2019 DRAFTING REQUEST

Bill

For:	**Administration-Budget**	Drafter:	**tdodge**
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Date:	**10/26/2018**	May Contact:	

Same as LRB:

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Pre Topic:

DOA:.....Stinebrink, BB0038 -

Topic:

Long-term care; managed care

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/?	tdodge 1/30/2019	ccarmich 1/31/2019			
/P1	tdodge 2/2/2019	ccarmich 2/4/2019	mbarman 1/31/2019		
/P2	tdodge 2/15/2019	ccarmich 2/16/2019	lparisi 2/4/2019		State S&L
/P3	tdodge 2/21/2019	wjackson 2/21/2019	chanaman 2/17/2019		State S&L

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/P4	tdodge 2/22/2019		mbarman 2/21/2019		State S&L
/P5		aernsttr 2/25/2019	jmurphy 2/22/2019		State S&L
/P6		kfollett 2/25/2019	dwalker 2/25/2019		State S&L
/P7			lparisi 2/25/2019		State S&L

FE Sent For: **<END>**

Dodge, Tamara

From: Hanaman, Cathlene
Sent: Friday, October 26, 2018 1:22 PM
To: Dodge, Tamara; Walkenhorst Barber, Sarah
Subject: FW: Statutory Language Drafting Request - 2019-21
Attachments: LTC and MC Stat Language.docx

From: Stinebrink, Cory R - DOA
Sent: Friday, October 26, 2018 1:21 PM
To: Hanaman, Cathlene <Cathlene.Hanaman@legis.wisconsin.gov>
Cc: Dombrowski, Cynthia A - DOA <Cynthia.Dombrowski@wisconsin.gov>; Stinebrink, Cory R - DOA <Cory.Stinebrink@wisconsin.gov>
Subject: Statutory Language Drafting Request - 2019-21

Biennial Budget: 2019-21

Topic: Long -Term Care/Managed Care

Tracking Code: BB0038

SBO Team: HSI

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Agency Acronym: 435

Agency Number: 435

Priority: Low

Intent:

See attached.

Attachments: True

Please send completed drafts to SBOStatlanguage@spmail.enterprise.wistate.us

1. Statutory language change to amend administrative rule at DHS 10.33, removing outdated adult long-term care functional eligibility requirements and replacing with current functional eligibility criteria consistent with the long-term care functional screen.

2. Bring State statutes related to Medicaid managed care grievances, appeals, and the fair hearings process into compliance with federal regulations as amended under the Medicaid Managed Care Final Rule.

3. Eliminate s. 46.2825 Regional Long-Term Care Advisory Committees.

4. Request statutory language to update requirements related to ADRCs, including (a) elimination of obsolete language as the result of statewide expansion of Family Care/IRIS and sunset of the COP and adult legacy waiver programs, and (b) limiting ADRC governing board responsibilities to require reviews of only grievances and appeals related to regional ADRCs.

5. Request statutory language changes related to the statewide expansion of Family Care and IRIS and the sunset of the COP program, including (a) elimination of the adult COP program numeric appropriation (appropriation 473 under s. 20.435(4)(bd)) and integration of those funds into the Medicaid benefits appropriation; and (b) elimination of the obsolete adult COP program statute at s. 46.27 along with any other obsolete statutory language related to the adult COP program.

Long-Term Care and Managed Care Statutory Language Changes

Decision Needed

1. Should the Department request non-statutory language changes in the biennial budget directing the Department to amend DHS 10.33 to (a) resolve certain inconsistencies between Family Care statutes, administrative code, and Departmental policies and practices, and (b) result in ongoing annual savings to the Medicaid program?
2. Should the Department request statutory language changes to Chapters 46 and 49 sections related to managed care entity[1] hearings and appeals to bring the State into compliance with new federal requirements under the Medicaid Managed Care Final Rule, eliminating the risk of federal disallowance?
3. Should the Department request statutory language changes in Chapter 20 to integrate Community Options Program (COP) funding into the Medicaid budget and request related statutory language changes in Chapter 46 to reflect Family Care/IRIS statewide expansion and the elimination of the COP and adult legacy waiver programs?
4. Should the Department request statutory language changes to Chapter 46 to eliminate Regional Long-Term Care Advisory Committees?
5. Should the Department request statutory language changes to Chapter 46 to revise statutes defining Aging and Disability Resource Center (ADRC) functions within the long-term care system?

Background

1. The Department operates four Medicaid adult long-term care (LTC) programs: Family Care, Include, Respect, I Self-Direct (IRIS), Family Care Partnership (Partnership), and Program of All-Inclusive Care for the Elderly (PACE). As of July 1, 2018, Family Care and IRIS are available in all 72 Wisconsin counties, Partnership in 14 counties, and PACE in 3 counties.

2. As of July 1, 2018, Medicaid Home and Community-Based Services (HCBS) programs provide long-term care services and supports to approximately 70,000 members. This represents the large majority (approximately 85%) of all elderly, blind, or disabled Medicaid members who are eligible for long-term care. The remaining 15% (around 12,000 members) receive long-term care services in institutional settings such as nursing homes and intermediate care facilities for individuals with intellectual disabilities.

3. As shown in the table below, around 70% of all HCBS program enrollees participate in Family Care, Wisconsin's largest Medicaid adult long-term care program. As an alternative,

[1] Proposed changes pertain to both long-term care MCOs and acute/primary care HMOs.

around 25% participate in IRIS, the State's self-directed long-term supports option. Around 5% of HCBS enrollees participate in Partnership, an integrated health and long-term care program that includes long-term care services, acute and primary Medicaid services, and Medicare services. A small handful of individuals in Milwaukee and Waukesha counties participate in PACE, a program that combines the services offered through Medicare, including Medicare prescription drugs, Wisconsin Medicaid, and home and community-based long-term care services.

HCBS Program	Estimated Adult HCBS Program Enrollment as of 7/1/2018	Proportion of Total Enrollees
Family Care	48,725	69.5%
IRIS	17,421	24.9%
Partnership	3,372	4.8%
PACE	576	0.8%
TOTAL	**70,093**	**100.0%**

4. The Family Care program was established as part of the 1999-01 biennial budget, and was initially implemented as a five-county pilot program in 2000. Statewide expansion of Family Care occurred gradually over the past 20 years, with expansion to new counties dependent on the availability of State funding, county resources and capacity, and county willingness to participate in managed care. The IRIS program was added in 2008 to increase member choice and provide an alternative to managed care, and has since expanded statewide along with the Family Care program. PACE began in 1990 and Family Care Partnership in 1995.

5. Aging and Disability Resource Centers (ADRCs) were also established in the 1999-01 biennial budget. ADRCs provide information and assistance to older adults and individuals with disabilities, their families, and other stakeholders. Through the ADRC, information is available on a broad range of programs and services, individuals can get help applying for programs and benefits, and the ADRC serves as the local access point for publicly funded long-term care. As of August, 2018, Wisconsin has 46 ADRCs, each of which serves a single county or a group of counties.

6. State statutes related to Family Care and ADRCs under Chapter 46 were originally created as part of the 1999-01 budget bill. An associated administrative rule, Chapter DHS 10, was published for Family Care in 2000. Although statutes have been amended periodically as the State expanded these programs, the core statutory and administrative rule language governing ADRCs and adult long-term care programs have remained largely unchanged since initial implementation. The IRIS, Partnership, and PACE programs are not directly referenced in state statutes or administrative rules.

7. Over the past 20 years, various non-statutory policy and program changes were implemented to comply with new federal laws and regulations, keep up with changing standards and best clinical practices, and improve program administration. As a result, a growing number of sections in Chapter 46 and DHS 10 are outdated and no longer reflect Departmental practices

and programs. This paper identifies and provides recommendations for various sections of statute and administrative rule that have been assessed as in need of change.

Adult Long-Term Care Programs Functional Eligibility Level of Care

8. For many years, the Department has been aware of an inconsistency between statute, administrative rule, and the Department's functional eligibility requirements for adult long-term care programs as determined by the adult long-term care functional screen. This inconsistency directly impacts eligibility for long-term care programs and the level of services received by certain Family Care members.

9. The adult long-term care functional screen determines functional eligibility for long-term care and categorizes individuals into one of two levels of care need: either a nursing home level of care (NH LOC) or a non-nursing home level of care (non-NH LOC). The NH LOC designation is assigned when an individual is assessed as having care needs equivalent to those provided in an institutional setting. The distinction between the NH LOC and non-NH LOC has important consequences for both participants and the Department. The NH LOC covers eligibility for a broader array of programs (Family Care, Partnership, PACE, and IRIS) and within Family Care qualifies individuals for a broader array of services at a much higher capitated rate than the non-NH LOC, which provides for a limited benefit package.

10. Individuals eligible for long-term care services at the non-NH LOC may participate in Family Care but with the more limited benefit package noted above; however, to participate in IRIS, Partnership, or PACE, an individual must be determined eligible at a NH LOC. Thus, a non-NH LOC determination impacts the benefit level a member receives under Family Care, but also limits an individual from participating in other long-term care programs, since those individuals would be ineligible to enroll in IRIS, Partnership or PACE.

11. Current statute at s. 46.286(1)(a) broadly defines the two functional eligibility levels of care, NH LOC and non-NH LOC, while Chapter DHS 10 of the administrative code includes specific criteria for categorizing individuals into these two categories. DHS 10 was developed as part of a larger long-term care reform effort that occurred in the year 2000, when Family Care was still a pilot program. Although the other adult long-term care programs were not included in DHS 10, many of the rule's provisons are applied to these programs.

12. Since promulgation of DHS 10, Department clinical staff amended the NH LOC criteria and the functional screen has been updated to capture the functional deficits associated with revised NH LOC criteria. When this change occurred, the DHS 10 functional eligibity level of care language became outdated and no longer reflected Departmental policy for the adult long-term care programs.

13. The adult long-term care functional screen tool results in a NH LOC designation for individuals assessed as needing assistance with two or more activities of daily living (ADL) and one or more 'critical' instrumental activity of daily living (IADL). A critical IADL is limited to a deficit in one of the three following areas: medication management, money management, and food preparation.

14. By contrast, DHS 10 offers a wider range of criteria by which an individual may be found eligible for the NH LOC category, including:

    - 2 or more ADLs and 1 or more IADL (similar to functional screen determination, but DHS 10 does not limit the criteria to only the three 'critical' IADLs)
    - 1 or more ADL, 3 or more IADLs, and cognitive impairment
    - 4 or more IADLs and cognitive impairment
    - 5 IADLs

15. In certain cases, the inconsistency leads to the functional screen determining a non-NH LOC, whereas a NH LOC determination would have been made if DHS 10 criteria were used. Approximately 135 adult long-term care program participants per year appeal their non-NH LOC determination by arguing that they were incorrectly categorized as non-NH LOC and that they are actually eligible for a NH LOC based upon the less restrictive DHS 10 criteria. The Department estimates that approximately 70% (approximately 95) of these annual appeals are successful.

16. A 2011 Legislative Audit Bureau (LAB) audit of the Family Care program also identified this inconsistency, finding that the long-term care functional screen was stricter than the administrative code in assigning the NH LOC designation. The LAB audit recommended that the Department reconcile the descrepancy.

17. Outdated DHS 10 language causes confusion regarding how long-term care programs are administered and results in uncertainty for those applicants for whom the NH LOC determination differs, depending upon whether the functional screen or DHS 10 criteria is used.

18. The State's Administrative Law Judges (ALJ) almost universally reference DHS 10.33 criteria for all adult long-term care programs when ruling on an appeal related to the adult long-term care functional eligibility determination.

19. The most reliable way to ensure that current functional eligibility criteria are applied when determining an individual's level of care need is to update the outdated criteria from DHS 10.33 to ensure that this section of administrative code reflects current Departmental policies, practices, and programs.

20. The Department requests non-statutory language in the 2019-21 biennial budget requiring that DHS 10.33 be amended to reflect current NH LOC and non-NH LOC functional eligibility criteria.

21. Resolution of the functional eligibility policy discrepancy is be expected to result in annual savings to the Department. Currently, outdated DHS 10 language results in avoidable Medicaid benefit costs due to the successful number of annual appeals that find non-NH LOC members eligible for a NH LOC based on the outdated DHS 10 criteria. In CY 2017, 44% (135 of 307) of functional screen appeals were directly related to the less restrictive DHS 10 functional eligibility criteria. Since adult long-term care program participants are

required to be screened annually, it is likely that certain members for whom the discrepancy exists may be repeating the appeal process each year.

22. Assuming that the Department experiences a similar number of annual appeals in the 2019-21 biennium as in CY 17, approximately 95 individuals per year would win appeals and be assigned a NH LOC based on the less restrictive DHS 10 criteria. If administrative rule language were updated as recommended, it is expected that these appeals would be unsuccessful, resulting in annual savings to the Department equal to the difference in annual costs between NH LOC and non-NH LOC payments for the approximately 95 individuals whose appeals are currently successful based on DHS 10 NH LOC criteria.

23. In 2018, the average monthly Family Care cost for NH LOC is $3,233, while the non-NH LOC cost is $478, a difference of approximately $2,755 per individual per month, on average. Thus, the potential annual savings that could be realized by the Department is approximately $3.1 million AF ($1.3 million GPR). It is assumed that an administrative rule change effective July 1, 2019 would not affect an individual's functional eligibility level of care category until their next renewal, which includes an updated functional screen. Thus, it is anticipated that the full amount of savings would phase in over the course of SFY 20. If renewals are distributed evenly across all months in SFY 20 and the full amount of savings is realized in SFY 21, it is estimated that this change could save a total of $4.8 million AF ($2.0 million GPR) in the 2019-21 biennium.

24. To provide continuity of care to current Medicaid members who have a NH LOC designation as the result of successfully appealing their functional screen determination based upon DHS 10 criteria, the Department proposes that the NH LOC status of these individuals be maintained, until (a) a change of condition renders them ineligible for a NH LOC based on the outdated DHS 10 criteria or (b) they otherwise become ineligible for Medicaid.

25. It is expected that approximately half of all individuals with past successful appeals would be 'grandfathered' into the NH LOC category based on the outdated DHS 10 critiera. This is anticipated to reduce by half the amount of savings expected to result from the administrative rule change in the 2019-21 biennium, to an estimated $2.4 million AF ($0.98 million GPR).

26. The Department also remends a related change to s. 46.288(2), which would be to eliminate subsections (d) through (j), which require the Department to promulgate rules defining certain terms. The Department objects to the unnecessary level of specificity required by these subsections of statute.

Managed Care Hearings and Appeals Compliance with the Medicaid Managed Care Final Rule

27. On April 16, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that revised Medicaid managed care regulations, including new regulations governing grievances and appeals for individuals enrolled in Medicaid managed care programs.

28. Federal regulations at 42 CFR § 438.408 set forth the requirements for managed care grievances, appeals, and the State fair hearing process. Appendix B includes the federal

regulatory language applicable to the changes required in State statute described in this section.

29. The Managed Care Final Rule includes two regulatory changes that conflict with current State statutory language around Medicaid managed care member grievances, appeals, and the fair hearings process. First, the Managed Care Final Rule revised the Medicaid member appeal filing timeframes for managed care entities. Current statutes s. 49.45 and s. 46.287 consider any request for a State fair hearing related to Medicaid managed care benefits to be untimely if filed more than 45 days after the decision. However, the Managed Care Final Rule extends the filing period to 120 days from the date on which the member receives the MCO's adverse appeal decision.

30. Second, the Managed Care Final Rule implements a requirement that managed care members exhaust the managed care plan's appeal process before proceeding to a State fair hearing. Current statutes at s. 46.287 and 49.45(5) allow Medicaid managed care members the choice to appeal an adverse benefit determination through the MCO or by requesting a State fair hearing. The Managed Care Final Rule, as promulgated in 42 CFR § 438.408(f)(1), now limits managed care members to requesting a State fair hearing *only after* receiving notice that the MCO is upholding its adverse benefit determination. A member can also file a fair hearing if the managed care entity fails to adhere to the timeframes in the Managed Care Final Rule.

31. It is notable that both MCOs and ADRCs make decisions that adversely affect enrollees. Because 42 CFR § 438.408 mandates statutory changes only for adverse benefit determinations made by an MCO, statutory language for appeals of decisions made by a resource center need not be changed.

32. To comply with federal regulations and eliminate the possibility of federal disallowance, the Department recommends that the above statutory language changes be requested as part of the 2019-21 biennial budget. Detailed suggestions for statutory language changes are included in Appendix C.

33. In addition to removing the potential for federal disallowance, these changes may also have a fiscal impact on the Medicaid program, though any possible future impact is difficult to estimate. On one hand, the requirement that MCO members first exhaust their MCO's internal appeal process prior to requesting a State fair hearing may reduce the annual number of fair hearings in which DHS and MCO staff must participate, as some appeals may be successfully resolved through the MCO internal appeal process. On the other hand, the Managed Care Final Rule extends the timeframe during which a MCO member may request a State fair hearing to appeal a Medicaid benefit determination by an additional 75 days. This significant extension of the timeframe could result in an annual increase in the number of fair hearings DHS and MCO staff must attend.

34. Although the actual impact on the Department is unknown, the Department estimates that these changes could result in additional annual costs to the Department of approximately $50,000 all funds ($20,000 GPR) per year.

Statutory Elimination of the Adult Community Options Program and Consolidation into Medicaid

35. The adult long-term support Community Options Program (COP) is detailed in s. 46.27 of the State statutes and the Chapter 20 schedule reflects funding for this program under s. 20.435(4)(bd).

36. The sunset date for adult COP was June 30, 2018. Effective July 1, 2018, the adult COP was replaced by the Family Care, Family Care Partnership, and IRIS programs. As part of this change, funding previously designated for adult COP has shifted to the Medicaid budget and now funds services provided under Family Care, Family Care Partnership, and IRIS.

37. To reflect these changes, the Department recommends that the section of State statute related to adult COP at s. 46.27 be eliminated. Statutory language at s. 46.27(13) was included in the 2013-15 biennial budget permitting DHS to eliminate this program once the family care benefit is available in all counties.

38. The Department further recommends that the Chapter 20 schedule be amended to shift former adult COP funding under s. 20.435(4)(bd) to the Medicaid benefits appropriation at s. 20.435(4)(b). At the Department level, former SFY 19 adult COP base funding of $69,121,200 GPR will shift from DHS appropriation 473 to DHS appropriation 406.

39. Statutory language at s. 20.435(4)(b) should continue to appropriate funding for the Children's Community Options Program under s. 46.272. At the Department level, this funding is held in appropriation 470.

40. Related statutory language that the Department also recommends updating includes s. 46.285, for which the introductory paragraph should be retained, but subsections (1) and (2) eliminated. These subsections were created to address a specific issue in Milwaukee county that has since been resolved, rendering these subsections obsolete.

Eliminate Regional Long-Term Care Advisory Committees

41. Statutory language requiring the Department to create regional long-term care advisory committees and detailing the duties of these committees was created as part of the 2007-09 biennial budget. These advisory committees, comprised of ADRC governing board members, are statutorily required to review, monitor, evaluate, report upon, and guide development of many aspects of the long-term care system in the region they oversee. This includes evaluating the performance of managed care organizations (MCOs) and ADRCs operating within the region.

42. The 2015-17 biennial budget directed the Department to evaluate and submit a report to the Joint Committee on Finance detailing duplicative functions performed by the Department and ADRC governing boards and make recommendations for change.[2] One recommendation

[2] See https://www.dhs.wisconsin.gov/publications/p01241a.pdf

included in the Department's report, published in 2016, was the elimination of regional long-term care advisory committees.

43. Regional long-term care advisory committees were convened once in 2012, but are currently inactive. The statutory duties of regional long-term care advisory committees are significant in scope and complexity and exceed the capacity of a citizen advisory group. Further, no funding is allocated for the Department to provide technical assistance, training, and support to these committees.

44. Stakeholder feedback received by the Department has questioned whether it is appropriate to charge citizen regional long-term care advisory committees with such critical responsibilities as monitoring and evaluating the State's large and complex long-term care system. Stakeholders have indicated their support for the elimination of long-term care advisory committees, as long as alternative mechanisms are made available for ADRC governing boards to report findings and address issues related to unmet service needs with the Department.

45. Since 2008, the Secretary of the Department has convened the Wisconsin Long-Term Care Advisory Council, a group comprised of advocates, consumers, contractors, experts and service providers who are appointed by the Secretary. The Council is charged with providing advice and guidance to the Department on issues related to service quality, long-term care workforce issues, community development strategies, and stakeholder communications.

46. In the 2016 report to Legislature on duplicative functions of the Department and ADRC governing boards, the Department and stakeholder groups jointly recommended that in lieu of convening regional long-term care advisory committees, the Department could be required to solicit stakeholder participation and input on issues related to the state's long-term care system through the Wisconsin Long-Term Care Advisory Council.

47. The Department requests statutory language changes in the biennial budget eliminating regional long-term care advisory committees at s. 46.2825, along with associated statute at s. 46.281(1n)(d), which describe requirements of the Department related to these committees.

Revise Statutes Defining ADRC Functions within the Long-term Care System

48. As summarized in the table below, the Department has identified a number of areas in which duplication of services exists between ADRC governing boards and the Department, current statutes are obsolete, or current statutes require ADRCs to undertake functions beyond the scope of ADRC services. One recommended change described below was also identified in the Department's 2016 report to the Legislature identifying duplicative functions of the Department and ADRC governing boards.

49. There are currently several sections of statute focused on functions ADRCs must perform at the time Family Care or an ADRC is first introduced in a county. As of July 1, 2018, both ADRCs and the Family Care program are available statewide, rendering these statutes obsolete; thus, the Department recommends that these sections of statute be deleted.

50. The Department also recommends deletion of the now obsolete statute authorizing ADRC governing boards to assume duties of the long-term support planning committee. Long-term support planning committees oversaw county COP programs; however, once a county implemented Family Care, the responsibility for providing COP support services to frail elders and adults with physical and developmental disabilities transferred to the Family Care and IRIS programs. Historically, the COP program also served children with disabilities and adults with mental illness and substance abuse disorders. The 2015-17 biennial budget reallocated COP funding for these groups to the Children's Community Options Program (CCOP) and community aids community mental health allocations. Effective July 1, 2018, all COP funds will have been transitioned to other programs, making county long-term support planning committees obsolete and eliminating the need for ADRC governing boards to assume the duties of those committees.

51. Another recommended area for change relates to ADRC governing board review of all long-term care system grievances and appeals. Current statutes governing ADRCs require ADRC governing boards to review all grievances and appeals related to the State's long-term care system in the area served by the ADRC they oversee, to evaluate whether a need for systems changes is present, and to make recommendations for such changes.

52. The Department recommends amending this section of statute to limit ADRC governing board responsibility for review of grievances and appeals to only those that pertain to the ADRC overseen by the board. The DHS Division of Medicaid Services (DMS) is responsible for oversight of Family Care MCOs and the other long-term care programs operated by the Department. The Department carries out its oversight duties through contract monitoring, annual financial reviews, and contracting with an external quality review organization (EQRO), currently MetaStar, to implement a multi-level, statewide management system for managed long-term care quality.

ADRC Statutory Roles and Responsibilities		
Current Requirement	**Relevant Statute**	**Proposed Change**
Department must certify ADRC availability.	s. 46.281(3)	Delete. Obsolete now that ADRCs are available statewide.
ADRCs must provide information and assistance on the Family Care program.	s. 46.283(3)	Amend to ensure that ADRCs are required to provide information and assistance on all other HCBS programs (IRIS, Partnership and PACE).
ADRCs must perform outreach to nursing home and assisted living residents in new Family Care counties.	s. 46.283(4)(c)	Delete. Obsolete effective July 1, 2018 when Family Care became available statewide.
ADRC governing boards must appoint a regional long-term care advisory committee.	s. 46.283(6)(b)7	Delete. Obsolete if regional long-term care advisory committees under s. 46.2825 are eliminated.
ADRC governing boards must review all grievances and appeals concerning the long-term care system within the ADRC's region.	s. 46.283(6)(b)9	Amend. Limit ADRC governing board responsibilities under this section to only grievances related to the ADRC overseen by the governing board.
ADRC governing boards may assume duties of the long-term support planning committee, which oversees the COP program, if directed by a county.	s. 46.283(6)(b)10	Delete. Obsolete effective July 1, 2018 when Family Care became available statewide and the COP program ended.

53. EQRO quality oversight activities include annual onsite quality reviews; annual care management reviews, including review of a sample of members' individualized service plans; quarterly review of narrative reports; ongoing review of grievances and appeals; review of critical incidents and other adverse events experienced by members; and ongoing review of data on member utilization. The EQRO, under direction of the Department, undertakes discovery activities in accordance with Departmental quality strategies. The Department is responsible for executing remediation and quality improvement efforts.

54. As noted in the 2016 report to report to Legislature on duplicative functions of the Department and ADRC governing boards, stakeholders have also questioned whether it is appropriate for ADRC governing boards to be responsible for MCO oversight, since they lack the capacity to perform detailed analysis, are not authorized to require MCOs to provide data for such analysis, and lack the authority to enforce any changes they may recommend.

55. Finally, in order to ensure that ADRC clients are fully informed of all their options, the Department recommends that statutes governing ADRCs be expanded to explicitly direct ADRCs to provide information and assistance regarding IRIS, Family Care Partnership, and PACE, in addition to the Family Care Program.

Recommendations (See Appendix A for details)

1. Request non-statutory language in the biennial budget to amend administrative rule at DHS 10.33, removing outdated adult long-term care functional eligibility requirements and replacing with current functional eligibility criteria consistent with the long-term care functional screen. This change is anticipated to result in savings to the Department of $0.85 million AF ($0.34 million GPR) in SFY 20 and $1.57 million AF ($0.64 million GPR) in SFY 21.

REC 1	Change to Base			
	FY 20	FY 21	Biennium	FTE
GPR	$ (343,901)	$ (638,305)	$ (982,206)	0.0
FED	$ (502,228)	$ (932,045)	$ (1,434,273)	0.0
PR/PRS				
SEG				
TOTAL	$ (846,129)	$ (1,570,350)	$ (2,416,479)	0.0

2. Request statutory language changes in the biennial budget to bring State statutes related to Medicaid managed care grievances, appeals, and the fair hearings process into compliance with federal regulations as amended under the Medicaid Managed Care Final Rule. Taking no action on this recommendation could result in federal disallowance. The new language would require managed care members to exhaust the MCO appeal process prior to proceeding to a State fair hearing and would extend the filing period for a State fair hearing from 45 to 120 days for managed care members. This change is estimated to result in a small biennial cost to the Department of $50,000 AF ($20,322 GPR) in both SFY 20 and SFY 21.

REC 2	Change to Base			
	FY 20	FY 21	Biennium	FTE
GPR	$ 20,322	$ 20,324	$ 40,646	0.0
FED	$ 29,678	$ 29,676	$ 59,354	0.0
PR/PRS				
SEG				
TOTAL	$ 50,000	$ 50,000	$ 100,000	0.0

3. Request statutory language changes in the biennial budget to eliminate s. 46.2825 Regional Long-Term Care Advisory Committees.

REC 3	Change to Base			
	FY 20	FY 21	Biennium	FTE
GPR	$ -	$ -	$ -	0.0
FED	$ -	$ -	$ -	0.0
PR/PRS				
SEG				
TOTAL	$ -	$ -	$ -	0.0

4. Request statutory language changes in the biennial budget to update requirements related to ADRCs, including (a) elimination of obsolete language as the result of statewide expansion of Family Care/IRIS and sunset of the COP and adult legacy waiver programs, and (b) limiting ADRC governing board responsibilities to require reviews of only grievances and appeals related to regional ADRCs.

REC 4	Change to Base			
	FY 20	FY 21	Biennium	FTE
GPR	$ -	$ -	$ -	0.0
FED	$ -	$ -	$ -	0.0
PR/PRS				
SEG				
TOTAL	$ -	$ -	$ -	0.0

5. Request statutory language changes in the biennial budget related to the statewide expansion of Family Care and IRIS and the sunset of the COP program, including (a) elimination of the adult COP program numeric appropriation (appropriation 473 under s. 20.435(4)(bd)) and integration of those funds into the Medicaid benefits appropriation; and (b) elimination of the obsolete adult COP program statute at s. 46.27 along with any other obsolete statutory language related to the adult COP program.

REC 5	Change to Base						
	FY 20		FY 21		Biennium		FTE
GPR	$	-	$	-	$	-	0.0
FED	$	-	$	-	$	-	0.0
PR/PRS							
SEG							
TOTAL	$	-	$	-	$	-	0.0

Appendix A

RECOMMENDATION 1: Emergency rulemaking to update DHS 10.33 related to Family Care functional eligibility level of care requirements.

Relevant Sections of Statute or Administrative Rule	Proposed Changes
DHS 10.33	Request non-statutory language in the biennial budget requiring amendment of DHS10.33 with updated long-term care functional eligibility requirements.
s. 46.288(2)(d)-(j)	Retain the language in 46.288(2) related to rulemaking requirements related to long-term care functional eligibility, financial eligibility, and cost sharing, but delete subsections (d) through (j), which require rules to codify definitions.

RECOMMENDATION 2: Managed care hearings and appeals updates to comply with Medicaid Managed Care Final Rule

Relevant Sections of Statute	Proposed Changes
s. 46.287(2) and (3)	Revise language to extend the State fair hearing filing period for managed care appeals from 45 to 120 days. Amend language to implement a requirement that managed care members exhaust the managed care plan appeal process before proceeding to a State fair hearing. See Appendix C for details.
s. 49.45(5)	Revise language to extend the State fair hearing filing period for managed care appeals from 45 to 120 days. Amend language to implement a requirement that managed care members exhaust the managed care plan appeal process before proceeding to a State fair hearing. See Appendix C for details.

RECOMMENDATION 3: Eliminate Regional Long-Term Care Advisory Committees

Relevant Sections of Statute	Proposed Changes
s. 46.2825	Eliminate Regional Long-Term Care Advisory Committees and all related statutory references.
s. 46.281(1n)(d)	Eliminate requirements of the Department related to Regional Long-Term Care Advisory Committees, if statutory language eliminating these committees is implemented.
s. 46.283(6)(b)7	Eliminate requirement that ADRC governing boards must appoint a regional long-term care advisory committee.

RECOMMENDATION 4: Updates to statutes governing ADRCs

Relevant Sections of Statute	Proposed Changes
s. 46.283(6)(b)9	Amend requirement that ADRC governing board must review all grievances and appeals concerning the long-term care system within the ADRC's region. Limit responsibilities for review of grievances under this section to only those grievances related to the ADRC overseen by the governing board.
s. 46.281(3)	Delete requirements that the Department certify ADRC availability. This section of statute is obsolete; ADRCs are available statewide.
s. 46.283(3)(f)	Direct ADRCs to also provide information and assistance on IRIS, Partnership, and PACE programs, in addition to Family Care.
s. 46.283(4)(c) Should be (e)	Delete obsolete provision that ADRCs must perform outreach to nursing home and assisted living residents in new Family Care counties. Family Care is available statewide.
s. 46.283(6)(b)10	Delete the requirement that ADRC governing boards may assume duties of the long-term support planning committee, which oversees the COP Program, if directed by the County. This section of statute is obsolete effective July 1, 2018 when the COP program ended due to Family Care becoming available statewide.

RECOMMENDATION 5: Updates to statutes resulting from Family Care and IRIS statewide expansion and sunset of COP and adult legacy waiver programs.

Relevant Sections of Statute	Proposed Changes
s. 20.435(4)(b) and s. 20.435(4)(bd)	Request statutory language to remove COP funding from (4)(bd) and shift funding to (4)(b)
s. 46.27	Eliminate the section of Chapter 46 that defines the adult long-term support community Options Program (COP), which ended on June 30, 2018, when Family Care expanded statewide.
s. 46.2805(1)(b)	Update federal authority reference for Partnership.
s. 46.285	Retain the introductory paragraph but delete subsections (1) and (2). These numbered sections were created to address a specific issue in Milwaukee County, which has since been resolved and which renders these sections of statute obsolete.

Appendix B

Below is current language from the Code of Federal Regulations Chapter 42 that necessitates changes to State statute related to Medicaid managed care hearings and appeals.

42 CFR § 438.408

(a) Basic rule. Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

.....

(f) Requirements for State fair hearings—(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) External medical review. The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.
(B) The review must be independent of both the State and MCO, PIHP, or PAHP.
(C) The review must be offered without any cost to the enrollee.
(D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(2) State fair hearing. The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

Appendix C

Below are the Department's suggested changes to s. 46.287 and s. 49.45 that would bring State statute into compliance with federal regulations, as amended by the Managed Care Final Rule. Note: Footnotes are for the purpose of providing additional information only, and are not intended to be included as part of statutory language changes.

Proposed changes to s. 49.45(5)

(a) Any person whose application for medical assistance is denied or is not acted upon promptly or who believes that the payments made in the person's behalf have not been properly determined or that his or her eligibility has not been properly determined may file an appeal with the department pursuant to par. (b). Review is unavailable if the decision or failure to act arose more than 45 days before submission of the petition for a hearing, except as provided in par. (1) or (2).

1. For a hearing request related to a decision by a managed are entity, the petitioner has 120 calendar days from the date of receipt of the managed care entity's notice upholding its adverse benefit determination or 120 calendar days from the date of the managed care entity's failure to act on the contested matter within the time frames specified by the department. An adverse benefit determination is defined as the following:

a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

b. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed;

c. The denial, in whole or in part, of a payment for service;

d. The failure to provide services in a timely manner;

e. The failure of the managed care entity to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

f. The denial of a member's request to dispute financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; and

g. For a resident of a rural area with only one managed care entity, the denial of a member's request to obtain services outside the network under 42 CFR 438.52(b)(2)(ii).

2. If a different time limit for a hearing request is specified by federal regulation, that limit shall apply.

(b)

1. Upon receipt of a timely petition under par. (a) the department shall give the applicant or recipient reasonable notice and opportunity for a fair hearing. The department may make such additional investigation as it considers necessary. Notice of the hearing shall be given to the applicant or recipient and, if a county department under s. 46.215, 46.22, or 46.23 is responsible for making the medical assistance determination, to the county clerk of the county. The county may be represented at such hearing. The department shall render its decision as soon as possible after the hearing and shall send a ~~certified~~ copy of its decision to the applicant or recipient, to the county clerk, and to any county officer charged with administration of the Medical Assistance program. The decision of the department shall

have the same effect as an order of a county officer charged with the administration of the Medical Assistance program. The decision shall be final, but may be revoked or modified as altered conditions may require. The department shall deny a petition for a hearing or shall refuse to grant relief if:

a. The petitioner withdraws the petition in writing.

b. The sole issue in the petition concerns an automatic payment adjustment or change that affects an entire class of recipients and is the result of a change in state or federal law.

c. The petitioner abandons the petition. Abandonment occurs if the petitioner fails to appear in person or by representative at a scheduled hearing without good cause, as determined by the department.

d. The issue is an adverse benefit determination made by a managed care entity and the petitioner has not exhausted the internal appeal procedures with the managed care entity.

Proposed changes to s. 46.287

(1) DEFINITION. In this section, "client" means a person applying for eligibility for the family care benefit, an eligible person or an enrollee.

(2) HEARING.

(a)

~~**1.**~~ Except as provided in subd. ~~2~~3., a client may contest any of the following applicable matters by filing~~, within 45 days of the failure of a resource center or care management organization to act on the contested matter within the time frames specified by rule by the department or within 45 days after receipt of notice of a decision in a contested matter,~~ a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1), within:

1. 45 calendar days of the failure of a resource center or county to act on the contested matter within the time frames specified by rule by the department or within 45 calendar days after receipt of notice of a resource center's or county's decision in a contested matter, regarding any of the following:

a. Denial of eligibility under s. 46.286 (1).

b. Determination of cost sharing under s. 46.286 (2).

c. Denial of entitlement under s. 46.286 (3).

~~**d.** Failure to provide timely services and support items that are included in the plan of care.~~

~~**e.** Reduction of services or support items under the family care benefit.~~

~~**f.** Development of a plan of care that is unacceptable because the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee or the plan of care provides care, treatment or support items that are insufficient to meet the enrollee's needs, are unnecessarily restrictive or are unwanted by the enrollee.~~

g. Termination of the family care benefit.

h. Imposition of ineligibility for the family care benefit under s. 46.286 (4).

i. Denial of eligibility or reduction of the amounts of the family care benefit under s. 46.286 (5).

j. Determinations similar to those specified under s. 49.455 (8) (a), made under s. 46.286 (6).

k. Recovery of family care benefit payments.

2. 120 calendar days of the failure of a managed care entity to act on the contested adverse benefit determination within the timeframes specified by rule by the department or within 120 calendar days from the date of receipt of notice of a managed care entity's decision upholding its

adverse benefit determination. An adverse benefit determination is defined as any of the following:

a. Denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the managed care entity's administration of the long-term care functional screen, including a change from a nursing home level of care to a non-nursing home level of care.

b. Failure to provide timely services and support items that are included in the plan of care.

c. Denial or limited authorization of a requested service, including determinations based on type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

d. Reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.

e. Denial, in whole or in part, of payment for a service.

f. The failure of a managed care entity to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

g. The denial of a member's request to dispute financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

h. Denial of an enrollee, who is a resident of a rural area with only one managed care entity, to obtain services outside the network.

i. Development of a plan of care that is unacceptable to the enrollee because any of the following apply:

i. the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee;

ii. the plan of care does not provide sufficient care, treatment or support to meet the enrollee's needs and support the enrollee's identified outcomes;

iii. the plan of care requires the enrollee to accept care, treatment or support that are unnecessarily restrictive or unwanted by the enrollee.[3]

j. Involuntary disenrollment from the managed care entity.[4]

23. An applicant for or recipient of medical assistance is not entitled to a hearing concerning the identical dispute or matter under both this section and 42 CFR 431.200 to 431.246.

(b) An enrollee may contest a decision, omission or action of a care management organization other than those specified in par. (a)2., by filing a grievance with the managed care entity~~or may contest the choice of service provider. In these instances, the enrollee shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute.~~ A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. If the ~~dispute~~grievance is not resolved to the satisfaction of the

[3] This is not a federally-defined adverse benefit determination, but is a state-defined adverse benefit determination.
[4] This is not a federally-defined adverse benefit determination, but it is a state-defined adverse benefit determination. Termination of the Family Care benefit was not included because that responsibility falls to the ADRC. While an MCO disenrolling a member may result in the member being terminated from Family Care, the MCO does not terminate the Family Care benefit.

enrollee, he or she may request a Departmental review of the managed care entity's grievance decision[5]~~hearing under the procedures specified in par. (a) 1. (intro.)~~.

(c) Information regarding the availability of advocacy services, ~~and~~ notice of adverse actions taken, and appeal rights shall be provided to a client by the resource center or managed care entity~~care management organization~~ in a form and manner that is prescribed by the department by rule.

[5] The federal definition of 'appeal' is 'a review by an MCO, PIHP, or PAHP of an adverse benefit determination.' The federal definition of 'grievance' is 'an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.' Since s. 46.287 pertains specifically to fair hearings, section (b) could potentially be eliminated in its entirety if it is inappropriate to address non-fair hearing related issues in this section of statute.