line 8	Please change the term "the long-term care system" to "resource centers, care management organizations and the family care benefit"
p. 15, line 10	Please change the term "the long-term care system" to "the family care benefit"
p. 15, line 14	Please change this to read "...quality of services provided by resource centers and care management organizations"
pp. 16-17	See first comment above regarding proportionality requirement. The same concern applies to local councils
p. 19, line 15	Please change the term "the long-term care system" to "resource centers and care management organizations"
p. 19, note following line 15	These recommendations are to the county board(s) of supervisors and county executive/administrator if applicable, or tribal governing board, who must consider them in deciding: - whether to authorize one or more existing county/tribal agencies to apply to the department for a contract to operate a resource center or CMO, and if so, which agencies and for which target groups - if a county, whether to create a quasi-governmental authority (or district) to apply to the department for a contract to operate a resource center or CMO



Reference	Comments
	These recommendations are also to the Department; see Attachment 1.
p. 19, line 20	Please delete the word "nonprofit" from this line. Only resource centers are required to be nonprofits; CMOs may be nonprofit or for-profit.
p. 20, lines 5-6	As drafted, it sounds like the local council has to consult with the state council before evaluating and determining... I suggest changing the phrasing to: 2. Under criteria prescribed by the department in consultation with the council on long-term care, evaluate... Alternatively, since the requirement for the department to consult is prescribed elsewhere, it could just be deleted here.
p.20, line 20	This needs to be reworked; resource centers are not certified.
p. 21, line 1	Can we add, after "Receive", the phrase "information about"? As drafted, it makes it sound like the Council is receiving complaints from individuals for the purpose of acting on them.
p. 21, note following line 6	Yes, this is fine.
p. 22, line 4	Please change "a coordinated long-term care system" to "coordination among them"
p. 22, lines 12-13	As drafted, this sounds too much like an official "policing" role, as if the council could independently "cite" the resource center or CMO; can we add, at the beginning of the clause, "assist the department and the county board of supervisors or tribal governing body to"? If that is not clear enough, just drop this provision.
p. 22, note following line 22	Let's just take out this provision; it's not that central to the purposes of the Council and would take too much work to get it right.
p 23, lines 4 through p. 24, line 17	This subsection needs work in several respects. First, the phase-in schedule has been changed, so that Resource Centers are phased in over 54 months, rather than 36 months. Second, a county cannot simply establish a Resource Center at will. This works more like the CMO phase-in. A county wanting to operate a Resource Center will apply to the Department, which intends to phase in Resource Centers in an orderly way across the state, in tandem with CMOs. Without this planful approach, Resource Centers could exist for a long time, doing pre-admission screening without any CMO or Family Care benefit to offer people. Worse, we will not have available revenues to fund the Resource Center until the CMO is available to offer alternative services to people whose services are now being funded by Community Aids funds that will be transferred to the new system.

Reference	Comments
	Please redraft these provisions to accommodate the following: Within each county, there is only one Resource Center unless a tribe/band/GLITC operates a Resource Center for tribal members within the county's boundaries. For the first 54 months after enactment & receipt of any necessary federal waivers, the Department will contract only with counties, quasi-governmental authorities, tribes, bands or GLITC (or any joint application from these entities) to operate a Resource Center, except: If a county declines to apply, applies but fails to meet contract standards, or has not applied within 54 months, the Department may contract with a private nonprofit (that does not have any connection with a CMO) to operate a RC. In this case, some services of the RC may need to be contracted separately in order to meet requirements of state and federal law.
unnecessary to draft	Given the way that the intro to s. 46.283 (3) is written, I believe the above is sufficiently detailed and this is what we would prefer. If it is really necessary to be more specific about how we would carve up the contracts: - The main contract with a private nonprofit would be to provide the services listed under s. 46.283 (3) (a) through (d), and (g) through (k) - The Department will contract with a county department under 46.21, 46.215, 46.22 or 46.23 for services listed under 46.283 (3) (m) and require that these services be accessible through the RC, through inter-agency agreement, including agreement that staff performing this function will be co-located with RC. *(This is necessary because only public employees can determine eligibility.)* - The Department will contract with either a county department (cites above), or another appropriate agency to perform the balance of functions listed under s. 46.283 (3) and to make these services available through the RC. Whether or not the county operates the Resource Center, the Department will contract, separately from the Resource Center contract, with a county department to provide services under 46.90 and ch. 55, and will require that these services be coordinated closely with RC functions.
	Given the way the introduction to s. 46.283 (3) is written, I think the phrase "if the resource center is a county agency" should be deleted from

Reference	Comments
	paragraphs (L) and (m). Please delete lines 13-17 on page 24. We should be less prescriptive in the statutes about how and with whom we contract to assure that all the listed services will be available through one Resource Center. There are so many possible permutations here. Please delete lines 18-20 on page 24. We should handle this administratively. If it is really necessary for some reason to list all the county departments that could apply to operate a Resource Center, please include aging units under s. 46.82.
p. 24, line 21 and note following	We do not need a certification process for Resource Centers. Organizations will simply apply to us for a contract.
p. 25, lines 8-9	Please change "state and federal" to "public and private." Please delete the phrase "and financial planning services."
p. 25, lines 20-22	This is fine, except please add that this assignment is consistent with criteria established by the department. Also, we should probably add a departmental duty under s. 46.282 (1) to establish these criteria.
p. 26, line 23	There will be no county matching requirement for Resource Center funding. (There will be a match requirement on Adult Protective Services funding, but that funding will be allocated and contracted through Community Aids, not through the Resource Center contract.)
pp. 27-29 46.285	The Department's decision is final regarding how to deal with conflict of interest issues when a county wants to serve as both Resource Center and CMO. Such a county will have 4 options: (1) Create a quasi-governmental authority (or a district) to operate the Resource Center and operate the CMO directly; (2) Create a quasi-governmental authority (or a district) to operate the CMO and operate the Resource Center directly; (3) Create a quasi-governmental authority (or a district) to operate both the Resource Center and the CMO; or (4) Operate both the Resource Center and the CMO directly, in which case the Department will contract with an independent organization to conduct screens and provide LTC choice counseling. All the material in the Department's proposal about separate governing

Reference	Comments
	boards of county agencies is therefore not longer relevant, since this degree of separation is insufficient to meet federal requirements. Moreover, it is possible that private organizations will have contracts to operate these organizations, and we do not wish to be too prescriptive about their board structure and duties. Therefore, almost all of this material should be deleted as too detailed for inclusion in the statutes. We can and should handle it administratively. I suggest dropping all of sub. (6) and instead including in sub. (3) something like the following. Governance by a board that reflects the ethnic and economic diversity of the geographic area served by the resource center and at least one-fourth of whose members are older persons or persons with physical or developmental disabilities or their family members, guardians or other advocates.
p. 30, lines 12-15	I suggest deleting the clause "and shall permit the county to be the exclusive operator of a care management organization in that county for the target groups that the county elects to serve." I don't think that would be in the actual contract, and it is redundant with the last sentence of this paragraph.
p. 31 notes	Re: PACE and Partnership, please see above comments on definitions. Re: "target group", I suggest changing s. 46.284 (1) (b)2. to read: 2. Because the county does not elect to serve both older persons and persons with a physical disability or is unable to meet requirements for both these client groups, an additional care management organization is necessary to serve the group that is not served by the county.
p. 31, lines 6-12; p. 32, lines 23-24 and note following	Regarding sub. (2) (a): We don't want to certify an entity "as a care management organization"; instead, we want to certify that an applicant meets requirements. Of those applicants who are certified as meeting requirements, one or more will be selected to receive a contract to actually operate a CMO. See Attachment 1. Please drop the phrase "to maintain certification" from sub. (2) (c); let's just say that they are required to do these things.
p. 33	Please add, after line 7: 5. Meet department requirements for solvency protection. 6. Annually submit to the department a financial audit that meets the requirements of CFR 42.438.
p. 34, note following line 11	Yes, these provisions are fine.
p. 34, line 13 through p. 37, line	My comments regarding Resource Center governing boards apply here as well. I would drop this whole subsection and include in sub. (2)(a)

Reference	Comments
	something like the following: Governance by a board that reflects the ethnic and economic diversity of the geographic area served by the resource center and at least one-fourth of whose members are older persons or persons with physical disabilities or their family members, guardians or other advocates.
p. 37, note following line 11	I agree that any exemption for PACE, Partnership or other managed care programs under Medicaid should be handed through an exception to s. 50.49. Cites for PACE and Partnership programs are in my notes above; I have not yet gotten the information I requested on other programs. If I get the requested citations in the next several days, I will forward.
p. 37, line 13 through p. 39, line 2	This material on eligibility and entitlement needs work and I need to consult with others in commenting. We will follow up with comments by Tuesday, December 22.
p. 39, line 7 through p. 41 line 4	I agree with the change from "person" to "client." Yes, the broader term "client" should include eligible persons and enrollees, as drafted. It is my understanding that family members, guardians and advocates don't have these rights for themselves; rather, they assist the client to exercise the client's right. I will follow up on this with people who are more expert than I in this area. Re sub. (2) (a): Use of the term "other benefit programs" is fine. Re sub. (3): Sorry, my fault for including disenrollment here in the earlier instructions. No, one cannot receive the family care benefit without being enrolled in a CMO. Par. (a) should be, as you suggest, "enroll in a care management organization and receive..." Par. (b) should be moved to the rights of enrollees. Re: sub. (4) (b) and (c): To address the concerns raised by the drafter's notes following line 4, I suggest something like the following modifications: (b) Development of a plan of care that: 1. is tailored to meet his or her unique needs and circumstances as indicated by performance of an individualized assessment; 2. as much as possible preserves the enrollee's health, safety and well being; and 3. as much as possible keeps the enrollee free from abuse or neglect. (c) Prompt receipt~~, from providers,~~ of services and support items that are included in the plan of care and that are adequate and appropriate in meeting the enrollee's individual needs. We do need to include somewhere a provision making it clear under what circumstances people have a right to a state fair hearing, which should include the following (slightly revised from material submitted earlier):

Reference	Comments
	All clients (not just those who are Medicaid-eligible) should have a right to a State Fair Hearing for review of the following issues without being required to first exhaust any other procedure: 1) Denial of eligibility, or of an appropriate level of eligibility, for Family Care 2) Denial of timely services 3) Reduction or termination of services 4) The plan of care developed for the person is unacceptable to the enrollee because it requires to live in a place he or she does not want to live or to accept services, treatments or support items that are insufficient to meet the enrollee's needs, are unnecessarily restrictive, or are unwanted Enrollees should have a right to a Fair Hearing for any other grievance about the type, amount or quality of service or service provider, only after the grievance has first been reviewed by the DHFS contract monitoring unit for the Resource Center or CMO All fair hearings should be *de novo* reviews of the grievance expressed by the consumer and are not merely intended to review prior decisions. Upon receipt of a request for fair hearing, the Office of Administrative Hearings should notify the DHFS contract monitor, who should be responsible to conduct a concurrent grievance review in an attempt to resolve the dispute prior to the actual hearing date A client should be able to bring a court action at any time against any person or organization, including the state or any political subdivision thereof, causing the consumer to suffer damage as the result of the unlawful violation of his/her rights Whenever any adverse action is taken or any request denied, a client should receive notice about the various due process procedures available, an explanation of how each works, and advice about which might be most appropriate to pursue
	We will definitely need rule-making authority to further define eligibility criteria. Suggested language: (4) Criteria and processes for determining functional and financial eligibility and entitlement under s. 46.285, including but not limited to rules defining the terms "primary disabling condition," "mental illness," "substance abuse," "long-term, irreversible condition," "requires ongoing care, assistance or supervision," "condition that is long-term or potentially

Reference	Comments
	long-term," "at risk of losing independence or functional capacity," "publicly-funded long-term care services," "gross monthly income," "deductions and allowances" and "available assets," as used in s. 46.285. We will also need rule-making authority related to the grievance and appeal processes. Especially since we have demonstration counties already in place and waiting to implement as soon as we have state law and necessary federal waivers, we strongly request emergency rule-making authority so that we can implement in the demonstration counties during the much longer process of permanent rule-making. We suggest a non-statutory provision such as: Using the procedure under s. 227.24 of the statutes, the department of health and family services shall promulgate rules required under s. 46.287 of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under s. 46.287 of the statutes, as created by this act, but not to exceed the period authorized under s. 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) and (3) of the statutes, the department of health and family services is not required to make a finding of emergency.

Transitions to the new system

You asked for clarification of our request for authority to waive COP and waiver requirements to enable transition to the new system. We request that the Department to be authorized to waive, on a county-specific basis and within the limits of federal laws and regulations, all rules and guidelines related to the Community Options Program, including the COP Waiver under s. 46.27 (11) and the CIP II Waiver Program under s. 46.277.

In addition, we request language authorizing the Secretary to grant to a county limited waivers from specified statutory requirements, within the limits of federal laws and regulations, if the Secretary finds the waiver necessary to facilitate the transition to the new LTC system in the county. The specific statutory provisions we request authority to waive or exempt on a county-specific basis are as follows:

Statute reference	Topic
46.27 (3) (e) intro and 1. and 2.	Significant proportions
46.27. (3) (f)	Cap on CBRF spending
46.27 (5) (d)	COP-R cost-sharing applies to COP-W recipients
46.27 (6) (a) 1., 2., and 3.	COP assessment requirements, including pre-admission

Statute reference	Topic
	screening (and, since these statutes are constructed so that services flow from eligibility for assessment, this is where one would shut off intake to COP for elderly and/or physically disabled people when Family Care is available for them)
46.27 (6) (b) intro and 1. and 2.	Case plan requirements
46.27 (6r) (c)	Part of CBRF cap
46.27 (7) (b)	Maximum average COP payment
46.27 (7) (cm)	8-bed limit on CBRF
46.27 (11) (c) 5m. (intro)	COP-W cap on CBRF
46.47 (11) (c) 6. (incl. a. and b.)	COP-W 4-bed limit on CBRF
46.277 (3) (a)	Mandates county participation in CIP II
46.277 (4) (a)	CIP II eligibility
46.277 (5) (d) 1m.	CIP II CBRF restrictions
46.277 (5) (d) 2. (incl. a. and b.)	CIP II 4-bed limit on CBRF

Insurance Exemption
Please add the following to the draft:

s. 600.01 (1) (b) 10. is created to read:
10. A care management organization that contracts with the department of health and family services under s. 46.284 to provide long-term care services funded by the family care benefit, as defined under s. 46.28 (4) for long-term care services and enrolls only individuals who are eligible under s. 46.285.

Explanation:
We have agreed with the Office of the Commissioner of Insurance (OCI) that the above provision should be added to exempt from insurance regulation any CMO that does not provide acute and primary health care services and enrolls only public pay clients who are in need of LTC services. OCI does not feel that CMOs will provide insurance products that fall under their jurisdiction. CMOs will not enroll individuals who do not receive a public subsidy; therefore their management of publicly funded benefits can and should be governed by DHFS contracts with these organizations. Moreover, all enrollees will be in need of services by virtue of the functional eligibility requirements; this is not an "insurance" model in which risk is spread

across a broad population, most of whom are "healthy." While there is some risk involved, it is spread much more narrowly than is the case for an HMO.

OCI has agreed to assist DHFS to develop financial protections in our CMO contract provisions and to help us develop the capacity to monitor and ensure financial solvency of CMOs.

Quasi-governmental authority or alternative

We have found another model for a county authority, that might be of use. Section 59.57 allows the creation by a county board of an Industrial and Economic Development Authority. With the help of our Office of Legal Counsel, I would be happy to try adapting that model for our purposes if that would be helpful.

cc: Fredi Bove - OSF/Budget
Chuck Wilhelm - OSF
Shelley Malofsky - OLC
Joyce Allen - OSF/CDSD
Mary Rowin - OSF/CDSD
Tom Hamilton - OAF/CDSD
Kevin Lewis - SO

Attachment 1

Revised instructions for CMO selection process after first two years of CMO operation with capitated funding (i.e., when open bidding is required)

1. Consistent with criteria established by the department after consulting with the state Council on Long-Term Care, the local LTC Council determines the number of CMOs that should operate in its area, and provides its determination to the Department.

2. If the local LTC Council determines that only one CMO is needed, the Department will solicit applications and select the most qualified organization with which to contract.

3. If the Council determines that two or more CMOs are needed, the Department will solicit applications, certify those applicants that meet standards, and provide the list of certified applicants to the Council. The Council selects at least two of the applicants and notifies the Department of its selections. The Department contracts with the selected organizations.

4. In either case and at any time: The Department is required to assure that sufficient care management organization capacity is available in each location to serve all current and potential enrollees. If empirical data indicates that existing care management organizations do not have, and cannot develop, sufficient capacity, the Department will request that the local LTC Council select additional organizations from the list of certified applicants.

Changes to LRB–0030/P1:

- Delete s.46.282 (1) (c) related to the State Council's role in reviewing the Department's preliminary decision on the number of CMOs in an area and who gets a contract.
- Revise s. 46.282 (3) 2. so that it includes the responsibilities outlined above.
- Add to the Department's contracting responsibilities under s.46.284 (1) so that it includes the steps outlined above, including number 4.

Attachment 2

Limiting inclusion of people with developmental disabilities in this legislation

Secretary Leean has recommended to the Governor that people with developmental disabilities not be covered by Family Care, except in a limited number of demonstration sites. We have discussed the implications of this decision and determined that:

- The state and local LTC Councils will continue to cover the full range of LTC programs and services. People with developmental disabilities and/or their family members, guardians or other advocates will continue to be included in the membership requirements.
- Language about consumer representation on the Resource Center governing boards will continue to reference persons with a developmental disability since the current pilot centers will continue to serve this population. *(no longer included)* ?
- In general, CMOs will serve only older persons and persons with a physical disability. (I have suggested changes related to governing board requirements above.)
- In general, the Family Care benefit will cover only older persons and persons with a physical disability. (Suggested changes to the eligibility provisions will include exclusion of persons whose primary disabling condition is a developmental disability.)
- Pre-admission screening will be required for all admissions of people with a developmental disability to a nursing facility or ICF-MR, but <u>not</u> to an adult family home, CBRF or other residential LTC facility. *(See 11/30 instructions)*

I believe the rights section can continue to cover people with developmental disabilities. They will still be covered by the Resource Center, so they should be included in the definition of "client." They will be defined out of "eligible person," and therefore also cannot be an "enrollee," except in the pilots.

To allow the demonstration sites to cover people with a developmental disability, we suggest creating of a provision either in the statutes or in non-statutory provisions along the lines of the following:

> "Notwithstanding s. 46.285, a person whose primary disabling condition is a developmental disability is eligible for the family care benefit if the person is a resident of a county operating a care management organization as a pilot program under s. ~~46.271(2m)~~."

1997 Wis Act 237, sec. 9122 (4)

STATE OF WISCONSIN – LEGISLATIVE REFERENCE BUREAU – LEGAL SECTION
(608–266–3561)

From Gretchen Fossum 1/8/99

From briefing with Governor:

(1) Delete local long-term care councils

(2) Sunset Council on long-term care after 2 years

(3) Delete client rights

(4) Delete repeal of s. 16.009 (2) (em)

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Tuesday, January 12, 1999 12:00 PM
To: Kennedy, Debora
Subject: Family Care Draft

ltcAppro.doc

Here is the department's piece on the appropriations.

<<ltcAppro.doc>>

Appropriation-related Provisions in Family Care — Family care benefit; cost sharing requirements

I. Suggested ~~Language~~ for new Chapter 20 appropriation:

s. 20.435(4)(g): All Moneys received from ~~Family Care~~ client cost-sharing ~~provisions~~ requirements under s.46.286(2) to ~~be used to pay~~ expended for the provision of ~~Family Care long-term care~~ services under the family care benefit under s.46.284 (4)

II. Suggested Language for Appropriation-related provisions in Chapter 46

A. For Resource Centers: Insert in s. 46.283(5): The Department shall utilize funding in s.20.435 (4)(pa) (5)(p), (7)(b), and (7)(md)to purchase the services enumerated in this section.

B. For CMOs: Insert in s.46.284(4): The Department shall utilize funding in s.20.435 (4)(b), (4)(g), (4)(o), (7)(b), and (7)(bd) for payments to Care Management Organizations contracted under this section

46.283(5)
46.284(4)

What is 20.435(4)(pa)? (20.435(5)(p) - LRB.0028)
(4)(b)? (20.435(5)(b) - LRB.0028)
(4)(o)? (20.435(5)(o) - LRB.0028)
(

CR; 20.435(4)(g)
AM; 20.435(7)(b)
AM; 20.435(7)(bd)
AM; 20.435(4)(pa) -(5)(p)
AM; 20.435(4)(b) - (5)(b)
AM; 20.435(4)(o) - (5)(o)
AM;