

CAPOW 2009-11 Biennial Budget Report*

- **Assisted Living Facilities Certification and Licensing Fees (signed into law).** Increase biennial certification and licensing fees for certain assisted living facilities by 27 percent. Increase licensing fees for community-based residential facilities from \$306 per facility and \$39.60 per resident to \$389 per facility and \$50.25 per resident and for adult family homes from \$135 per facility to \$171 per facility. Increase certification fees for adult day care centers (ADCCs) from \$100 per facility to \$127 per facility.
- **Certification Fees for One- and Two-Bed Adult Family Homes (signed into law).** Authorize DHS to assess one- and two-bed adult family homes (AFHs) with a one-time certification fee, beginning in 2009-10. The revenue will be used to support activities performed by the Division of Quality Assurance relating to the regulation of these facilities. The administration estimates that the fee will initially be set at \$510 per facility.
- **Re-Inspection Fees (signed into law).** Authorize DHS to assess a fee of \$200 on certain health care providers in cases where DHS took an enforcement action for a violation, and where the Department subsequently conducts an onsite inspection of the provider's facility. The fee will apply to adult day care centers, community-based residential facilities, adult family homes, residential care apartment complexes, nursing homes and intermediate care facilities for the mentally retarded that are not operated by the state, hospitals, and home health agencies.
- **Certification Fees for Personal Care Service Providers (signed into law).** Authorize DHS to assess independent personal care providers an annual certification fee. The administration estimates that the fee will initially be set at \$1,100 per agency per year. Revenue generated from the fee will be used to regulate certain entities that provide personal care services under the state's MA program.
- **Disability Ombudsman Advocacy Services for IRIS Participants (signed into law).** Require DHS to provide participants in the IRIS program access to advocacy services provided through the disability ombudsman program.
- **Southern Wisconsin Center (signed into law).** Changes reflect an assumption that 70 individuals would be relocated from SWC in the 2009-11 biennium, *rather than 154 individuals*. Additional provisions include:
 - Prohibit DHS from exercising its authority to transfer a resident from SWC to a less restrictive setting unless the resident's guardian or, if the resident is a minor and does not have a guardian, the resident's parent provides explicit written approval and consent for the transfer. Further, prohibit DHS from filing a petition of an order for protective placement to transfer a resident from SWC to a less restrictive setting unless the resident's guardian provides explicit written approval and consent for the transfer, as described above.

- Require DHS to create a form on which a resident of SWC, or the resident's guardian, may indicate a preference for where the resident would like to live. Require DHS to make the form available to all residents of SWC and their guardians, and maintain the completed form with the resident's treatment records.
- Require DHS to ensure that, if a resident is to be relocated from SWC, members of SWC's staff who provide direct care for the resident are consulted in developing a residential placement plan for the resident. Provide that, if a SWC resident is relocated after the bill's general effective date, DHS must provide the resident's guardian or, if the resident is a minor and does not have a guardian, the resident's parent information regarding the process for appealing the decision to relocate the resident and the process for filing a grievance regarding the decision.
- Require DHS to submit an annual report to the Joint Committee on Finance, by October 1, that describes the status of all individuals that were placed in the community from SWC as part of the facility's restructuring process.
- Specify that the report would include the following: (a) an assessment of the impact that relocation has had on the health status of individuals relocated within the previous three state fiscal years, which could be measured by assessing the person's weight and changes in medications, preventable hospitalizations and emergency room visits, incidence of chronic disease, and changes in performance of activities of daily living, (b) a list of each setting in which each individual lived over the past three years; (c) information on the involvement that guardians or family members of the individuals have had with the individuals in the previous state fiscal year; and (d) the cause of death for each individual who died in the previous state fiscal year.
- **Oversight of Care Management Organizations Fee (signed into law).** Establish fees care management organizations (CMOs) will pay to fund Wisconsin Commissioner of Insurance's (OCI) costs of regulating CMOs. CMOs provide long-term care and support to individuals who participate in the Family Care program. Annually, OCI will determine the total estimated cost of performing examinations, application reviews, and financial monitoring activities, and collect an amount from each CMO that is proportionate to the CMO's share of total enrollees in the Family Care program.
- **Wisconsin Quality Home Care Authority (signed into law).** The following changes were made to the Governor's proposal to create the Wisconsin Quality Home Care Authority. A description of the Governor's proposal can be found on the Legislative Fiscal Bureau's homepage by clicking [here](#).
 - Define "home care" as supportive home care, personal care, and other non-

professional services of a type that may be covered under a medical assistance waiver that are provided to consumers to assist them in meeting their daily living needs, ensuring adequate functioning in their home, and permitting safe access to the community. Authorize DHS to promulgate rules to clarify the services that meet this definition.

- Delete the provision that would specify which consumers are subject to the provisions under the bill, and instead define "consumer" as an adult individual who receives home care services, as defined above, and who meets all of the following criteria: a. The individual is a resident of any of the following: (a) a county where the county board of supervisors has acted to adopt the requirement that the county reimburse independent providers of home care services in accordance with the collective bargaining agreement; (b) a county in which the Family Care program is available; (c) a county in which the Program of All- Inclusive Care for the Elderly, as defined in federal statute, is available; (d) a county in which the self-directed services program, as defined under federal statute, is available or in which a program operated under an amendment to the state medical assistance (MA) plan, as allowed under federal statute, is available. b. The individual self-directs all or part of his or her home care services and is the employer of record, as defined below, of a provider. c. The individual is eligible to receive home care benefits under any of the following: (a) the Family Care program; (b) the Program of All-Inclusive Care for the Elderly; (c) a program operated under a waiver from the Secretary of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) or the self-directed services option, as allowed under federal statute; or (d) a program operated under an amendment to the state MA plan.
- Modify the definition of a provider, as specified in the bill, to clarify that an individual that provides home health services is excluded from the definition of a provider, as it relates to the Wisconsin Quality Home Care Authority, while that individual is providing services in the capacity of an employee of any of the following: (a) a home health agency; (b) a personal care provider agency; (c) a health care provider; (d) a company or agency providing supportive home care; (e) an independent living center; or (f) a county agency or department.
- Permit Dane County to participate in the program, without further action by the Dane County Board. Permit current board members of the Dane County Quality Home Care Commission to serve on the board of the new Authority for the remainder of their terms.
- Clarify that the consumer should be listed as the employer on the provider's income tax forms.
- Modify the duties of home care payers, as specified in the bill, to include the requirement that, in addition to informing the Authority of the date of

hire, payers, including managed care organizations, the state and participating counties, must also inform the Authority of the date of termination of any provider hired by a consumer to provide home care services.

- Delete the current list of duties of consumers specified in the bill ("requirements for benefits") and replace these provisions with the requirement that consumers do all of the following: (a) inform the Authority of the name, address, telephone number, date of hire and date of termination of any provider hired by the consumer to provide home care services; and (b) compensate providers in accordance with any collective bargaining agreement that applies to home care providers and make any payroll deductions authorized by the agreement.
- Modify the bill to include the requirement that a care management organization make any payroll deductions authorized by any collective bargaining agreement. In addition, require any county that adopts the provision in the bill to compensate providers in accordance with the collective bargaining agreement and make any payroll deductions authorized by such agreements.
- Modify the bill to clarify that the Authority must establish and maintain a registry of eligible home care providers who choose to be on the registry for purposes of employment by consumers, and provide referral services for consumers in need of home care services. Require the Authority to provide DHS with the list maintained by the Authority of all home care providers.
- Specify that any collective bargaining agreement may not interfere with the rights of the consumer to hire, discharge, suspend, promote, retain, lay off, supervise, or discipline home care providers or to set duties and conditions of employment. Delete reference to "terms of employment."
- Delete the requirement that the Authority notify providers of the terms of the collective bargaining unit, because this is the duty of the legal representative of the collective bargaining unit.
- Require DHS, upon request, to provide a list of home care providers to any labor organization that can demonstrate a showing of interest among at least 3 percent of the home care providers, or that is the certified representative of any unit of home care providers in the state, or was the certified representative of such a unit prior to the creation of the statewide Authority.
- Further, require that DHS provide a list of providers to the labor organization conditional upon the labor organization's agreement to maintain the confidentiality of the list and to use the list solely for the purpose of communicating with the home care providers concerning their exercise of rights pertaining to collective bargaining.

- Require DHS to negotiate all collective bargaining agreements, subject to an approved method of rate setting approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Delete the provision that states that any withholding of MA benefits by DHS for failure of the recipient to comply with the provisions in the bill is subject to approval by CMS.
- Specify that activities related to organizing the collective bargaining unit may take place following the first effective date of the bill. However, retain the provision in the bill that prohibits any collective bargaining agreement from taking effect before July 1, 2011.
- Delete the provision that specifies that the provisions in the bill first apply to a recipient of home care services on the date that the recipient's individual service plan is reviewed.
- Reduce funding provided for the WQHCA by \$225,000 GPR annually and increase funding by \$225,000 FED annually to reflect that DHS could claim an estimated 90% of the costs of the program as an MA administrative expense. Further, increase funding by \$225,000 GPR annually for the Joint Committee on Finance's supplemental appropriation, which would be available to support the costs of the Wisconsin Quality Home Care Authority if DHS determines that the state cannot claim federal MA administrative funds to support the Authorities' costs.
- **Family Care -- Expansion to Additional Counties in the 2009-11 Biennium.** For additional information on Family Care please visit the Department of Health Services Family Care Homepage by clicking [here](#). The Family Care implementation map can be found [here](#).
 - Provide \$1,190,400 in 2009-10 and \$1,339,500 in 2010-11 to fund projected increases in Family Care costs, other than capitation payments, for current Family Care counties.
 - *Aging and Disability Resource Centers (ADRCs)*. Reduce funding by \$967,200 in 2009-10 and by \$967,200 in 2010-11 to fully fund the 54 ADRCs that will have begun operation by the end of 2008-09. This item reflects funding changes needed to fully support the state's share of ongoing costs of ADRCs that began operating in 2008-09.
 - *Family Care Adult Protective Services (APS)*. Provide \$1,530,900 annually to fund APS allocations to counties where the Family Care program has been implemented prior to the 2009-11 biennium. DHS has committed to provide an annual APS allocation equal to 2% of the community aids basic county allocation to all Family Care expansion counties to help fund adult protective services. These services include responding to, and reporting

alleged abuse, neglect or exploitation, short-term protective interventions, and reviews of court-ordered placements.

- *Disability Ombudsman*. Provide \$626,700 in 2009-10 and \$775,800 in 2010-11 to fund the costs of funding disability ombudsman services. Under current statute, DHS is required to provide advocacy services on behalf of individuals under the age of 60 who receive benefits through the state's Family Care program. DHS currently contracts with Disability Rights Wisconsin for the statewide provision of these services.
- Reduce funding by \$3,466,900 in 2009-10 and provide \$25,481,100 in 2010-11 to reflect the net cost of expanding the Family Care program to additional counties in the 2009-11 biennium.
- *Family Care Capitation Payments*. Reduce funding by \$13,004,600 in 2009-10 and provide \$9,761,300 in 2010-11 to reflect the net cost of funding capitation payments to managed care organizations (MCOs) in counties that will begin offering Family Care benefits in the 2009-11 biennium.
 - ***The Joint Committee on Finance made the following modifications*** to reflect reestimates of funding needed to support capitation payments by: (a) reducing funding by \$2,158,500 in 2009-10 and increasing funding by \$487,700 in 2010-11; and (b) increasing estimates of SEG revenue to the MA trust fund by \$2,158,500 in 2010-11 and reducing estimates by \$487,700 in 2010-11 and making corresponding funding changes from the MA trust fund for MA benefits costs.
 - Further, the Joint Committee on Finance recommended \$1,319,800 in 2009-10 and \$7,576,200 in 2010-11 to support the cost of capitation payments for Family Care benefits provided to individuals currently on the waiting list for long-term care services in Milwaukee County. Require DHS to use these funds to enroll individuals currently on the waiting list earlier than the anticipated enrollment schedule assumed in the bill.
- *Aging and Disability Resource Centers (ADRCs)*. Provide \$4,404,000 (\$3,170,800 GPR and \$1,233,200 FED) in 2009-10 and \$9,378,000 (\$6,752,100 GPR and \$2,625,900 FED) in 2010-11 to fund the costs of operating ADRCs in seven counties, including Dane, Langlade, Lincoln, Rock, Walworth, Winnebago, and Milwaukee Counties, that DHS expects to begin implementing the Family Care program during the 2009-11 biennium.
- *Family Care Adult Protective Services (APS)*. Provide \$935,900 GPR in

2009-10 and \$1,853,900 GPR in 2010-11 to fund APS allocations to counties where the Family Care program is implemented in the 2009-11 biennium. Counties would be eligible for an APS allocation starting three months after implementation of the Family Care program.

- *Quality Assurance.* Provide \$4,197,800 in 2009-10 and \$4,487,900 in 2010-11 to fund program infrastructure and administrative costs associated with expansion of the Family Care program statewide. Infrastructure and administrative costs include external quality review, quality management, actuarial services, disability ombudsmen advocacy services, and information technology.
- *Advocacy Services.* Reduce funding by \$175,300 in 2009-10 and by \$103, in 2010-11 to support the costs of a contract DHS has with Disability Rights Wisconsin to provide advocacy services for individuals under the age of 60 who receive the Family Care benefit.
 - Modify statutory provisions relating to advocacy services by: (a) repealing a requirement that DHS allot \$525,000 annually to support a contract with a provider of advocacy services; and (b) specifying that the provider of advocacy services under the contract have a goal to provide one advocate for every 3,500 individuals under age 60 who receive the Family Care benefit, rather than one advocate for every 2,500 individuals under age 60 who receive the Family Care benefit, as provided under current law.
 - **The Joint Committee on Finance deleted the** provision that would require DHS to ensure that there is at least one advocate for every 3,500 individuals under age 60 who receive the Family Care benefit.
- *Eligibility and Entitlement.* Repeal provisions that provide an exception for individuals that do not meet functional eligibility criteria to qualify for benefits provided under the Family Care program. The administration indicates that there are no current enrollees that would be affected by this change.
- *MCOs' Responsibility to Make Benefits Available.* Currently, DHS must ensure that a managed care organization (MCO) makes Family Care benefits available to all eligible individuals residing in a county for which Family Care benefits are offered within 24 months after the effective date for which these benefits first become available. The bill would lengthen this transition period to 36 months for all managed care organizations that implement the Family Care benefit on or after January 1, 2008.
- *Definition of Terms by Rule.* Repeal a requirement that DHS define the following terms as part of the rule-making process: (a) primary disabling condition; (b) mental illness; and (c) substance abuse.

- *Payments to the State Centers for People with Developmental Disabilities.* Clarify payment responsibility for individuals enrolled in the Family Care program that receive services from one of the state Centers for People with Developmental Disabilities by requiring MCOs to pay the portion of the payment that is for services covered under the Family Care benefit and DHS to pay the remainder of the payment not covered by the federal government.
- **Family Care Expansion – Llanglade County (vetoed).** As passed by the Legislature, Assembly Bill 75 would have required the Department of Health Services (DHS) to contract with an entity to begin offering services provided by an aging and disability resource center in May, 2010, and Family Care benefits provided by a managed care organization starting in July, 2010, in Llanglade County as part of the expansion of the Family Care program in the 2009-11 biennium.

The Governor's partial veto deletes this provision. In his veto message, the Governor indicates that he intends for DHS to begin offering these services in Llanglade County beginning on these designated dates, provided that all certification standards are adequately met prior to implementation of the Family Care program in Llanglade County.

- **Medicaid Transportation Broker (vetoed in part).** As passed by the Legislature, Assembly Bill 75 would have required DHS, prior to contracting with an entity for transportation management services for the state's MA program, to submit a report to the Joint Committee on Finance that described the steps taken by DHS to guarantee that the entity would have been required to do all of the following: (a) coordinate its management activities, on an ongoing basis, with existing local transit systems; and (b) guarantee adequate access, as defined by DHS, to nonemergency transportation services for MA recipients throughout the state, including in rural counties.

The Governor's partial veto deletes the requirement that DHS submit a report to Joint Finance prior to contracting with an entity for MA transportation management services.

- **Oversight of Medicaid Savings Plan (vetoed).** As passed by the Legislature, Assembly Bill 75 would have required DHS to submit to the Joint Committee on Finance, by August 1, 2009, its plan to administer MA and MA-related programs with \$625 million (all funds) in reductions. The enrolled bill would have required DHS to include in that plan a description of the manner in which reductions and efficiencies would be realized, including an estimate of the state and federal cost savings, by state fiscal year, which would result from each component of the plan and from the plan as a whole. Under the enrolled bill, the original plan submitted by DHS would have been deemed approved unless Joint Finance scheduled a meeting and approved an alternative plan by September 1, 2009.

The Governor's partial veto deletes the requirement that DHS submit to Joint

Finance its plan to administer the MA and SeniorCare programs within the funding appropriated for those programs during the 2009-11 biennium. By deleting this DHS reporting requirement, the Governor's partial veto also deletes the passive review process that AB 75, as passed by the Legislature, would have created with respect to the DHS plan.

- **ICF-MR Preservation Study.** As passed by the Legislature, Assembly Bill 75 would have required the Secretary of DHS to appoint a committee to study and report on the need for existing intermediate care facilities for the mentally retarded (ICFs-MR) in maintaining an effective, high-quality planned system of services for persons with developmental disabilities.

The membership of the committee would have included at least one member of the Senate, at least one member of the Assembly, representatives of operators and administrators of ICFs-MR, and representatives of consumer advocates. DHS would have been required to submit the committee's report, and any recommendations made by the committee, to the Joint Committee on Finance by December 1, 2009.

*By deleting whole sentences and parts of sentences, and combining the remaining parts of sentences into a single sentence, the Governor intended to create the following provision: **Facilities for the Mentally Retarded. The Secretary of Health Services shall study and report on maintaining an effective, high-quality planned system of services for persons with developmental disabilities to the Joint Committee on Finance. However, Article V, Section 10 of the State's Constitution prohibits the Governor from creating a new sentence by combining parts of two or more sentences of an enrolled bill.*** The Governor's veto remains as is unless there is a constitutional challenge, or the Legislature acts to override the veto, or pass stand-alone legislation, which would require the Governor's signature.

**The above information was compiled using a variety of sources including the Legislative Fiscal Bureau's comparative summaries of budget recommendations (Governor and Joint Committee on Finance; Assembly, Senate, and Conference Committee), Legislative Fiscal Bureau's 2009-11 Budget Papers, the Legislative Fiscal Bureau's summary of partial vetoes of the 2009 Wisconsin Act 28 (budget bill), and Governor Doyle's 2009-11 Veto Message.*