

ELECTED AND APPOINTED OFFICIALS MEETING MINUTES

Monday, June 21, 2010

1:00 p.m. – 3:30 p.m.

Present: Carole Andrews, Jean O’Leary, Brian Shoup (Brown); Mark Moeller, Roger Tepe, Mike VanEss (Door); Jim Abrahamson, Bill Kelsey (Kewaunee); Robin Elsner, Bob Fraik, Kathy Just (Marinette); Tony Waupochick, Catherine Waukau, Barb Nelson (Menominee); Lois Trever, Craig Johnson, Mike Reimer (Oconto); John Gallagher, Steve Gueths, Barbara Larson-Herber, Rick Kane (Shawano); Gail Hanseter, Denise Pommer (Menominee Tribe); Rolf Hanson, Mary Kennedy, and Debbie Peterson (NEW).

1. There were no changes/additions to the agenda.
2. All attendees introduced themselves.
3. There was no public comment.
4. There were no changes/additions to the April 26th meeting minutes.
5. Information items:
 - A. Fiscal Agent Report:
 - Expenses through Friday, June 18, are \$76,736.30. There are approximately \$20,000 in expenses paid previously, bringing the fiscal year July 1, 2009 – June 20, 2010 total to \$96,736.30. There are several outstanding expenses before we can close the books on the year: Community Care consulting services, legal fees, and staff salaries. Estimate expenses for the first year to be \$120-130,000. Our original grant was for approximately \$396,500. Balance of the grant money will carry over (roll over) into our new contract year.
 - Major expenses have been hiring of two staff and establishing an office.
 - B. State and other MCO activities:
 - Participate in monthly meetings and conference calls with other MCOs. We will begin paying dues once we go operational.
 - C. Planning Director Report:
 - Pre-operational budget:
July 1, 2010 – February 28, 2012
Submitted to State DHS May 21, 2010
DHS/NEW review June 28, 2010
\$2.3M request:

January – June, 2011	\$400,000
July – December, 2011	\$947,000
January – February, 2012	\$959,000
 - 3Q and 4Q 2010
Analysis of current waiver and Medicaid costs for 7 counties
Establish the District
Initial assessment of provider network

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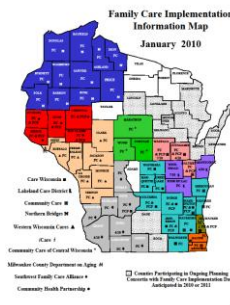
- Design NEW FC Care Management model
 - Hire additional Planning Staff member
 - 1 Q 2011
 - Board completes initial organization
 - Board hires CEO
 - Human Resource System planning
 - Develop Memorandums of Understanding (MOUs) with counties
 - Establish Enrollment and Eligibility Committee
 - issue RFI for Care Management software
 - 2Q 2011
 - FC notifies State for Procurement RFP
 - FC responds to Procurement RFP
 - Select claims processing vendor
 - Select care management vendor
 - Finalize Human Resource Plan
 - Hire HR Manager
 - 3 Q 2011
 - Receive State intent to contract
 - County Boards pass second resolution
 - Prepare first year budget request
 - Complete certification process
 - Hire lead Financial, Data, Provider Network, and Information Staff
 - Initiate Care Management recruiting
 - Finalize banking relationships
 - Arrange for working capital
 - 4 Q 2011
 - Obtain MCO certification
 - Develop final access plan
 - Complete all eligibility and enrollment processes and training
 - Hire initial set of Care Management and RN staff
 - Test systems
 - Set up general ledger and payroll systems
 - January – February 2012
 - Train initial set of Care Managers and RN's
 - Hire next set of Care Management RN's
 - Additional systems testing
 - Administrative
 - Base Camp
 - Web management transfer
 - Teleconferencing equipment
 - Elected and Appointed Officials tri-fold brochure
 - Per diem and mileage policy
6. Reports from counties on ADRC planning:
- ADRCs need to be in place 60 days prior to enrollment.

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- Door County had their first meeting with the State—looking at being a single county ADRC.
- Kewaunee County is planning a joint ADRC with Manitowoc County. They are developing their Board representation plan.
- Shawano is working with Oconto and Menominee Counties, Menominee and Stockbridge-Munsee Tribes and plan to have job descriptions and pay scales done by their next meeting scheduled for the end of July.
- Marinette is continuing to plan.
- Brown County has an existing ADRC in place.

7. A. Mary gave an update on “white” counties.

White counties are the far northern counties displayed as “white” on the map. They are counties that have not made a commitment on family care. Early in our planning, the State asked NEW to reach out to them and we promised them we would let them know when we were ready to proceed to form the District. None are interested in joining with NEW at this time.



B. State-Trial meetings: The Oneida and Menominee Tribes currently are the only Tribes providing Medicaid Waiver services. The State has been holding meetings with the Oneida Tribe for the last 3-4 months. Oneida was interested in continuing to provide waiver services but the State is now saying the Tribal Waiver program will end when Brown County enrolls in Family Care. The tribes are reimbursed at a rate of 100% by the Federal government. The Oneida Tribe has chosen the ADRC model where the State will fund Tribal Specialists for the ADRC.

The Oneida Tribe is proposing that their sovereign nation status be recognized by allowing members in Outagamie and Brown County to enroll in either county’s Family Care program. The State and the Tribe are working out arrangements for this as it could involve the Family Care programs serving Tribal members in a county in another county. The State and the Tribe are working on enrollment systems and MCO requirements if they do not have a provider network available. The State plans to be ready to implement this in Outagamie County by the end of the year.

The State and Tribe are also working on arrangements to pass through the 100% Federal funding for Tribal provided services and arrangements if Tribes want to provide Care Management in Family Care.

Menominee Tribe is involved with Wolf River ADRC and they are exploring possibilities. No decisions have been made by Menominee Tribe legislature. They want to continue to be involved and want to see waivers continue (would also like to be a care management unit).

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The Stockbridge-Munsee Tribe has asked to continue to be kept informed of NEW planning.

C. Draft responses to questions asked during Family Care Briefing:

Governance/Structure

Can you talk more about how the decision was made to go with a Long Term Care District and what other alternatives were, and why we ultimately chose this model?

The Northeast Counties analyzed three options: (1) counties having no part of the governance and allowing a private non-profit managed care organization to provide the services; or (2) public model process of creating a multi-county quasi-governmental Long Term Care district; or (3) counties could join together for a 66.03 agreement where they would be at risk for the Family Care operations. The counties agreed to the quasi-governmental unit structure to allow for public accountability but eliminate county risk.

Who appoints the consumer representatives to the District after the initial resolution?

The Long Term Care District statute only allows counties to appoint Board members. The Long Term Care District statute requires 25% consumer membership. Appointments and names of consumers will be in the first resolution. District bylaws will specify reappointments. The County representative on the Board does not necessarily have to be a County Board member. All Board members must not have a conflict of interest.

With so many differences in urban and rural areas, how can we have one District with one set of rules or guidelines?

In existing system we are all operating under one set of rules and regulations consistent across the State. Difference will only be in the delivery of services. There will be more choices of staff and structure.

With all the restrictions (federal, state) on a managed care organization, why would any MCO want to get into doing this—especially if they are supposed to be non-profit?

The mission of family care is to serve our fellow residents.

Financial

Where does the funding come from for expanding Family Care?

The State says that Family Care is budget neutral and reallocates funding from other state-funded programs like Medicaid Fee for Service and Waivers. APS (a research company) found that the pilot Family Care projects saved \$452/member/month. Savings are mostly in the area of State Medicaid costs for nursing homes and hospitals.

How is the "Capitated" rate determined? Who does it?

The State currently contracts with Price Waterhouse, an actuarial firm. Some

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assumptions are set by the State. Currently these assumptions are resulting in some under funding.

What would be the base limit per consumer?

Each MCO gets an average/member based on assumed level of acuity of need. For budgeting we used the figure \$3,000/member/month. No individual limit per consumer.

Does the MCO limit consumer services to limit business losses?

MCO is required to provide whatever service is necessary to meet need. Whatever the care team puts in the plan must be provided. A supervisor cannot override the care plan. Care plans are based on outcomes. MCO can substitute a more cost effective service, but consumer needs must be met. Care plans address needs versus want.

How are provider rates set?

Some services are Medicaid "card" services; State sets the rate and Family Care must pay the rate (nursing homes, personal care, home health etc). The MCO negotiates rates for non Medicaid "card" services.

Are MCO provider rates approved by the State?

No, the State approves the contract but rates are not set by the State.

What would happen if a MCO "failed" or went out of business?

This has happened. The State would encourage another MCO to serve the consumers. State believes in "healthy redundancy".

We have heard that some providers were not paid by MCOs for months. Does this mean that Family Care is running out of money?

No, one MCO had problems with a claims service. They had adequate cash to pay providers; there was an administrative issue.

Employees

How many employees will be within the District? How will they be selected?

Estimate 200 employees when all waiting lists/waivers are served. District will begin by setting up a personnel plan then hire a CEO.

County employees that go to the District will have the same benefits until the end of the collective Bargaining Agreement and then what happens?

County employees need to go through an application process. If District contracts with care management service, employee will need to apply to District when service ends. When a former county employee's Bargaining Agreement ends, the wage and benefit structure of the District will apply.

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Can employees that go to the District come back to the county and bump within the union? Would this be something that should be included in a county's Collective Bargaining Agreement?

Employees will be District employees and no longer county employees. Totally up to the county.

County Role/Impact

Has there been any discussion/anticipation of staffing issues and levels for Economic Support as they first determine eligibility? Can the counties that have already implemented Family Care share anything?

We haven't talked much about economic support. With some exceptions, anyone on waiver is enrolled at State level. NEW will develop a plan for Access of consumers to Family Care (enrollment and eligibility involving County and Tribal Economic support Units and ADRCs and will be using information from counties that have already enrolled.

How are counties assured that the State won't limit eligibility for Family Care in the future and the county end up being responsible for additional consumers? For example: could they modify the eligibility-screening tool or the functional screen to limit eligibility?

What the State tells us is: Family Care is State statute—changes can only be made by legislature. Opportunities exist for input.

Is it true that most of the people on waiting lists are in the urban areas?

Every county has both urban/rural areas. An example is Brown County: they have 55% of the projected enrollment and have a significant rural population. The number of people on the wait list is a third of the wait list—with 66% being served. Only one of the seven counties has a very small wait list.

By moving central and administrative operations to a higher level, will counties lose control?

Counties will not be running the programs but will have a significant role.

Counties will no longer be contracting with providers, not running program. They may provide care management under contract with the District during the transition.). Counties will approve board representatives and consumer members. They may want to have the District report back to their county boards on an annual basis. Counties and Family Care will have MOUs relating to overlapping services and how they are coordinated.

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Operations

How will quality be maintained—especially if extra staffing is needed and no extra money is available?

District plans to do a lot of quality activities—outside quality reviews, consumer satisfaction surveys. There will be extra money available since every person served off the wait list will provide an additional rate payment for the District.

What happens with our current providers with whom we are satisfied?

NEW FC plans on contracting with providers. Plan to use current county recommended providers and significantly increase the number of available providers.

Will clients be required to travel to out-of-county services?

Other way around—consumers have the opportunity to go outside the county. May be opportunity for some people to go to a provider they couldn't use before. Should have more providers available and should not require longer travel distances. As in the current system, some consumers may need to travel to obtain highly specialized services.

Concerns have been raised in some parts of the State that some consumers need to move out of their residential program because the MCO and the provider would not agree on the rate for service.

Out of 33,000 Family Care enrollees only about 100 statewide have moved out of a residential program due to rate issues—with only 15 moving to a larger facility.

How will out-of-state participants be handled; for example: Wisconsin residents eligible for nursing home services in Michigan and vice-versa?

The legal residency rules apply to who gets served when/where. There are no changes to the existing rules.

- Prospective Consumer Board Members – three consumer Board Members need to be selected by July 2010. Steering Committee is soliciting applications and nominations:
 - Application packets and letters have been sent to local/State Advocacy groups and other organizations.
 - Two applications and one request for application have been received to-date
 - Steering Committee sub-group will be reviewing applications and interviewing applicants.
 - Steering Committee will finalize a slate of Consumer Board Members.

8. Updates from counties:

- County meetings are progressing—Menominee, Marinette have held first; Oconto and Kewaunee scheduled.

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9. Next meeting August 30 at 1:00 p.m. at the NEW Family Care office; in the Classroom.

These minutes are respectively submitted by Debbie Peterson,
NEW FC Administrative Assistant, and **HAVE NOT BEEN APPROVED**
by the Northeast Wisconsin Family Care Elected Officials