Survival Coalition
of Wisconsin Disability Organizations

P.O. Box 7222, Madison, Wisconsin 53707

2015-17 Governor's budget proposal

http://docs.legis.wisconsin.gov/2015/related/proposals/ab21.pdf

DHS Budget Appropriation tables

Pages 304-320

These tables list all of the appropriation lines associated with DHS programs, the type of appropriation account (Federal, Segregated, Continuing, Annual, etc.), and the amount allocated in each year.

DHS budget appropriation lines statutory language (Ch. 20.435)

Sections 670-719 (pages 434-451)

These sections detail any DHS appropriation line (appropriations with the 20.435 prefix) that is being created, amended, or repealed.

The statutory language associated with an appropriation line may detail for what purpose funds may be used and how they are distributed.

Proposed Changes to DHS statutes related to adult long term care

Sections 1479-1642 (pages 615-678)

Changes to statutes related to long-term care programs. Detailed analysis of individual sections provided in the following pages.

Non-statutory provisions

Section 9118 (9) (pages 1755-1765)

Detailed analysis of individual sections provided in the following pages.

SECTION 1533 Termination of Legacy Waiver COP Program.
(See also non-statutory provisions: eliminating other long-term programs)

PROPOSED LANGUAGE

SECTION 1533. 46.27 (13) of the statutes is created to read:

46.27 **(13)** PROGRAM TERMINATION. Notwithstanding subs. (5), (6), (6g), (6u), (7), (7m), (8), and (11), after the date the family care benefit, as defined in s. 46.2805 (4), is available to eligible residents of a county, the department may discontinue the program under this section in that county.

ANALYSIS

When family care is available statewide, DHS can discontinue the COP program in counties.

Currently, eight counties—Dane, Rock, Adams, Vilas, Forest, Oneida, Florence, Taylor—are currently operating COP programs. Currently, seven Northeastern counties are transitioning to Family Care from COP per JFC action in 2014.

QUESTIONS AND CONCERNS

- What would be the transition process for existing participants in county legacy programs, persons on county waiting lists, and persons entering the new program? Who will be involved in the development of the plan, and how will it be implemented? The bill does not specify a timeline as to when transition to statewide family care would happen (could be anytime within the biennial budget).
- How would this impact local government budget planning for the new eight counties?
- What impact would transition have on existing county and provider contracts? Many local businesses have contracts with the county to help older adults and people with disabilities with transportation, community employment opportunities, residential living, personal and home health care, habilitation, and behavior supports.
- What small business impacts may occur—workforce reduction, reduction in services or the type of services purchased, operational budgetary uncertainty—for local provider agencies?
- What could the potential impact on small businesses, employers, and DVR be who have employees with disabilities who need on community supports (residential, transportation, community integrated job) if a shift in the LTC model results in service levels?
- What will the communications plan be in place to help FC participants and their families, stakeholders, providers, and legislators understand any changes and the transition process?
- Will the home and community based services—medical, community employment, residential, personal and home health care, habilitative, behavioral support—in the

proposed Family Care program be equal to or better than the services currently available in Family Care, IRIS, and legacy counties? If so, in what way?

- This Section indicates that DHS can cease providing federal Medicaid dollars to counties for the COP program. Can counties continue to provide services in addition to what is provided in the Family Care benefit?

Section 1541, Section 1542, Section 1554, Section 1555, Section 1564, Section 1620 Changes the definition of Family Care, Dissolution of LTC District MCOs

PROPOSED LANGUAGE

SECTION 1620. 46.2895 (12m) of the statutes is created to read:

46.2895 **(12m)** REQUIRED DISSOLUTION. A long–term care district that exists on June 30, 2015, shall dissolve under the procedures in sub. (13) before June 30, 2017, or before a date established by the department, whichever is later.

ANALYSIS

Changes the definition of Family Care Program to mean the program under sections 46.2805 to 46.288 of the statutes. In the bill draft, PACE and Partnership are re-numbered to 46.2805 (9m) and 46.2805 (4k).

Long-term care districts would not be included in this new definition, and the bill has them dissolve by June 30, 2017(LTC dissolution occurs on page 673, section 1620).This means that four Long-Term Care District MCOs-- Lakeland Care District, Western Wisconsin Cares, Community Care Connections of Wisconsin and ContinuUs—will dissolve on this date.

QUESTIONS AND CONCERNS

- Would this bill expand PACE and Family Care Partnership statewide or just the Family Care benefit? Would this bill allow current PACE and Family Care Partnership to continue without any changes?
- As drafted, this budget would cut the current pool of MCOs in half by eliminating Long Term Care Districts.
- What will happen to the four MCOs that are long-term care districts? Will these MCOs be out of business in 2017?
- What will be the process for current MCOs to re-establish themselves as private, non-profits and continue to operate?
- If these MCOs must dissolve, how does the Department plan to transition the members they serve to new MCOs?

- Lakeland Care District is one of the MCOs that was awarded a contract to expand Family Care into seven northeast counties starting in 2015. How will this transition currently in process and due to be completed in 2016 be managed?

Section 1545, Section 1546, Section 1547, Section 1549: changes definition of Care Management Organizations to include insurers

Proposed Language

Section 1549. 46.2805 (1) (dm) of the statutes is created to read:

46.2805 **(1)** (dm) Beginning on January 1, 2017, or the date specified in 2015 Wisconsin Act .... (this act), section 9118 (9), whichever is later, an insurer that is licensed and in compliance with the applicable provisions of chs. 600 to 646, that is certified as meeting the requirements for a care management organization under s. 46.284 (3), and that has a contract under s. 46.284 (2).

Analysis

The provision appears to require all Care Management Organizations (CMOs) to be licensed and regulated by the Office of Commissioner on Insurance in order to receive a contract to operate Wisconsin's publically funded long-term care programs.

This change would means that an HMO or other private insurer could meet the definition of a CMO, and could operate as a CMO. Currently, MCOs that operate Family Care Partnership/PACE—entities currently under contract to operate Family Care—that are not Long Term Care Districts are already regulated by OCI.

Questions and Concerns

- This provision would require all MCOs to become insurers; it also opens the door for private insurers (such as HMOs) to operate as MCOs.
- Currently Wisconsin's, Community Based Long-Term Care programs have an integrated care approach that is not a part of traditional private sector health insurance or HMO. Long term care provides personal care, community employment, transportation, residential, habilitative, and behavioral services.
- A successful integrated care model does not prioritize one element (such as health and safety) at the expense of other services that lead to greater independence, community involvement, and overall health.

- How will DHS ensure that all care management organizations are spending long-term care dollars that result in more independence and integration into the community (community employment, living, engagement)?
- What community outcomes will be established as expectations for all care management organizations, and how will performance be quantified?
- What happens if CMO performance is not resulting in integration, community outcomes, or is resulting in Medicaid funded institutional placements?
- Does the regulation of CMOs by OCI impact DHS's ability and leverage to set benchmarks and create benchmarks for improvement in certain areas?
- Wisconsin's integrated care model and long-term care system was developed over many years with local stakeholder (local government, stakeholder, and participant) input. Why was that not the course this time? Why the need for a change and without input?
- Wisconsin-based MCOs serve local communities and with local service providers and small businesses. These relationships translate into local employment and local spending.
- If Wisconsin-based MCOs go out of business, what are the economic repercussions for the local workforce, business, and economy?
- Milwaukee County operates Family Care in eight different counties. Can a county be regulated by OCI as a CMO to continue to operate Family Care?

Section 4553: Authority to regulate CMOs and promulgate administrative rules to license CMOs

PROPOSED LANGUAGE

SECTION 4553. 601.41 (12) of the statutes is created to read:

601.41 **(12)** CARE MANAGEMENT ORGANIZATIONS. The commissioner may apply the provisions of chs. 600 to 646 to a care management organization, as defined in s. 46.2805 (1) (dm). The commissioner may promulgate rules to license care management organizations, as defined in s. 46.2805 (1) (dm), as insurers and to otherwise regulate care management organizations.

The bill repeals the current MCO permitting requirement through OCI (page 668, section 1601), and allows OCI to apply insurance regulations to CMOs. A new licensure requirement is authorized, and OCI is authorized to promulgate administrative rules. CMOs will be regulated by OCI, but it appears that DHS will maintain quality assurance and quality improvement oversight of long term care programs (page 659, section 1562).

QUESTIONS AND CONCERNS

- The proposed language indicates regulation of CMOs and promulgation of administrative rules by OCI is discretionary.
- Does this discretion mean that provisions of Chs. 600 to 646 may **not** be applied to CMOs if OCI chooses not to regulate?
- Can CMOs be licensed if OCI chooses not to promulgate administrative rules?
- If OCI licenses CMOs, does that mean they are certified by DHS, which would have the discretion to certify whether an applicant is eligible for a LTC contract (see section 1595)? Would this proposal establish two processes managed by different agencies? One potential process for licensure, and one for certification?
- What is the scope and intent of potential administrative rules? Are there special regulatory concerns/regulations that should apply to CMOs managing Medicaid funded long-term care programs?
- Are there elements of the rule that the legislature would like to direct OCI to take, such as requiring a license, requirements that must be met to be licensed, duration of a license, license review and renewal process, oversight and license revocation processes, etc.?
- What does the phrase "to otherwise regulate care management organizations" reference? What other regulations are potentially authorized by this section?
- How will DHS, which retains quality assurance and improvement oversight as the state Medicaid agency, fulfil its oversight responsibilities over entities regulated by another agency?

Section 1550 Adds primary and acute health care services to family care benefit

PROPOSED LANGUAGE

SECTION 1550. 46.2805 (4) of the statutes is amended to read:

46.2805 **(4)** "Family care benefit" means financial assistance for long–term care and support items for an enrollee and any financial assistance, as specified by the department, for primary and acute health care services under s. 49.46 (2) for an enrollee.

ANALYSIS

The definition of the Family Care Benefit is amended to " means financial assistance for long–term care and support items for an enrollee and any financial assistance, as specified by the department, for primary and acute health care services under s. 49.46 (2) for an enrollee."

Wisconsin Stats 49.46 is a reference to the Medical Assistance, recipients of Social Security aids section.

Questions and Concerns

- Are all primary and acute care services listed in 49.46 being added to the family care program?
- In Family Care, IRIS, CIP/COP, services are defined in the federal Medicaid waiver, and acute and primary care are not covered in the waiver. Participants in all these programs use Medicaid card services to access primary and acute care (as well as other long-term care services).
- Medicaid card services allow participants to choose any doctor/other service provider that takes Medicaid/Medicare patients.
- By rolling acute and primary care into the Family Care benefit, participants would have to choose from providers who are in the provider network of the statewide MCO they are in.
- Would this change result in a restriction of patient choices? Current Medicaid/Medicare card service users would no longer have a choice from of a pool of doctors/providers that take Medicaid/Medicare patients, rather they would choose from a pool of doctors/providers associated with a specific statewide MCO.
- Would this result in people having to change doctors or providers, if there current provider is not part of a provider network. We believe that a current IRIS participant who had contracted with someone who is "willing" would not be guaranteed of continuing that relationship if the IRIS program is eliminated and all IRIS participants are rolled into managed care (see also Section 1597).
- People in Family Care Partnership and PACE—these programs were originally intended for people that are dually eligible for Medicare and Medicaid—already get acute and primary care as part of the benefit and access this care through the capitated rate.
- Currently, the capitated rates for primary and acute care accessed through Family Care Partnership and PACE are based on both Medicaid and Medicare capitated rates for each service. The capitated rates for participants accessing primary and acute care through Medicaid Card services are based only on Medicaid capitated rates for each service.
- Currently, for individuals that are dually eligible for Medicaid and Medicare who are participating in the Family Care Partnership and PACE programs, the MCO receives a blended Medicaid and Medicare capitated rate for providing care to the member.
- Currently, when individuals who are only Medicaid eligible use Family Care Partnership and PACE, the MCOs only receive the Medicaid capitated rate, which is not adequate to meet the needs of these members.
- When Family Care rolls in acute and primary care (meaning that these services are no longer accessed separately via Medicaid card services), will there be an increased cost to the benefit package and the capitated rate will need adjustment to reflect these added services.
- What is the estimated cost of adding primary and acute care services, and what increase in the capitated rate will be necessary to cover these services?

- How will the proposed integrated care model ensure participants have access to providers of home and community based services that are separate from primary and acute care? As an example, what if a participant's community employment services provider is in one network and their doctor is in another?

Section 1558, Section 1622, Section 1623, Section 1625, Section 1565: Eliminates the IRIS program and modifies self-directed services definition

PROPOSED LANGUAGE

SECTION 1558. 46.2805 (10m) of the statutes is amended to read:

46.2805 **(10m)** "Self–directed services option" means the option in the family care program ~~that is operated under a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (c)~~ in which an enrolled individual selects his or her own services and service providers.

Repeals 46.2899(1):

"Definition. In this section, "self-directed services option" means a program known as Include, Respect, I Self-direct or IRIS operated by the department under a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (c)"

Repeals 46.2897:

Self-directed services option; advocacy services. The department shall allow a participant in the self-directed services option that is operated under a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (c) to access the advocacy services contracted for by the department under s. 46.281 (1n) (e).

Repeals 46.2899(1) Self-directed services definition:

Definition. In this section, "self-directed services option" means a program known as Include, Respect, I Self-direct or IRIS operated by the department under a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (c).

ANALYSIS

Eliminates the self-directed services (IRIS) program, which provides participants with an individual budget and the flexibility to design a cost-effective personal plan within DHS set guidelines. Replaces IRIS with an element of self-direction within the managed care model.

Elimination of IRIS effectively requires the current 11,000+ IRIS participants to enroll in managed long term care or decline LTC services. It thus potentially adds 11,000+ customers (plus any

enrollments that might occur prior to elimination) to the managed care census base and eliminates any competition with the managed care model.

QUESTIONS AND CONCERNS

- Family Care currently allows for the self-direction of some services, but the bill appears to create an entirely new Self Directed Services option within Family Care. What will the parameters of this new option be and how will they differ from IRIS? What about the self-directed personal care waiver that is currently only available through IRIS?
- How will the availability, variety, and kinds of choices change in a managed care model? Will participants be restricted/forced to hire certain service providers affiliated with a CMO even if the provider is higher cost, geographically farther away from the participant, or has a less effective track record for successful outcomes than other providers?
- IRIS allows people to contract with any business or vendor directly creating efficiencies and growing business in their local community vs a private network chosen and serving at the pleasure of the CMO.
- Will participants be required to access support coordination from a CMO or will they be permitted to continue the efficient and chosen unpaid natural supports to meet the care coordinator needs? This is especially important in rural areas of the state that do not have many providers, where providers are geographically far apart, and/or when care needs are intimate and there is a need to hire trusted caregivers that will be retained (caregiver turnover can result in the participant having to retrain multiple staff).
- Will participants continue to be able to hire family members? Many family members whose loved ones use IRIS are actually serving as care coordinators, saving public dollars that would go to care teams and social workers if they were using traditional long-term care.
- IRIS was crafted with significant input from long-term care participants and their families. The program's flexibility is designed to ensure people get what they need without paying for things they don't need. Growing participation in IRIS indicates many people with long-term care needs find value and choose it rather than the self-directed services option in Family Care. 22% of people choose IRIS.
- IRIS has been a cost-effective solution to keeping people in their homes and out of costly institutional settings, however an accurate comparison between IRIS and Family Care has not been conducted. Family Care does not factor in full administrative costs and IRIS is not adjusted for acuity.

Section 1561: Removes Legislative Joint Finance Committee oversight over DHS Family Care Contracts

PROPOSED LANGUAGE

Repeals the following statutory language:

(b) If the department proposes to contract with entities to administer the family care benefit in geographic areas in which, in the aggregate, resides more than 29 percent of the state population that is eligible for the family care benefit, the department shall first submit to the joint committee

on finance in writing the proposed contract for the approval of the committee. The submission shall include the contract proposal; and an estimate of the fiscal impact of the proposed addition that demonstrates that the addition will be cost neutral, including startup, transitional, and ongoing operational costs and any proposed county contribution. The submission shall also include, for each county affected by the proposal, documentation that the county consents to administration of the family care benefit in the county, the amount of the county's payment or reduction in community aids under s. 46.281 (4), and a proposal by the county for using any savings in county expenditures on long-term care that result from administration of the family care benefit in the county. The department may enter into the proposed contract only if the committee approves the proposed contract. The procedures under s. 13.10 do not apply to this paragraph.

ANALYSIS

The bill removes the competitive bid/RFP process and JFC approval for MCO contracts from statute. The intention seems to be to move the contracting process to a certification process. However, there is still a reference to contracting in the bill: "No entity may operate as a care management organization under the requirements of this section unless so certified and under contract with the department." (pages 666-668).

QUESTIONS AND CONCERNS

- This provision seems to give the department unilateral authority to enter into contracts with no review—no public input, Joint Finance Committee or other legislative oversight, or independent non-partisan oversight body.
- Currently there are eight counties that do not have Family Care. Previously, the Joint Finance Committee has reviewed and provided oversight of all contracts that have expanded Family Care into a county.
- Current statutory language triggers Joint Finance review whenever a contract impacts a geographic area where 29% of the state population eligible for the family care benefit resides. Proposed budget language would enable statewide contracts. Why would contracts that are applicable across the entire state not be reviewed by the legislature's finance committee, when contracts that affected smaller regions and populations were required to be reviewed?
- Would removal of this section mean that any contracts the department enters would be subject to a s. 13.10 process?

Section 1573 Permits private entities to act as resource centers

Enables DHS to contract with private entities to act as resource centers, and authorizes DHS to contract with private entities other than resource centers to perform resource center functions. Under current law, resource centers are Aging and Disability Resource Centers (ADRCs) that are operating locally in each county.

Current law limits contracts to counties, long-term care districts, tribal governing bodies, or non-profit organizations if the department determines that the [nonprofit] organization has no significant connection to an entity that operates a care management organization.

Questions and Concerns

- As proposed, it appears that a "private entity" is a broad term that could mean a private for-profit entities, private or public non-profit, a public/private partnership, quasi-public or public entity.
- When ADRCs were created, the distinction between for-profit and not-for-profit entities was a major consideration and determinant on how resource centers operate. No ADRC can have any vested interest or financial gains in establishing eligibility for the programs or specific options selected by consumers, and firewalls have been established to prevent conflicts of interest. What requirements will be put in place to safeguard against financial conflicts of interest if for-profit and other entities become eligible for resource center contracts.
- Individuals exploring options for community based care that will help them retain their independence need objective information—preferably from people familiar with their local community—to help choose options tailored for their individual situation and needs.
- Does this revision allow for-profit entities of any size, based in any location, to provide service(s) (see also Concerns and Questions under Sections 1578/1560)?
- If so, would that mean private entities would be advising and potentially steering Wisconsin seniors and people with disabilities to Medicaid programs that impact Wisconsin businesses and individual taxpayers?
- With the proposed elimination of county Long-Term Care Districts (which can contract with DHS to operate resource centers), could the addition of private entities as eligible contractors result in one kind of contractor (such as private entities) having the sole statewide contract for services currently provided by resource centers?
- What specific function(s) currently performed by ADRCs might be part of a contract with a private entity?
- Especially if the entity was not Wisconsin based, how might service be impacted by lack of local knowledge and community?
- If a private entity was awarded a contract for services, how would a for-profit entity make money acting as a resource center?
- What mechanisms would be in place to ensure individuals receive full accessibility to sites and services provided about options and therefore, could make an informed choice? What metrics will be established to monitor billing, and evaluate the impact of services on recipients?
- What entity will administer the functional screen for long-term care programs? How will the screen be administered (in-person, over the phone)? What training requirements will be in place to ensure accurate and consistent administration of the functional screen?

- The potential for financial conflicts of interest between for-profit resource centers and care management or other insurance organizations is a concern. Conflicts of interest could have financial consequences for the state Medicaid budget if the choices presented to individuals have higher capitated rates or services are insufficient to keep people at home (leading to costly Medicaid funded institutionalization).
- The term "no significant connection" in current law—currently applied to non-profits, and would applicable to private entities in proposed revision—is relative. DHS has the sole authority to evaluate relationships between private entities and care management organizations. There are no parameters defined for what may be an unacceptable connection or appearance of conflict of interest, nor any specific provisions for legislative oversight of contracts or review of resource center activities.

Section 1578 and Section 1560 Allows DHS to limit the information resource centers provide individuals and other technical changes (Section 1587)

PROPOSED LANGUAGE

SECTION 1578. 46.283 (3) (intro.) of the statutes is amended to read:

46.283 **(3)** (intro.) The department ~~shall assure that at least all~~ may in a contract with a resource center or other entity specify that the resource center or other entity provide any of the following ~~are available to a person who contacts a resource center for service~~ services or functions:

SECTION 1560. 46.281 (1g) (a) of the statutes is renumbered 46.281 (1g) and amended to read:

46.281 **(1g)** CONTRACTING FOR RESOURCE CENTERS AND CARE MANAGEMENT ORGANIZATIONS. ~~Subject to par. (b), the~~ The department may contract with entities or resource centers as provided under s. 46.283 (2) to provide any of the services under s. 46.283 (3) and (4) ~~as resource centers~~ in any geographic area in the state, and may contract with entities as provided under s. 46.284 (2) to administer the family care benefit as care management organizations ~~in any geographic area in the state~~.

Current law requires all resource centers to provide the same information about nine elements listed in the statute. These provisions would allow DHS to select an item or items from the statutory list, and there would be no requirement to ensure individuals are aware of all options. (Section 1578). Section 1560 gives the department discretion to contact with resource centers

or entities for "any of" the items listed in the statutes, which implies that a contract could exclude item(s).

Questions and Concerns

- The original purpose of resource centers was to provide "one stop shopping" and a single point of entry to Wisconsin's Long Term Care system (i.e. eligibility determinations and options counseling) and the services that support it (i.e. benefit specialists, information and referral).
- This proposal appears to allow the RC functions to be scattered among several entities. How does such a proposal serve the original intent of the resource centers? What elements of the current system have been identified as requiring a change to the entire system?
- Do the ADRC statutory changes in the bill allow a private, for-profit entity to contract with the state as an ADRC?
- Clarification of the word "any." Does this mean that if DHS chooses to contract with an entity that the contract could restrict the services/functions that are/are not done, or would the contracted entity be required to provide any of the services/functions from the list?
- Currently, a resource center is operating in each of Wisconsin's 72 counties to provide a local access point for information for a diverse customer base that may have specialized communication needs. Will the Department maintain the same level of access to resource centers in its contracting plans?
- Current law requires information be consistent between resource centers. Will contracts differ between resource centers as to the services or functions it performs?
- Which item(s) from the statutory list does the Department feel could be optional in resource center contracts?
- Should the legislature have the authority to review and approve department contracts, and the direction/instruction it is giving to the contracted entities?

Section 1581: Redefines geographic area covered by resource centers

Proposed Language

Section 1581. 46.283 (4) (a) of the statutes is renumbered 46.283 (3) (L) and amended to read:

46.283 **(3)** (L) ~~Provide~~ Provision of services statewide or within the entire geographic area prescribed for the resource center or other entity by the department as specified in the contract.

Analysis

Proposed revision considers the state of Wisconsin as its own meta geographic region. Currently, the geographic area has been confined to a county. This would enable the department to define in a contract the required geographic area that must be covered (which may be statewide).

QUESTIONS AND CONCERNS

- Does this revision enable for-profit entities of any size, based in any location, to advise and potentially steer Wisconsin seniors and people with disabilities to Medicaid programs that impact Wisconsin businesses and individual taxpayers?
- If an entity is contracting for statewide work, what metrics can be put in place to evaluate access, local service, and measure outcomes of contract deliverables?
- If DHS defines in a contract the required geographic area that must be covered as "statewide," could that result in limiting the pool of eligible applicants?

Section 1595 Removes requirement for competitive bids for contracts

PROPOSED LANGUAGE

SECTION 1595. 46.284 (2) (bm) of the statutes is amended to read:

46.284 **(2)** (bm) The department may contract with counties, long-term care districts, the governing body of a tribe or band or the Great Lakes inter-tribal council, inc., or under a joint application of any of these, or with a private organization that has no significant connection to an entity that operates a resource center. ~~Proposals for contracts under this subdivision shall be solicited under a competitive sealed proposal process under s. 16.75 (2m) and the department shall evaluate the proposals primarily as to the quality of care that is proposed to be provided, certify those~~ The department may contract with any applicants that ~~meet~~ it certifies as meeting the requirements specified in sub. (3) (a)~~, select certified applicants for contract and contract with the selected applicants~~. The department is not required to solicit proposals for contracts to be a care management organization under a competitive sealed proposal process.

This provision would remove the requirement for a competitive bid process for CMOs. The Department would determine which applicants meet statutory criteria. The Department would be presumptively allowed to contract with any applicant that it certified, and may also reject any applicants it chooses.

QUESTIONS AND CONCERNS

- The elements outlined in 46.284 (3) (a) are broad, and the descriptive terms used in the statutes— such as "adequate availability," "thorough knowledge," "ability to," "expertise in"—are relative and subjective. What is the Department's interpretation of the specific quantifiable elements that would be required to meet each statutory item?
- What specific criteria, metrics, demonstrated outcomes and data, etc. will be used by the Department to evaluate applicants?
- What will be the process for determining whether an applicant is certified, and what will certification signify (i.e. does being certified imply quality)?
- What specific performance measures, metrics, data, outcomes including community employment and living and quality of life measures (such as collected by the National Core Indicators) etc. will be required from contractors?
- If the Department is allowed to award Medicaid funded contracts without a competitive bid process, how will the legislature review the adequacy of cost controls and the sufficiency of the contract to provide services for constituents?
- If a contracted service goes over budget, will the Joint Finance Committee be asked to approve a s. 16.515 request after bills have been incurred?
- The proposed language indicates that the department may choose to not contract with an applicant even if it meets criteria. Does this provision raise any liability considerations for the state?
- Without a competitive bid process, could the Department decide to award an exclusive contract? What would be the implications for competition, the state selecting for the highest quality services at the lowest cost, and consumer choice?

Section 1597 Removal of "any willing provider" language

PROPOSED LANGUAGE

Repeals 46.284 (2)(c)

(c) The department shall require, as a term of any contract with a care management organization under this section, that the care management organization contract for the provision of services that are covered under the family care benefit with any community-based residential facility under s. 50.01 (1g), residential care apartment complex under s. 50.01 (6d), nursing home under s. 50.01 (3), intermediate care facility for persons with an intellectual disability under s. 50.14 (1) (b), community rehabilitation program, home health agency under s. 50.49 (1) (a), provider of day services, or provider of personal care, as defined in s. 50.01 (4o), that agrees

to accept the reimbursement rate that the care management organization pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the care management organization requires of other providers with which it contracts to provide the same service.

ANALYSIS

Current law requires Family Care MCOs to contract with any provider willing to accept the MCO's payment, service and contract expectations; this statutory provision serves to promote Family Care enrollee choice of providers. The proposed budget would eliminate this provision, and permit statewide MCOs operating Family Care to restrict what entities will be allowed to participate in their respective provider networks.

QUESTIONS AND CONCERNS

- We believe this means that statewide insurers have the ability to limit the number of providers they contract with, and could result in the exclusion of an unknown number current provider agencies from a provider network.
- This may result in fewer providers overall or fewer providers covering a larger geographic area.

Section 1598 Removes protection for small businesses to cover actual costs of services

PROPOSED LANGUAGE

Repeals 46.284 (2)(d)

As a term of a contract with a care management organization under this section, the department shall prohibit a care management organization from including a provision that requires a provider to return any funding for residential services, prevocational services, or supported employment services that exceeds the cost of those services to the care management organization in a contract for services covered by the family care benefit.

ANALYSIS

This provision removes a prohibition against DHS including certain language in a CMO contract. Removal of this language would allow CMOs to recoup any monies from providers in the event that the budgeted cost of services was greater than the actual cost of services.

QUESTIONS AND CONCERNS

- Does removal of this provision create a disincentive for providers to do the most cost effective work?
- What impact would this have on the provider network and Wisconsin small businesses?

Section 1599 Current MCOs would need an exemption from DHS to continue operating at current scale

SECTION 1599. 46.284 (3) (b) 10. of the statutes is amended to read:

46.284 **(3)** (b) 10. Coverage statewide or for a geographic area specified by the department if the department grants the applicant an exception to statewide coverage.

Under current law, MCOs are required to operate within certain geographic boundaries determined by the Department. This provision would require an exception to be granted by the Department for any applicants operating at less than a statewide scale.

QUESTIONS AND CONCERNS

- Does this provision privilege entities that currently operate statewide or are national companies that could come into Wisconsin and operate on a statewide scale
- Any current MCO could be eliminated from operating family care at the discretion of the department, via not being granted an exception
- Does this put Wisconsin grown businesses—MCOs, providers, and their Wisconsin workforce— at risk?

Section 1600: preference for entities providing primary or acute care services

PROPOSED LANGUAGE

SECTION 1600. 46.284 (3) (b) 11. of the statutes is amended to read:

46.284 **(3)** (b) 11. The ability to develop strong linkages with systems and services that are not directly within the scope of the applicant's responsibility but that are important to the target group that it proposes to serve~~, including.~~

11m. If the department chooses to make primary and acute health care services part of the family care benefit, the ability to provide or provide access to primary and acute health care services under s. 49.46 (2) as determined by the department.

QUESTIONS AND CONCERNS

- Does this language privilege insurers or HMOs that may also administer a health care delivery system?
- If primary and acute health services are emphasized , does that mean that by default other long-term care services—community employment, community living, transportation, habilitative, personal care, behavior health services—are de-prioritized? Community based services keep people healthier, more independent, and out of costly Medicaid funded institutions.
- People using long term care have varying primary and acute health care needs, how will that be considered in the capitated rate? Will CMO's be provided funding for acute services not needed under this proposed plan?
- If a contract to administer long term care programs is awarded to an entity that also directly bills the same long-term care programs for primary and acute health care services, is there a conflict of interest? How does the legislature ensure cost controls are in place and ensure that all other community based services are accessible and meeting community integrated outcomes?

Section 1610 Transfer restricted to open enrollment period

PROPOSED LANGUAGE

SECTION 1610. 46.286 (3g) of the statutes is created to read:

46.286 **(3g)** TRANSFERRING CARE MANAGEMENT ORGANIZATIONS. An enrollee may transfer his or her enrollment to a different care management organization but only during an open enrollment period specified by the department, unless the enrollee meets an exception specified by the department.

ANALYSIS

Restricts a long-term care participant's ability to change CMOs to an open enrollment period.

QUESTIONS AND CONCERNS

- What is the frequency and duration of an open enrollment period? Monthly, bi-annually, annually, biennially, every five years etc?
- How long are participants given to change CMOs? What is the notification process?
- What information is provided, and is information presented to participants in accessible formats that clearly outlines the differences between choices?
- Is there a neutral party with no financial interest in the outcome of a participant's decision that is available to assist or answer participant questions when making a decision?

- What department defined exception(s) would enable a participant to change CMOs outside of an open enrollment period?
- Will performance information of CMOs in certain benefit areas be transparent (posted on the web) for participant to see to allow informed choice making? For instance, if employment outcomes are important to a participant, will a participant be able to compare CMOs and understand which CMO has highest rate of community employment?
- Will CMO's be able to determine who they accept during enrollment process? Can someone be denied access to the CMO of their choice?

Non-Statutory provisions related to DHS adult long term care programs

Section 9118 (9) Changes to Family Care Program

PROPOSED LANGUAGE

(b) *Waiver request; generally.* The department shall request any approval from and shall submit any amendments or waiver requests to the federal department of health and human services that are necessary to implement changes to the family care program, the program of all–inclusive care for the elderly, or the Family Care Partnership Program, including all of the following:

ANALYSIS

Directs DHS to request approvals or submit waiver requests to the Centers for Medicaid Services for permission to amend Wisconsin's long-term care programs as proposed in this bill.

Required elements that must be submitted in a waiver request include:

1. Administration by care management organizations of the family care program statewide instead of by geographic region, unless the department allows the care management organization a waiver to administer the family care benefit in a specific geographic region.
2. Addition of any primary and acute health care services selected by the department as a benefit under the family care program.
3. Selection under section 46.284 (2) (bm) of the statutes as a care management organization of any applicant that the department certifies meets the qualifications instead of using the competitive procurement process.
4. Requirement under section 46.286 (3g) of the statutes that an enrollee change care management organizations only during an open enrollment period specified by the department.
5. Prevention of the creation of new long–term care districts and dissolution of existing long–term care districts under section 46.2895 of the statutes.

6. Elimination of the insurance requirements for care management organizations under chapter 648 of the statutes.

QUESTIONS AND CONCERNS

- The scope of the waiver amendments is not restricted to the elements identified in this section. Additional changes that are not specified or directed by the legislature could be requested in a waiver.

> (c) *Family care in all counties.* The department shall request any approval or submit any waiver request necessary to the federal department of health and human services to administer the family care program in every county in the state. If the federal department of health and human services does not disapprove the request, the department shall ensure that the family care program is available to eligible residents of every county in the state by January 1, 2017, or by a date specified by the department, whichever is later. If the department specifies a later date than January 1, 2017, it shall submit a notice of that date to the legislative reference bureau for publication in the Wisconsin Administrative Register.

ANALYSIS

Directs DHS to submit a request for a waiver to the Centers for Medicaid Services (CMS) to expand family care to all counties, and directs DHS to implement expansion unless the waiver request is declined in total.

QUESTIONS AND CONCERNS

- The time CMS takes to review waiver requests, negotiate with states and amend the content of proposed waivers, and/or make decisions about waiver approval/disapproval varies and is not in sync with state timelines. If the state begins implementation prior to being granted permission by CMS, it runs the risk of having to change or reverse course during a transition. State and county fiscal impacts may result.
- The proposed language does not set parameters over the content of the waiver application or establish any legislative oversight or approval of the waiver application before it is submitted. The current proposal gives the department sole authority and discretion to revise the waiver at will and potentially significantly change the Family Care program constituents rely on.
- This provision directs DHS to submit waiver(s) to establish a statewide Family Care program; this could mean that a statewide family care waiver could make changes to the program as a

whole, which may affect counties that are operating the current version of Family Care as well as expanding Family Care to counties that have never had it.

(d) *Waiver request not approved; saving provision.* If the federal department of health and human services does not approve of any request or submission of waiver request under paragraph (b) or (c) the department may administer that portion of the family care program under the applicable provision of sections 46.2805 to 46.2895, 2013 stats.

ANALYSIS

If the federal CMS does not approve any request, the current Family Care program reverts to operating under the current statute.

QUESTIONS AND CONCERNS

- The non-statutory direction in the previous sections indicates that transition will move forward as authorized under the budget bill. If CMS disapproves requests after changes are made to the current long-term care infrastructure—dissolution of county programs, dissolution of long-term care districts, administrative rule and contract processes, etc.—how will the state be able to return to operating Family Care as it is under current statute?
- If the budget is adopted as proposed, the statutory sections will have been repealed, amended, and created as drafted. This is a non-statutory provision that will expire in the next biennial budget cycle. Should this saving provision be incorporated into statutory revisions, and should the budget bill be revised so that all proposed language is reinserted in the event of CMS disapproval?

(e) *Other long-term care programs discontinued.* If the federal department of health and human services does not disapprove the request to administer the family care program in every county in the state, the department may elect to discontinue enrollment of participants in or administration of any of the programs under sections 46.271, 46.275, 46.277, 46.278, or 46.2785 of the statutes at any time determined by the department that is after the date that the family care program is available to eligible residents of every county in the state under paragraph (c).

ANALYSIS

Authorizes the Department to institute enrollment caps and stop department administration of the following long term care programs when Family Care is available in every county: Long Term Support Pilot Projects, Community Integration Program (CIP) for residents of state centers, CIP for relocated persons or meeting reimbursable levels of care, CIP & brain injury waiver, Community Options Program.

QUESTIONS AND CONCERNS

- Two of the CIP programs identified are intended to assist individuals to get out of costly institutions and relocate them into the community. The budget bill does not propose to close the state institutions for the developmentally disabled, so shouldn't the Department continue to administer this program?

(10) MERGER OF DIVISIONS INTO MEDICAID SERVICES DIVISION. Before March 31, 2016, the department of health services shall submit to the state budget office in the department of administration a report of the final organization of the merger of the division of the department of health services relating to long-term care and the division of the department of health services relating to health care access and accountability into a single division of the department of health services relating to Medicaid services.