

State of Wisconsin
Department of Health Services

Long-term Care Managed Care Infrastructure Project

Business Operations Infrastructure
Request for Information (RFI)

1682-RFI-PM

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Questions concerning this RFI should be directed to:

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1. Introduction

The State of Wisconsin has been pursuing redesign of its Medicaid long-term care and health service programs for several years, with an emphasis on developing home and community-based programs that provide effective alternatives to institutional and large residential settings whenever possible, for target populations that include the elderly and adults with physical or developmentally disabilities . These efforts have been manifested in a new long-term care service delivery structure that is currently being implemented statewide. This new structure offers program choices for Medicaid-eligible individuals, including managed care programs (Family Care, Family Care Partnership, PACE) and a self-directed support program (IRIS). The new structure also created Aging and Disability Resource Centers (ADRCs) to provide long-term care information and assistance to all state citizens, support program choice counseling, complete initial functional eligibility screening, and perform program enrollment.

The new managed care programs are member-focused, with individualized care plans based on defining the personal long-term care outcomes of each member, in addition to meeting his/her health and safety needs. Care management is accomplished through an interdisciplinary team that includes social service, nurse, and at times other health or human service professionals needed to address the member's specific concerns. Care management includes a full assessment of needs, development of a care plan focused on personal outcomes, preparation of a service plan, provision of internal and outsourced services, and measurement of results. Managed Care Organizations (MCOs) contract with the state Medicaid agency (Department of Health Services) to operate these programs, receiving per-member-per-month capitated revenue. Statewide implementation has been accomplished across the geographic area of 47 counties, with 23 remaining counties in various stages of planning for implementation over the next two years. The Wisconsin Department of Health Services has the responsibility to perform management and oversight of these Medicaid waiver programs, and support the eligibility determination, enrollment and capitation payment systems for these programs. The generic 2009 state issued contracts to MCOs and ADRCs are located at: <http://dhs.wisconsin.gov/lc/lc/StateFedReqs/FC-RC-CMO-Contracts.htm>.

2. Purpose of the RFI

This RFI is intended to explore the potential for establishing a common system infrastructure that can support an array of Family Care, Family Care Partnership, PACE, and IRIS business and program operations in an integrated manner. Currently these needs are being addressed by each individual organization, which results in the redundancy of infrastructure investments. Core functions necessary for all MCO and ADRC organizations could be addressed by sharing some common systems, providing an opportunity for cost savings, improved commonality of program delivery, and greater efficiency for Department of Health Service oversight responsibilities. A system(s) that can be shared among all the Family Care partners also allows better access to the information needed for successful program implementation.

The information received from vendors in response to this RFI will be useful in understanding the current "state of the art" systems that could support the multiple functions carried out by MCOs, ADRCs, and the Department of Health Services. This information will first be useful in defining the scope of common systems that may be practical to consider, and subsequently to inform the development of one or more Requests for Proposals (RFPs) to solicit system solutions to support these functions. This RFI requests that vendors provide information regarding their systems and expertise that could support the business functions outlined in this document.

3. Family Care Overview

3.1 Background and Strategic Approach

In 2008, under the direction of the Secretary of the Department of Health Services (DHS), an independent consultant advised that greater program efficiency and effectiveness could be obtained through expanded collaboration between program delivery agencies and the Department.

The Family Care Business Infrastructure and Systems Project offered an approach that could prove to be advantageous for both the State's stewardship responsibilities and the service delivery responsibilities of program agencies, which include:

- Statewide program consistency; uniformity in member experiences.
- Higher efficiency; opportunities to reduce administrative costs.
- Improved member outcomes; opportunities to develop, share and systemically sustain better best-practices.
- Standardized processes to facilitate technical support opportunities across organizations.
- Reduced risk; the DHS becomes more proactive in ensuring the operational needs of program delivery agencies are met.

3.2 Summary of Needs

Overall, the Department needs to consider the best long-term strategic direction for sustaining the infrastructure necessary to support the entire Family Care delivery model, seek ways to control administrative costs, and ensure uniformity in program delivery. We are challenged to take advantage of opportunities to use consolidated outsourced and shared services, consistent with a more proactive collaborative approach, through:

- Use of common information technology systems to reduce costs and promote standard practices, where feasible and of value.
- Use of cooperative purchasing to take advantage of procuring in greater volume.
- Outsourcing of some Managed Care Organization (MCO) and Self-Directed Supports (SDS) business functions to promote focusing on core program responsibilities and take advantage of specialized expertise to perform other operations.

The Department's action items in this area are to explore broad system packaging opportunities in the market place and to leverage existing Department systems that could benefit MCO, Aging and Disability Resource Center (ADRC), and SDS operations' support while sustaining use of locally implemented Health and Human Services systems where appropriate. These initiatives are seen as touching all of the above points, using common information systems, seeking volume discounting, and outsourcing to take advantage of specialized expertise.

The result is Family Care partners who work closely together to accomplish a shared goal. The Department can be successful only if the MCOs and ADRCs are successful. This approach is intended to be a collaborative work effort with the MCOs and ADRCs to define common specifications, processes, and systems to ensure consistency of outcomes.

3.3 Current Programs Description

Current service delivery programs include the Family Care program, the Family Care Partnership program, PACE (Program of All-Inclusive Care for the Elderly), and IRIS (Include, Respect, I Self-Direct) all of which are for Medicaid eligible individuals. These Medicaid home and community-based waiver programs, and other long-term support programs are comprehensive, flexible long-term care service systems that strive to foster independence and quality of life, while recognizing the need for health, safety and support services. These programs attempt to provide high quality care that supports member outcomes in the most cost-effective way possible. The Family Care programs and IRIS serve three target populations: frail elderly individuals and adults with physical or developmental disabilities. Enrollment totals for Family Care, Family Care Partnership, PACE, and IRIS are expected to reach 53,000 members. For more information: <http://dhs.wisconsin.gov/lcicare>.

Family Care Program

The goals of Family Care are to:

- Give people better choices about the services and supports available to meet their needs.
- Improve people's access to services.
- Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.
- Create a cost-effective long-term care system for the future.

The Family Care benefit package includes medical and non-medical services as defined in Wisconsin's s. 1915 (b/c) home and community-based waivers approved by CMS, as well as Wisconsin state plan services. Services defined under Wisconsin statutes and administrative code may be further clarified in Wisconsin Medicaid Program Provider Handbooks and Bulletins, MCO Contract Interpretation Bulletins, and as otherwise specified in contracts between DHS and MCOs. For more information: <http://dhs.wisconsin.gov/lcicare>.

Family Care Partnership Program

The Family Care Partnership Program is a fully integrated Medicare and Medicaid program that integrates health and long-term support services for people who are elderly or disabled. The goals of Partnership are to:

- Improve quality of health care and service delivery while containing costs.
- Reduce fragmentation and inefficiency in the existing health care delivery system.

- Increase the ability of people to live in the community and participate in decisions regarding their own health care.

The Family Care Partnership Program integrates Medicare, Medicaid, and home and community-based waiver services into a single health plan with coordinated coverage for a range of services from clinic visits and home health care to hospital and nursing home stays. For more information: <http://dhs.wisconsin.gov/wipartnership>.

Program of All-inclusive Care for the Elderly

The Program of All-inclusive Care for the Elderly (PACE) also provides fully integrated acute and primary, and long-term care to frail elderly individuals. Covered benefits are the same as those for Family Care Partnership. Detailed information regarding the Family Care and Family Care Partnership programs can be found on the DHS web site at <http://dhs.wisconsin.gov/lcicare/INDEX.HTM>.

Include, Respect, I Self-Direct

IRIS (Include, Respect, I Self-Direct) has been developed as an option to provide more choice to consumers eligible for publicly funded long-term care. IRIS is a Wisconsin statewide, self-directed, home and community-based waiver program. Within their individually assigned monthly budget allocation, IRIS participants use public funds and natural supports to wisely craft creative support and service plans that meet their self-identified long-term care outcomes, maximize their independence and ultimately help achieve the lives they want.

Within IRIS, participants have a budget based on their individual needs and use this budget for their services and supports. They work with an Independent Consultant Agency and a Financial Service Agency to develop a plan and purchase services and supports, such as hiring in-home workers. The IRIS program covers only services available under home and community-based waivers; participants receive other services through the Medicaid “card” fee-for-service system. Detailed information regarding IRIS can be found on the DHS web site at <http://dhs.wisconsin.gov/bdds/IRIS/index.htm>.

3.4 Managed Care Entities

Appendix B (Long Term Care Consumer View – Summary Level) and Appendix C (Long Term Care Consumer View – Functional Level) show the high level functionality with the corresponding organization as the consumer moves through the Family Care process, from the initial request for information to receiving services from a provider. Entities involved in this process are defined below, as are others.

DHS Division of Long-Term Care

The Wisconsin Department of Health Services, Division of Long Term Care (DLTC) oversees the provision of long-term support options for the elderly and people with disabilities. The DLTC also operates the Department's institutions for persons with developmental disabilities.

The DLTC has embarked on an initiative to expand managed long-term care options in Wisconsin. In February 2006, Governor Jim Doyle announced his goal to expand Family Care and promote the integration of long-term care and health care services over the next five years. Family Care is the Department's array of managed long-term care programs. The Office of Family Care Expansion (OFCE) manages the Family Care implementation by regional areas, including supporting planning by counties and other stakeholders in each region. OFCE is the primary point of contact between the Department and long-term care managed care entities.

In addition to OFCE, there are the Office of Resource Center Development (ORCD), and the Bureau of Long-Term Support (BLTS). ORCD manages the Aging and Disability Resource Centers (ADRCs) and BLTS manages the IRIS program. See DHS Organization Chart in Appendix D.

Program operations have the responsibility to support and inform DHS management and strategic planning; continually monitor quality of care management and services; discover and remediate problems; and continually improve best practices and quality, measured from the perspective of program enrollees.

The Department's goal is to ensure the effective and efficient management of business operations and service delivery by the ADRCs, Family Care and Family Care Partnership organizations, PACE, and IRIS. The Department's approach is to assist them in the evaluation and acquisition of the necessary business infrastructure and business systems to support program requirements.

Aging and Disability Resource Centers

The ADRCs are service centers that provide a place for the public to get accurate and unbiased information on all aspects of life related to aging or living with a disability, and provide enrollment assistance into a variety of applicable health care service plans and publically-funded programs. ADRCs provide a central source of reliable and objective information about a broad range of programs and services and help people understand and evaluate the various options available to them. ADRCs provide information and assistance to frail elders and adults with disabilities regarding public benefits that may be available, as well as other programs and services available in their area. Program eligibility is determined based on information from a functional screen tool and from financial eligibility evaluation. Once appropriate eligibility is determined, enrollment assistance is provided; the ADRC enrolls the applicant into the available program of their choice, and communicates enrollment status to the Income Maintenance (IM) unit and to the management of the chosen program. ADRCs follow the standards embraced by Alliance of Information and Referral Systems (AIRS). For more information: <http://airs.org>.

Income Maintenance

Income Maintenance is a county unit that determines financial eligibility, determines cost share, confirms non-financial (functional) eligibility, and certifies eligibility for Family Care, Family Care Partnership, PACE, and IRIS clients using the Client Assistance for Reemployment & Economic Support (CARES) state system.

Managed Care Organizations

Managed Care Organizations (MCOs) manage the Family Care, Family Care Partnership, and PACE programs. In order to assure access to services, MCOs develop and manage a comprehensive network of long-term care services and support, either through purchase of service contracts with providers, or by direct service provision by MCO employees. Family Care cases are managed by an interdisciplinary team (IDT) of individuals that includes nurses, social workers, and other member representatives. The IDT works closely with the member to administer assessments, develop plans of care, and monitor the member's outcomes. MCOs are responsible for assuring and continually improving the quality of care and services members receive. MCOs receive a per member per month (PMPM) capitation payment to manage care for their enrollees, who may be living in their own homes, group living situations, or nursing facilities.

Service Providers

External service providers manage their business operations for all aspects of service delivery including processing service authorizations, providing services, maintaining qualified staff, billing for services and receipt of payments. Service providers are both medical and non-medical providers of services.

Third Party Administrators, Pharmacy Benefit Managers

A third party administrator (TPA) is an organization that processes claims or certain aspects of employee benefit plans for a separate entity. Third party administrators are prominent players in the managed care industry and have the expertise and capability to administer all, or a portion of, the claims process. They are normally contracted by a health insurer or self-insuring companies to administer services, including claims administration, premium collection, maintain enrollment, and other administrative activities. An MCO will often use a TPA to manage its claims processing, provider networks, utilization review, or membership functions.

Third party administrators also may handle many other functions such as the processing of employee benefit plans that may have highly technical aspects; difficult administration of these benefit plans can make using a specialized entity such as a TPA more cost effective than doing the same processing internally.

A Pharmacy Benefit Manager (PBM) is a third party administrator of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. PBMs also often have the ability to offer initiatives that give value and flexibility to participants, such as tablet splitting, sampling and mail order service.

Independent Consultant Agency

The Independent Consultant Agency (ICA) creates an independent consultant network from which IRIS participants select their Independent Consultant, and provides assistance, training, and oversight to consultants. The ICA interacts with the

Financial Services Agency (FSA), ADRCs, IM, and the DHS as needed regarding IRIS continuing eligibility, provides quality management planning and oversees initiatives, and provides reports to the DHS as requested.

An Independent Consultant is an individual within the ICA who provides information about IRIS, and provides support and assistance to IRIS participants, assists in the development of each participant's Individualized Support and Services Plan (ISSP), oversees quality management activities, and processes IRIS paperwork. The Independent Consultant assures that supports are present that preserve the participant's health and safety and ongoing IRIS program eligibility.

Independent Consultants are required to contact participants at least five (5) times in the participant's first year, including three (3) face-to-face contacts. Two of the contacts of substance must occur within the first 45 days of the person's participation as a part of the basic quality assurance approach as is described in the State's approved waiver. In subsequent years the expectation for minimum contact with the participant is four (4) times per year including two (2) face-to-face contacts.

Financial Services Agency

A Financial Services Agency (FSA) disburses funds on behalf of a self-directed supports (SDS) waiver participant according to the individual's approved individual support and service plan. In the case of employed staff, the FSA maintains documentation that all employment eligibility laws are followed, and is responsible to ensure that tax withholding; unemployment compensation and workers' compensation related responsibilities are met. Directed by the participant, the FSA makes disbursements for goods and services listed on the approved plan, and issues monthly expense reports to the waiver participant and to the ICA.

The FSA coordinates IRIS participant Medicaid cost share payments; provides budget management training and support; administers payroll and employment records for hired employees; pays authorized provider invoices; provides reports to participants, ICA, and the DHS, and submits claims encounter data to the DHS.

External Quality Review Organization

The Department contracted with an External Quality Review Organization (EQRO) to conduct external quality review (EQR) activities for the Family Care program. On an ongoing basis, EQR activities evaluate the quality of the services that are arranged for or provided to Family Care enrollees or potential enrollees under the contract the Department has entered into with MCOs and ADRCs. The goal of EQR activities is to gain an understanding of how each MCO is or is not meeting the needs of its enrolled population and how each ADRC is meeting the needs of potential Family Care enrollees. The EQR activities must be conducted by an external entity. The current contract is with MetaStar (www.metastar.com).

Centers for Medicare and Medicaid Services

The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The Centers for Medicare and Medicaid Services (CMS) operates under the direction of HHS and oversees Medicare health plans, Medicare financial management, Medicare fee for service operations, Medicaid and children's health, survey and certification activities, and quality improvement activities.

3.5 Current Wisconsin Department of Health Services Systems

There are currently several State systems in place and the proposed system(s) will need to interface with them. Appendix E (Family Care Organization and Functional Matrix) shows each Family Care Partner and their interactions with other organizations for each of their functions.

Appendix F (Family Care Process Interaction Flow Diagram) shows a high-level process diagram between the various systems and partners. This diagram attempts to show the variation of interactions between the different state systems and the Family Care partners. Some of these interactions are in the form of data (reports or data transfers), while others are in the form of needed access for the department or the interactions of the consumer.

Both of these appendices are published separately with the RFI on VendorNet. For more information: <http://vendornet.state.wi.us>.

Functional Screen Information Access

Functional Screen Information Access (FSIA) is a web-based application, which collects data and determines functional eligibility for adult and children's long-term care programs, and mental health and alcohol and other drug abuse programs. The application also contains a personal care screening tool, which calculates a personal care time allocation based on a functional profile. This tool is used by ADRCs and MCOs to determine functional eligibility for Family Care members. For more information: <http://dhs.wisconsin.gov/lc/lc/FUNCTIONALSCREEN/Index.htm>.

Program Participation System

The Program Participation System (PPS) is a web-based application that is intended to centralize the program enrollment for Family Care, and currently manages the waitlist for Family Care expansion. This application displays financial eligibility information from the Client Assistance for Reemployment & Economic Support (CARES) system and displays functional eligibility information from FSIA. In the future, this application will be used for recording enrollment. For more information: <http://dhs.wisconsin.gov/lc/lc/Generalinfo/pps.HTM>.

Wisconsin Incident Tracking System

The Wisconsin Incident Tracking System (WITS) is a web-based application that collects data from counties relating to critical incidents. Currently, WITS is collecting data for Elder Abuse cases and Adults at Risk. For more information: <http://dhs.wisconsin.gov/aps/wits/index.htm>.

Client Assistance for Reemployment & Economic Support

The Client Assistance for Reemployment & Economic Support (CARES) system is an application that collects Medicaid eligibility information. It is used by county Income Maintenance agencies to determine financial eligibility for Family Care and IRIS. It is also used by the MCOs for bimonthly enrollment reconciliation. For more information: <http://dhs.wisconsin.gov/em/index.htm>.

Medicaid Management Information System

The Wisconsin Medicaid Management Information System (MMIS) is an application that collects program enrollment information, and acute and primary card service claims processing. It is used by MCOs to support enrollment management and reconciliation. The MMIS application also maintains Medicaid Provider information. This same list of providers along with the various maintenance functions might prove useful in sharing with the MCOs. For more information:

<https://www.forwardhealth.wi.gov/WIPortal/Providers/Training%20Home/tabid/63/Default.aspx> (training resources),
<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx> (portal home page), or
<https://www.forwardhealth.wi.gov/kw/pdf/2008-24.pdf>.

Information Access

The Family Care MCOs would greatly benefit from having access to Medicaid and Medicare claims data, and Minimum Data Set (MDS) to assist with effectively managing members.

The data on members that resides in the DHS data warehouse and in Vital Records could be beneficial to the MCOs managing their members' care.

Encounter Reporting

The Encounter Reporting application is a data collection and validation utility that is used to collect encounter and other data submissions (e.g., ADRC information and assistance data) from Family Care partners. This application applies business rules to enforce consistency of data. This data is being made available for analysis through a warehouse environment using Business Objects as a querying tool. MCOs must submit Family Care encounter data on a monthly basis. For more information: <http://dhs.wisconsin.gov/lcicare/encounter/index.htm>.

Claims Processing

Family Care service claims are paid by MCOs either through the use of internal business processes or through contracted TPAs. The DHS is currently evaluating vendor responses to the State of Wisconsin RFP # 1677-DLTC-PM. This RFP defines how service claims are required to be processed and how the encounter data for claims must be submitted.

In addition, there is an interface between the Member Centered Plan (MCP) as part of this RFI and the service pre-authorizations that are received by the TPA for

authorizing services. For more information: <http://vendornet.state.wi.us> and reference RFP # 1677-DLTC-PM.

Personal Experience Outcomes

The Personal Experience Outcomes iNtegrated Interview and Evaluation System (PEONIES) is a protocol for measuring and using personal experience outcomes for people receiving long-term care services in the community. Through this project, interviewing techniques are used to learn about the outcomes people want in their lives. For more information:

http://www.chsra.wisc.edu/peonies/PEONIES_Index.html.

3.6 State Policy and Recommended Standards

Any Proposed solution must protect data; only allow authorized access to data; and when interacting with state systems (hardware or software) should comply with applicable state and agency standards (unless an exception can be justified).

The Healthcare Information Technology Standards Panel (HITSP) is a cooperative partnership between the public and private sectors. The Panel was formed for the purpose of harmonizing and integrating standards that will meet clinical and business needs for sharing information among organizations and systems. For more information: <http://www.hitsp.org>.

3.7 Federal Security and Other Required Standards

National Standards for Culturally and Linguistically Appropriate Services

The Office of Minority Health (OMH) has the duty to improve and protect the health of racial and ethnic minority populations through the development of health policies, programs, and standards that will eliminate health disparities. Any proposed solution should follow the Culturally and Linguistically Appropriate Services (CLAS) standards developed by OMH. See the final report at <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>.

HIPAA Security Standard

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to follow national standards for the security of electronic health care information. The final rule adopting HIPAA standards for security was published in the Federal Register on February 20, 2003. This final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. The standards are delineated into either required or addressable implementation specifications. The Department of Health and Human Services and its partners have adopted and implemented the required HIPAA standards required. All designed, developed, and implemented system solutions by or on behalf of the Department of

Health and Human Services must follow the same criteria and standards. For more information: <http://www.cms.hhs.gov/SecurityStandard>.

Section 508 Standards

Section 508 requires that when federal agencies develop, procure, maintain, or use electronic and information technology, federal employees with disabilities have access to and use of information and data that is comparable to the access and use by federal employees who are not individuals with disabilities, unless an undue burden would be imposed on the agency. Section 508 also requires that individuals with disabilities, who are members of the public seeking information or services from a federal agency, have access to and use of information and data that is comparable to that provided to the public who are not individuals with disabilities, unless an undue burden would be imposed on the agency. For more information: <http://www.section508.gov/>.

Health Information Exchange / Health Information Technology

Health Information Exchange (HIE) provides the umbrella framework to describe the comprehensive management of health information and its secure exchange between consumers, providers, government, quality entities, and insurers. Health information technology (HIT) in general is increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system.

MITA is a HIT initiative to promote improvements in the Medicaid enterprise and systems that support it through collaboration between CMS and the states. MITA is also a framework that provides a blueprint consisting of models, guidelines and principles to be used by states as they implement technology solutions. The Wisconsin Department of Health Services is committed to establishing a plan to fulfill the goals and objectives of MITA beginning with an overall evaluation of its current efficiencies and deficiencies to determine areas of improvement. The DHS has awarded a contract for a gap analysis and will lead to a phased implementation and remediation plan to address deficiencies.

National Association of Insurance Commissioners Standards

The National Association of Insurance Commissioners (NAIC) () has a standard protocol for financial reporting to be used by MCOs. For more information: <http://www.naic.org/>.

Separation of ADRC and MCO

Though there is overlap in both function and data between the ADRCs and the MCOs, these two organizations are independent and must remain separate. Security measures are necessary for the non-sharable data while still allowing for some data to be shared between the two organizations.

4 Submitting a Response

Interested vendors should submit a response to items described in section 5.0.

Responses may be submitted electronically (preferred) in either Microsoft Office or .PDF formats, or in writing. Written responses should be typed and submitted on 8.5 by 11 inch paper. Responses are not limited in size, however; responses should be tailored to the specific items described. Marketing materials and brochures may be submitted as supplemental information, but marketing materials and brochures are not in themselves considered a response to this RFI and will not be evaluated as such.

Responses should be organized and presented in the order and by the number specified in this RFI. Proposals must be organized with the following headings and subheadings. Each heading and subheading should be separated by tabs or otherwise clearly marked. Responses should be organized into the following sections, and must include:

- Company information.
- Technical information.
- Pricing information.

The responses to the requested information and any supplemental materials should be returned to the following address no later than **October 16, 2009 at 1:00 PM CDT**. Responses should be sent to:

Attention: Steve Harvancik
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1 W. Wilson, Room B150
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5 Vendor Response

Section 6.0 contains information regarding the functional requirements of several distinct managed care entities. This information is included in this RFI to provide vendors with a basis understanding of the operational needs of these long-term care managed care entities. **Responses to this RFI should address all questions in 6.7 through 6.12.** All responses must include the core functions (as indicated in **6.1**). Vendors should respond to all topics listed; those topics for which the vendor does not supply a system or solution should be acknowledged with "N/A" or other similar notation to provide clarity to the reader. Additional information regarding the vendor systems, services, and/or solutions is welcome. Their corresponding function number (example 6.2.1 for Information & Assistance) must reference all topics.

There will be a Question and Answer Webinar for the vendors to review the RFI and ask questions. The date is the afternoon of **September 14, 2009**. The Webinar format will be that of a panel addressing questions. The panel consists of DHS Program experts and DHS IT experts. Please register for this event at the following URL:

<http://media1.wi.gov/DHFS/Viewer/?peid=2310f1af-4922-4fc2-808f-6e6f8e9a71c4>

6 Requirements Information

6.1 Core Functions Necessary for Response

The following sets of activities are considered critical/core by Family Care partners in providing the programs and services:

- In the case of the ADRCs, the core functions are:
 - Information & Assistance,
 - Functional Screening, and
 - Financial Pre-Screening.
- For the MCOs, the core functions are:
 - Case Management,
 - Member Centered Plan (MCP)/Comprehensive Assessment,
 - Service Coordination,
 - Quality Assurance / Quality Improvement Process, and
 - Financial Risk Management.
- Finally, for the Department the core functions are:
 - Program Implementation,
 - Program Oversight - Quality, and
 - Program Oversight - Financial.

The following describes the full array of functions for the entire service delivery structure that need to be supported.

6.2 Aging and Disability Resource Centers

ADRC responsibilities include:

- 6.2.1 Information & Assistance (I&A); People receive information and assistance to get what they need. The ADRC maintains a resource database with information on programs and services available to its client populations and a client tracking database to document client contacts and services provided. The overall goal of Information and Assistance is to be able to deliver the information that is needed to link inquirers with available and appropriate resources at the lowest cost without duplication of effort. This vision of service delivery through technology involves collaboration in maintaining a client tracking system and resource database; collecting, analyzing and reporting inquirer data; publicizing the information and assistance system and available services that are a part of the system; ensuring broad access to I&A services; providing information and referral to inquirers; and following up with inquirers as appropriate.

- 6.2.1.1 Referral Activities; The process of connecting people with the appropriate organization without requiring the person to place a separate call. Referral activities can include the ADRC receiving referrals and/or providing a referral to an organization.
- 6.2.1.2 Pre-Admission Consultation; People have the information they need to make an informed decision prior to moving to a nursing home or assisted living facility.
- 6.2.1.3 Long-term Care Options Counseling; People have the information they need to make informed choices about long-term care options.
- 6.2.1.4 Client Advocacy; People know their rights and responsibilities and receive assistance, if needed, in exercising those rights and responsibilities.
- 6.2.1.5 Access to Employment Opportunities; This includes the process of connecting people with appropriate employment opportunities.
- 6.2.1.6 Mental Health and Substance Abuse Services; People are connected to the mental health and substance abuse agencies that provide the services that they need and are eligible to receive.
- 6.2.1.7 Consumer / Client Tracking; For consistent and accurate management of the “day-to-day” operations, the desired solution should include a client tracking system for information, assistance, and referral activities and all other activities of the ADRC. The client tracking activities include, but are not limited to, recording client demographics, tracking client needs, generating service referrals and providing consistent follow-up to determine fulfilled outcomes. Appropriate processes and system will also produce the management reports needed to ensure quality service delivery on a timely basis. The ADRC captures data on each individual making a contact with the organization. Information collected includes client demographics, what services and/or information is requested, the ADRC activity provided, and the population to which the client belongs.
- 6.2.1.8 Short Term Service Coordination; People who are unable to manage for themselves get help in arranging and coordinating services to meet multiple, complex and diverse needs.
- 6.2.1.9 Access to Urgent Services; Not immediately life-threatening, urgent needs are those where a lack of response within forty-eight hours would cause significant pain, place the person at serious risk of harm, or create or significantly increase a person's risk of unnecessary hospitalization or institutionalization.

- 6.2.1.10 Access to Emergency Services; People receive immediate assistance in a crisis situation.
- 6.2.1.11 Transitional Services for Students and Youth; Young adults with disabilities experience seamless transition and entry into the adult long-term care system.
- 6.2.2 Functional Screening; The ADRC administers the initial long term care functional screen to determine an individual's functional eligibility for managed long term care and the self directed supports waiver (IRIS), when available. If an individual is found functionally eligible, a level of care is generated.
- 6.2.3 Financial Pre-Screening; The ADRC assists individuals not currently on Medicaid with the Medicaid application process. The process includes an overview of financial eligibility requirements, review of financial and non-financial circumstances, gathering information to support the Medicaid application and completing, signing and submitting the application to Income Maintenance.
- 6.2.4 Marketing, Outreach and Public Education; People know about and use the services of the ADRC. The Aging and Disability Resource Center establishes goals for and monitors the effectiveness of its marketing activities. As part of this effort, the ADRC tracks the number of contacts it has with individuals in the client population(s), and with others on their behalf, for the purpose of providing or obtaining information and assistance. In addition, the ADRC creates and maintains marketing and educational materials. These publications, media campaigns and other activities are directed to large audiences of current or potential service recipients, members of the ADRC client populations or caregivers. All the publications and goals are monitored by the Department.
- 6.2.5 Prevention and Early Intervention; People are helped, when possible, to retain or improve functioning and to delay or prevent the need for comprehensive long-term care services.
- 6.2.6 Resource Database (Provider Management); An important element of the information and assistance structure is the resource database. The resource database stores detailed information for service providers (typical and atypical), community volunteer resources and informal supports (e.g. family members). This component allows for the efficient referral to these available services and the resources or providers of those services. Maintenance of the resource database is primarily adding, deleting, changing and updating of provider service information and demographic files and the detail associated with those files. Data can be maintained manually and/or through an automated program.
- 6.2.7 Data Collection and Survey Support; Tools needed to identify unmet needs of the client populations in the community.
- 6.2.8 Reporting and Records; Data is available to meet the reporting requirements of funding sources, qualify for federal financial participation, evaluate service quality and adequacy, and inform decision-making at the state and local levels. Some of this reporting is done electronically to the department using the encounter reporting application.

- 6.2.9 Cultural Competence and Diversity / Accessibility; People feel comfortable using the ADRC and its services. People with physical or functional limitations or language differences are able to use the services of the ADRC.
- 6.2.10 Access to Public Benefits; People are linked to government programs and benefits to which they are entitled and/or eligible. People have access to publicly funded long-term care programs and services, are able to make informed decisions regarding enrollment in managed long term care or the self-directed supports waiver and experience a timely, accurate, and streamlined process for eligibility determination and enrollment. ADRCs determine functional eligibility, facilitate financial eligibility determination, and assist with the enrollment process.
- 6.2.10.1 Waiting List Coordination (during transition - short term); The waiting list is used for individuals that are potentially eligible for long-term care (LTC) services but there is no capacity to serve these individuals. The system and options available to meet their LTC needs may have changed since the individual's name was placed on the list. Once there is notification of capacity, the ADRC will contact the individuals on the wait list, provide counseling, and engage in pre-enrollment activity for potential LTC services. Based on the results of these interactions, a number of individuals will be removed from the waiting list each month.
- 6.2.10.2 Enrollment Consultation; Individuals who select to enroll with a long-term care program are assisted by ADRC staff with available program options and completion of enrollment documentation.
- 6.2.10.3 Elderly Benefits Counseling; Older people receive information about, and assistance in, applying for public and private benefits for which they are eligible.
- 6.2.10.4 Disability Benefits Counseling; Adults with developmental disabilities, physical disabilities, mental illness and/or substance abuse disorders receive information about, and assistance in, obtaining or retaining public and private benefits for which they are eligible.
- 6.2.11 Complaints, Appeals and Grievances; People are able to register complaints and grievances and exercise their due process rights. The ADRC creates and maintains internal policies and procedures for both informal and formal resolution of complaints regarding the services that it provides and the collection of information and data related to this process, including the notification of the decision and the review process performed by the Department.
- 6.2.12 Elder / Adults-at-Risk and Adult Protective Services; People are free from abuse and neglect. The ADRC makes and receives referrals to the county or tribe's designated elder / adults-at-risk agency and adult protective services agency, as appropriate. The referrals must be tracked and acted upon within a designated timeframe. To assist with the referral

process the ADRC establishes memorandums of understanding regarding referrals, investigations and coordination of services with the county or tribal agency or agencies responsible for elder / adults-at-risk and/or adult protective services.

6.2.13 Consumer Web Access; ADRCs are required to provide consumers with access to service and resource information through the Internet. The ADRC's web site, which may be part of a larger agency web site, is designed to communicate its services to the client populations and general public. This web site includes a description of all services and contact information for the ADRC (telephone number, hours of operation, email address, etc.). The resource database, previously described, should be available from this web site and be user friendly, searchable and accessible to persons with disabilities.

6.2.14 Business Operations Management

6.2.14.1 Provider Contract Management; This includes negotiating the terms and conditions in contracts and ensuring compliance with the terms and conditions, as well as documenting and agreeing upon any changes that may arise during its implementation or execution. The process of systematically and efficiently managing contract creation, execution, and analysis for the purpose of maximizing financial and operational performance and minimizing risk.

6.2.14.2 Quality Assurance / Quality Improvement Process; The ADRC provides quality services and incorporates the principle of continuous quality improvement in its operations.

6.2.14.3 Time Keeping / Scheduling; Maintain scheduling and time keeping for staff in the organization.

6.2.14.4 Payroll; Management maintenance of all financial records related to employees, contractors and subcontractors salaries, wages, bonuses and deductions.

6.2.14.5 Human Resources (benefits, talent management); Maintain a human resources and personnel function for the organization that includes hiring, training, professional certifications, background checks, etc.

6.2.14.6 Internal Business Operations Contract Management; The ADRC may create and maintain contracts internal, yet integral to its daily service operations (e.g., after hours 911 services).

6.2.14.7 Basic Financial Systems and Processes Management; The ADRC tracks transactions including sales and rentals, purchases, income, and payments by an individual or organization using standard bookkeeping and accounting practices using a general ledger, accounts payable, accounts receivables, purchase orders and inventory control.

6.2.14.8 Financial and Budget Management; Short-term and long-term decisions are made based on analysis performed on current and projected assets and liabilities. The management of this

function includes the development and submission of a line-item budget, budget narrative and expenditure reporting to the DHS.

- 6.2.14.9 Facility Management; The ADRC coordinates and oversees the safe, secure, and environmentally sound operations and maintenance of the physical workplace its associated contracts in a cost effective manner aimed at long-term preservation of value. Duties may include the care of phone systems, HVAC systems, electric power, plumbing and lighting systems; cleaning; decoration; grounds keeping and security. Regarding phone systems, there is some interest in using the features of various local phone systems to assist in providing call data for reporting and analysis (e.g., number of calls made).
- 6.2.14.10 Reference Data Management; The ADRC has processes for collecting, aggregating, matching, consolidating, and distributing universal data shared over multiple systems throughout the organization to ensure consistency and control in the ongoing maintenance and applied use of this information.
- 6.2.14.11 Enterprise Content Management; This includes technologies, strategies, methods and tools used to capture, manage, store, preserve, and deliver content and documents related to an organization and its processes.
- 6.2.14.12 Workflow and Communication Management; The ADRCs participate in systematic planning, implementing, monitoring, and revision of all the channels of communication and sequence of activities within individual organizations, and between organizations. This also includes the organization and dissemination of new communication directives connected with an organization.

6.3 Income Maintenance

Income Maintenance responsibilities include (functions included for informational purposes only):

Financial Eligibility Determination; After Wisconsin Medicaid status has been determined by the ADRC, Income Maintenance staff receives a financial declaration and preliminary financial detail from the ADRC completed with the applicant and uses it to determine the financial eligibility of the applicant.

Cost Share Determination; Income Maintenance staff gathers additional financial information, determine the applicant's cost share, and administer cost share eligibility in CARES.

Cost Share Administration; Income Maintenance staff updates cost share information in CARES based on information received from members and MCOs.

Enrollment; Income Maintenance staff enrolls the applicant in CARES with a status of pending, based on the applicant's financial and functional eligibility. Once the enrollment consultant through the ADRC confirms the applicant's choice, Income Maintenance updates the status in CARES.

6.4 Managed Care Organizations

Specific MCO functions related to claims processing and encounter reporting are documented in more detail outside of this RFI. These functions are currently being addressed by RFP # 1677-DLTC-PM. Items in the following responsibilities list that are prefaced with an asterisk (*) are included in the current RFP and are only listed here for informational reference as they relate to other MCO functions.

MCO responsibilities include:

- 6.4.1 Case Management; These activities include assessment, care planning, assistance in arranging and coordinating services in the care plan, assistance in filing complaints and grievances and obtaining advocacy services, and periodic reassessment and updates of the person's care plan. Family Care case management differs from traditional case management in that a team of individuals that includes nurses, social workers, and other member representatives manages Family Care cases. Multiple team members perform case management activities and have input into a members care plan.
 - 6.4.1.1 Choice of Providers and Interdisciplinary Teams; MCOs inform members about the full range of provider choice available to them, including choice regarding interdisciplinary teams.
 - 6.4.1.2 Inform Members of the Benefit Package; MCOs provide a range of services to meet the needs and outcomes of its members, as identified in a comprehensive assessment process. Services must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
 - 6.4.1.3 Electronic Health Record (EHR) Maintenance; The MCO must maintain an EHR that refers to an individual's medical record in digital format. Electronic health record systems coordinate the storage and retrieval of individual records with the aid of computers. EHRs may be made up of electronic medical records (EMRs) from many locations and/or sources. Among the many forms of data often included in EMRs are patient demographics, medical history, medicine and allergy lists (including immunization status), and laboratory test results, radiology images, billing records and advanced directives.
 - 6.4.1.4 Member Centered Plan (MCP) / Comprehensive Assessment; Each MCO conducts an assessment and creates individual service plans and member centered plans for the client. MCOs also track employment participation among managed care members. This is intended to include self-employment and micro-enterprise, which typically involves selling goods

that an individual produces (e.g. art, crafts, jewelry, etc.) or selling services on an individual basis. The MCP is a comprehensive care plan that defines the outcomes expected from participation in the program. The detailed service plan is derived from the MCP and defines the specific services that are authorized in order to meet the greater objectives of the MCP. Various assessment tools are used by the MCOs (e.g., PraPlus, OASIS, and Braden Scale).

- 6.4.1.5 Service Pre-authorization; MCOs authorize, and determine providers available to provide services. MCOs follow documented policies and procedures for service requests that include consideration of member's health, long-term care, and social and quality of life outcomes. Services in the care plan are 100% pre-authorized.
- 6.4.1.6 Service Coordination; MCOs coordinate and monitor delivery of authorized services specified on member centered plans.

6.4.2 Quality Assurance / Quality Improvement Processes

- 6.4.2.1 Development of a quality management (QM) plan and infrastructure; MCOs must create and execute an annual quality management work plan that addresses overall effectiveness, sets new goals based on findings, and produces required quality reports. Activities include documentation of QM activities, obtaining member feedback (e.g. member surveys), monitoring quality of services, responding to unintended events, executing performance improvement projects, and conducting utilization reviews.
- 6.4.2.2 Performance monitoring (e.g. Utilization Management, Service Utilization); analysis and evaluation of the appropriateness, need and efficiency of services procedures and facilities according to established criteria or guidelines. Utilization management describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient.
- 6.4.2.3 Monitor and assess care management quality
- 6.4.2.4 Monitor critical incidents
- 6.4.2.5 Monitor appeals and grievances
- 6.4.2.6 Monitor fraud and abuse
- 6.4.2.7 Monitor data quality and conduct data integrity audits

- 6.4.3 Financial Risk Management The MCO ensures continuity of care for enrolled members through sound financial management systems and practices. Financial management systems must be sufficient to track, reconcile, report, and project the operational and financial results of the

MCO and support informed decision-making. Financial management practices must ensure the overall financial health of the organization and support the maximization of quality services with the funds expended.

- 6.4.3.1 Financial and Budget Management (risk, liability); MCOs ensure continuity of care for enrolled members through sound financial management systems and practices. Financial management systems shall be sufficient to track, reconcile, report, and project the operational and financial results of the MCO and support informed decision-making. Financial management practices shall ensure the overall financial health of the organization and support the maximization of quality services with the funds expended. This includes financial reconciliation and financial management, payroll and benefits system, risk management, liability, incurred but not reported (IBNR), claims processing, and general accounting processes. MCOs must demonstrate annually through a financial audit by an independent certified public accountant the reasonable assurance that their financial statements are free from material misstatement in accordance with Generally Accepted Accounting Principles (GAAP).

- 6.4.3.2 Financial Planning; MCOs must demonstrate annually that it has policies, procedures, and an approved budget in place to continue the fiscal operations required to serve the enrolled members. MCOs must communicate the fiscal health of the organization and demonstrate the integrity of the financial operations (cash flow, budgeting, forecasting, financial statement reporting). Short-term and long-term decisions are made based on analysis performed on current and projected assets and liabilities. The management of this function includes the development and submission of a line-item budget, budget narrative and expenditure report.

- 6.4.3.3 Enrollment Reconciliation; The MCO reconciles and resolves any enrollment issues, by comparing central enrollment data to local enrollment data.

- 6.4.3.4 Capitation Payment Processing; DHS pays MCOs a capitation for each enrolled member, on a monthly basis. The capitation covers actual days of member participation in the program.

- 6.4.3.5 Member Share Collections and Tracking; Member share includes post-eligibility treatment of income (cost share), room and board, voluntary contributions, and spend down. MCOs are responsible for collection of a member's monthly cost share or room and board and outstanding spend down, and are responsible for ongoing monitoring and reporting changes to these amounts, as appropriate (i.e., DHS, Income Maintenance). Room and board refers to the liability for institutional services, and spend down is for services not covered by the FC waiver. In some cases, the client funds

their account and spends that down for services that are not covered. The MCOs pay for the non-covered expenses on the clients' behalf from the spend down account.

6.4.3.6 Member Share Reporting; The MCO is responsible for collection of the member's monthly cost-share or room and board, along with voluntary contributions and spend down. The MCO's collection of monthly cost-share from waiver eligible Family Care participants is subject to Family Care waiver policy. The Department ensures that a waiver eligible Family Care participant is not required to pay any amount in cost share which is in excess of the average cost, as determined by DHS, of waiver services in a given month for all MCO waiver participants in the same target group. The MCO is responsible for the ongoing monitoring of the member shares.

6.4.4 Incident Tracking;

6.4.4.1 Client Incident Tracking and Reporting; The MCOs and their service providers record an event, incident, or course of action or inaction that is either associated with suspected abuse, neglect, other crime, or a violation of client rights. The MCO compiles and reports information related to its identification of, and response to, critical incidents on a quarterly basis to the Department. This information includes a brief description of each incident reported to the MCO management.

6.4.4.2 Complaints, Appeals, and Grievances; MCOs must have a system in place to maintain and implement due process procedures to review and resolve complaints, grievances, and appeals made by the member regarding program or provider services, and also provide access to the DHS grievance process. First level review of claims-related complaints may be delegated to the claims vendor.

6.4.4.3 Elder Adults / Adults at Risk and Adult Protective Services; MCOs coordinate with agencies responsible for Adult Protective Services and provide expertise as needed through memorandums of understanding.

6.4.5 Outcomes Tracking and Evaluation; MCOs track outcomes of services provided to members to document status, provide data for determining trends, etc. Progress toward personal experience outcomes is tracked in order to evaluate MCP and service plans.

6.4.6 Customer Service; A series of activities designed to enhance the level of consumer / member's satisfaction; that is, the feeling that the service or information has met the consumer/member's expectation. Its importance varies by service, information requested and the consumer/member. The MCOs have a process for addressing complaints, grievances, and appeals from members regarding service provision. Customer service may be provided by a person (e.g., care management), or by automated means called self-service. Examples of self service are Internet sites.

- 6.4.6.1 Internal Advocacy; The MCO designates an MCO employee to serve as a member advocate within the agency. This advocate assists members with issues and concerns that relate to the care management or the services provided through the MCO and assists in quality assurance activities throughout the MCO.
- 6.4.6.2 External Advocacy Relations; The MCO develops and maintains a working affiliation with independent advocacy services and other local organizations to ensure member accessibility, to assistance in grievance, appeal, and DHS review, or fair hearing processes.
- 6.4.6.3 Member informational materials; The MCO provides members, and their authorized representatives, with a member handbook and periodic updates to the handbook to explain changes in any of the minimum information requirements at least thirty (30) days in advance of the effective date of the change. Such changes must be approved by the DHS prior to distribution.
- 6.4.6.4 Provider Inquiry; MCOs manage a process that allows providers the ability to ask questions regarding service authorizations and/or benefits. (The claims TPA will handle claims-related inquiries.)
- 6.4.7 Member Registration; Members need to be registered to the local Family Care program. This is a separate process from enrollment, which occurs at the state level.
- 6.4.8 Enrollments and Disenrollments; MCOs conduct continuous open enrollment consistent with ADRC enrollment plans, and process disenrollments in collaboration with ADRCs and Income Maintenance agencies.
- 6.4.9 Access to CARES Data; MCOs have access to CARES data regarding members' Medicaid eligibility which assists MCOs in helping enrollees maintain their eligibility to receive the MCO benefits and in understanding their financial and other obligations to remain eligible.
- 6.4.10 Member Recertification; A person is eligible for membership in the MCO if the person meets all eligibility requirements defined in ss. 46.286 (1) and (2) Stats., and chs.HFS 10.32 and 10.34 Wis. Adm. Code. The ADRC and Income Maintenance determine eligibility prior to enrollment in the MCO or upon annual recertification of eligibility by the ADRC and Income Maintenance. MCOs verify eligibility through the DHS MMIS. Providers verify eligibility through the MMIS Automated Voice Response (AVR) system or through an eligibility verification vendor.
- 6.4.11 Functional Screen; MCOs assure all members have a current and accurate level of care. In most circumstances, the initial level of care determination is done by the ADRC prior to enrollment in the MCO. Subsequent re-determinations may be conducted by the MCO.
- 6.4.12 Provider Management (Provider and Resource database); The resource database is an important element to providing appropriate, safe and

consistent services to members. This component provides for efficient referral to available services and the providers of those services. Maintenance of the resource database consists of certified service providers, and includes adding, deleting, changing and updating of provider service information and demographic files, and the detail associated with those files. Data may be maintained manually and/or through an automated program.

6.4.12.1 Provider Maintenance (demographics, taxonomy, certifications or licensing requirements); This includes enrolling new providers, verifying provider licensees and certifications, reviewing, processing, distributing, and tracking status of application materials.

6.4.12.2 Provider Contract Management; This includes negotiating the terms and conditions in contracts and ensuring compliance with the terms and conditions, as well as documenting and agreeing any changes that may arise during its implementation or execution. The process of systematically and efficiently managing contract creating, execution, and analysis for the purpose of maximizing financial and operational performance and minimizing risk.

6.4.12.3 Provider Network Development; MCOs develop and manage the network of internal and external providers from which the MCO may acquire services. This information may include known limitations (e.g., capacity), cultural competencies, and accessibility.

6.4.13 Claims Processing*; MCOs must have a system to support claims processing and addresses issues related to claims handling. MCOs are responsible for payment of all authorized services in the benefit package provided to members.

6.4.14 Claims Encounter Reporting*; MCOs must report encounter level data (i.e., member, provider, date of service, procedure) monthly to the DHS in a specified format, in accordance with HIPAA regulations.

6.4.15 MCO as Service Provider; There are services that are provided by the MCO itself and in doing so they must have systems that allow them to act as a provider of services. As a service provider, an MCO must process service pre-authorizations, provide authorized services, generate internal claims documentation, and reconcile the payment for internally provided services. Case management and transportation are examples of services the MCO might provide.

6.4.15.1 Inventory Control; MCOs provide and maintain inventory control for the organization regarding supplies that are purchased in bulk and stored for future service delivery (e.g., DME, DMS, incontinence supplies). Items are tracked and billed internally.

6.4.15.2 Internal Service Capacity; The MCO must have the ability to provide and schedule the required internal services (staffing

and scheduling). The MCO must develop enough capacity to support their need of rendered internal services.

- 6.4.16 Data Collection; MCOs ensure data is available to meet the reporting requirements of funding sources, quality for federal financial participation, evaluate service quality and adequacy, and inform decision-making at the state and local levels. Some of this reporting is done electronically to the department using the encounter reporting application.
- 6.4.17 Survey Support; MCOs surveys its membership or a representative sample of its enrolled members to identify their level of satisfaction with the MCO's services. The membership survey includes a set of standard questions provided by the Department, and the MCO compiles the results and provides them to the Department. In addition to the membership survey, MCOs also survey providers to determine the level of satisfaction the providers have with the MCOs' responsiveness. Surveys may be conducted on a regular basis, and may also be conducted as specific needs arise.
- 6.4.18 Federal Reporting (CMS Encounter / MDS); Encounter reporting is the collection and reporting of encounter data to the DHS. Encounter data are detailed records of health care services or items that have been provided to members. Encounter data are used for rate setting and program analysis. Additionally, Partnership MCOs are federally required to include Minimal Data Set (MDS), Healthcare Effectiveness Data and Information Set (HEDIS), and some Enrollment / Special Status reconciliation.
- 6.4.19 Business Intelligence Ad Hoc Reporting; The MCOs require the ability to routinely process requests for data to perform analysis on the State's DSS DW (data warehouse) and/or local data.
- 6.4.20 Pharmacy Benefit Management; MCOs administering the Family Care Partnership program are responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. Family Care Partnership organizations generally contract with appropriate vendors for these services.
- 6.4.21 Pharmacy Management; This includes prescription filling, consulting, accounts receivable, workflow management, signature capture, IV processing, compounding, integrated point-of-sale solutions, pricing, and inventory management for pharmaceuticals. These functions may be contracted or may be provided internally.
 - 6.4.21.1 Pharmacy Dispensing Management; MCOs administering the Family Care Partnership program may need to support dispensing pharmaceuticals, including labeling and billing, accurately and safely through a controlled process that can be fully audited. These functions may be contracted or may be provided internally.
- 6.4.22 Local Policy Development; The MCO develops local policy based on state policy and programs available. Policies are developed regarding

implementation and operation of long-term care managed care programs and include, for example, incident tracking methods, provider and service delivery quality monitoring and reporting, service coding, claims payment, grievance and appeals resolution, benefit administration, enrollment and dis-enrollment functions, and functional and financial recertification.

- 6.4.23 Business Operating Management; MCO must be able to create their own reports, provide the ability for care managers to do their case notes via phone and have them transferred to data (voice recognition). They must also provide the ability to run modules of the application from the field on several different devices (laptop, PDA) on multiple platforms (Apple, Windows, UNIX), and provide calendars and task lists that trigger messages to users.
- 6.4.23.1 Time Keeping / Scheduling; MCOs must maintain scheduling and time keeping information for all staff in the organization.
- 6.4.23.2 Payroll; MCOs must maintain all financial records related to employees, contractors and subcontractors salaries, wages, bonuses and deductions.
- 6.4.23.3 Human Resources (benefits, talent management, case management competencies); MCOs must maintain a human resources and personnel function for the organization that includes hiring, training, professional certifications, background checks, etc.
- 6.4.23.4 Internal Business Operations Contract Management; The MCO must create and maintain internal contracts integral to its daily service operations.
- 6.4.23.5 Basic Financial Systems and Processes Management; The MCO tracks transactions including sales and rentals, purchases, income, and payments by an individual or organization using standard bookkeeping and accounting practices using a general ledger, accounts payable, accounts receivables, purchase orders and inventory control.
- 6.4.23.6 Facility Management; The MCO coordinates and oversees the safe, secure, and environmentally sound operations and maintenance of the physical workplace its associated contracts in a cost effective manner aimed at long-term preservation of value. Duties may include the care of phone systems, HVAC systems, electric power, plumbing and lighting systems; cleaning; decoration; grounds keeping and security. Regarding phone systems, there is some interest in using the features of various local phone systems to assist in providing call data for reporting and analysis (e.g., number of calls made).
- 6.4.23.7 Business Continuity and Disaster Planning; MCOs must plan for natural or human-induced interruptions in their delivery of managed care services. Business continuity refers to the creation and validation of a logistical plan for how an organization will recover and restore partially or completely

interrupted critical functions within a predetermined time after a disaster or extended disruption. Disaster planning encompasses the process, policies and procedures related to preparing for recovery or continuation of technology infrastructure critical to an organization after a natural or human-induced disaster. Disaster recovery planning is a subset of the larger process of business continuity planning and should include planning for resumption of applications, data, hardware, communications (such as networking) and other IT infrastructure.

- 6.4.23.8 Electronic Funds Transfer (for Payables and Receivables); MCOs use computer-based systems to perform financial transactions electronically. These transactions can include capitation receipts from the DHS, provider payments, and other financial exchanges.
- 6.4.23.9 IT Systems Inventory, Support, and Administration; MCOs need the capabilities of a fixed asset inventory system for tracking computer equipment, help desk software to allow for reporting and tracking computer issues.
- 6.4.23.10 Benefit Plan Maintenance; MCOs must have the processes and systems required for adding, deleting, changing and updating benefits plans shared over multiple systems (e.g. delegated or contracted case management).
- 6.4.23.11 Reference Data Management; MCOs have processes for collecting, aggregating, matching, consolidating, and distributing universal data shared over multiple systems throughout the organization to ensure consistency and control in the ongoing maintenance and applied use of this information. This information must follow all applicable Federal, State, and Local standards and policies (example HIPAA).
- 6.4.23.12 Enterprise Content Management; MCOs must manage the technologies, strategies, methods and tools used to capture, manage, store, preserve, and deliver content and documents related to an organization and its processes.
- 6.4.23.13 Data and Record Management; MCOs must have a system for maintaining records and for monitoring compliance with policies and procedures. This includes confidentiality and security, and access to data. This information must be available upon request by DHS for not less than five (5) years. This information must follow all applicable Federal, State, and Local data retention and security standards and policies.
- 6.4.23.14 Workflow and Communication Management; The MCOs participate in systematic planning, implementing, monitoring, and revision of all the channels of communication and sequence of activities within individual organizations, and between organizations. This also includes the organization

and dissemination of new communication directives connected with an organization.

6.5 Self-Directed Supports

The Self-directed Supports program (i.e., IRIS) is a publicly funded Wisconsin program where the consumer self-directs, community-based, long-term care supports and services. SDS has very similar program functions to the MCO. Specific differences involve the relationships between DHS, the ICA, and the FSA organizations, which are outlined above.

6.6 Department of Health Services

The Department of Health Services (DHS) is a state organization with the mission of protecting and promoting the health and safety of the people of Wisconsin. Responsibilities include long-term support and care programs, aging programs, physical and developmental disability programs, sensory disability programs, quality assurance and oversight of programs, regulation and licensing of a variety of facilities, and medical assistance and health care for low-income elderly and disabled persons.

Managing state managed care operations encompasses both the program administration and business operations administration by the State. The State creates policy and programs and has oversight of the local entities that administer the long-term care managed care programs. Responsibilities include policy development, program implementation, program oversight and quality monitoring, fiscal operations, enrollment and capitation administration, data governance, data collection and verification, data storage and business intelligence, code committee, and client incident tracking.

Within the Department, the Division of Long-Term Care (DLTC) oversees the provision of long-term support options for the elderly and people with disabilities, including the Family Care expansion effort that involves the Office of Family Care Expansion (OFCE), the Office of Resource Center Development (ORCD), and the Bureau of Long-Term Support (BLTS). Administration activities include quality monitoring, program oversight, reporting on quality indicators, incident tracking, and management of resources to implement and monitor long-term managed care programs.

The DHS Office of Family Care Expansion (OFCE) has responsibility for administration and implementation of long-term care managed care programs. OFCE assists MCOs in identifying system barriers to implementation of long-term care managed care programs and facilitates intra- and inter-agency communications and work groups necessary to accomplish full implementation.

The DHS Office of Resource Center Development (ORCD) has responsibility for the administration and implementation of the Aging and Disability Resource Centers. Bureau of Long-Term Support (BLTS) has the responsibility to administer and implement the IRIS program. Both of these state organizations also play a role in the oversight of the programs mentioned in this RFI.

DHS program responsibilities include:

6.6.1 Program Implementation

6.6.1.1 Contract Development and Maintenance; The DHS negotiates Family Care and Family Care Partnership contracts with MCOs, ensuring that the contracts meet the overall program goals, are workable for the MCOs and comply with federal requirements and state statutes. Contracts comprehensively define the relationship between the DHS and the MCOs.

6.6.1.2 MCO Procurement; The DHS ensures there are standardized processes and procedures for procuring MCO contractors for managed long-term care programs. The procurement process is not a request for bids; it is a request for proposals that results in identification of entities that are likely to meet MCO certification requirements.

6.6.1.3 Certification / Recertification; Family Care statute 46.284(3) contains certification requirements related to adequate availability of providers, expertise in determining and meeting the needs of covered target populations, and adequate and competent staffing to perform all the functions of the MCO. The DHS adds requirements to the certification review as it deems necessary, and/or as delineated in the DHS MCO contract (for instance, the contract stipulates that certain plans, policies or procedures must be approved prior to effective date of the contract.) Review standards are found in the contract.

6.6.1.4 Technical Assistance; Business and IT systems comply with Department and program strategic plans and contract requirements, and are positioned to support state and national technology objectives and directives. Systems users understand system functionality and have access to technical assistance resources as needed to make efficient use of technology.

6.6.1.5 External Advocacy / Ombudsman Program Management; The DHS works with various organizations to advance the cause of Family Care and with the two Ombudsman programs to ensure that the consumer is being served.

6.6.1.6 Develop IDT Materials and Other Training; The DHS develops training materials to ensure consistent training at the MCOs and ADRCs.

6.6.2 Program Oversight - Quality; Robust oversight of MCO contract compliance is in place to focus on achieving Family Care goals. Oversight and response to findings are handled consistently across all MCOs. There is an effective mechanism for making new policy and program improvements as appropriate based on findings of program oversight. Many of these functions are performed by the independent EQRO.

- 6.6.2.1 Quality Compliance Review (QCR); identifies and documents five practice categories of each MCO that affect the quality and timeliness of the care and services its Family Care members receive, as well as their access to those services. During the 2008 external quality review, the Family Care MCOs completed the Information Systems Capabilities Assessment (ISCA) as part of the QCR.
- 6.6.2.2 Performance Improvement Project (PIP) Validation; is necessary to ensure that each Family Care MCO's contractually required annual performance improvement project (PIP) has been developed and implemented using proper technique and design so that the MCOs can use the projects' data and findings for its organizational decision-making.
- 6.6.2.3 Care Management Review (CMR); determines each MCO's level of compliance with its contract with DHS, ability to safeguard members' health and welfare, and ability to work with members to identify the outcomes that members want and the resources they need to achieve them.
- 6.6.2.4 Standard Certified Assessment Maintenance; Maintain a uniform, comprehensive assessment tool and process for the MCOs. Provide training and technical assistance to care managers on how to conduct an assessment interview.
- 6.6.2.5 Issue Tracking and Resolution; The Department needs a document management system that allows the tracking of a variety of issues such as, requests, problems, suggestions and comments from the time an issue enters the department to when and how that issue is resolved.
- 6.6.2.6 Submit / Access QM Plan; ADRCs are required to develop an access plan with Income Maintenance and the MCO(s) in its area. Similarly, MCOs are required to develop an access plan. The Department reviews these plans periodically.
- 6.6.2.7 Data Audits; These are conducted to assess the quality and adequacy of Family Care data for analysis and involves profiling the data and assessing the impact of poor quality data on the organization's performance and results.
- 6.6.2.8 Performance monitoring; analysis and evaluation of the appropriateness, need and efficiency of services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable program plan (e.g. utilization management, service utilization). Utilization management includes evaluation of reported service data to analyze discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient.

- 6.6.2.9 Workforce Development and Provider Capacity; Process to ensure an adequate number of providers with the appropriate skills to meet the scope of services, including policies to ensure services do not decline during personnel shortages due to operational contingencies or changes in staffing structure or mix. Currently this is part of the MCO certification process.
- 6.6.2.10 Provider Quality; Surveys and an information system that collects quality issues and is available to MCOs.
- 6.6.2.11 Provider Credentials / Background Checks (for registered providers); The State currently monitors credentials of various types of providers. This process should be extended and made available to the various Family Care partners.
- 6.6.2.12 Respond to Ad Hoc Requests; The Department routinely receives requests that require an analyst to perform data analysis on the DSS DW.
- 6.6.2.13 Data Governance; The enterprise is responsible for central data governance and project prioritization functions to guide all entities within DHS.
- 6.6.2.14 Code Committee; Participates in enterprise code committee meetings and provides decision support for the managed care sub-committees. The Long-term Care Managed Care Code Committee (“Code Committee”) is comprised of representatives from each MCO as well as DHS. The goal is to collaborate to create, publish and maintain coding standards for data sharing that are HIPAA compliant and in support of the long-term care managed care programs.
- 6.6.2.15 Maintains I&A Categories; ORCD develops and maintains the I&A categories that are required to be used by each ADRC.
- 6.6.3 Program Oversight - Financial; The DHS and OCI cooperate to carry out a robust, continual monitoring of MCOs financial status, within a newly defined regulatory structure. This cooperative effort has a clear division of responsibility for all monitoring activities. The monitoring activity carried out by staff is supported by effective data management systems that present snapshots of MCO fiscal status and routine reports that are capable of forecasting financial health of individual MCOs. Financial situations are identified well in advance and agencies have time to plan to respond.
 - 6.6.3.1 Fiscal Analysis; Periodic analysis of various components of the MCOs’ financial statements to identify any concerning trends or opportunities.
 - 6.6.3.2 Solvency Monitoring; The Department monitors the operating capital and minimum risk and solvency reserves as required by contract.
 - 6.6.3.3 Fiscal Performance Monitoring; monitoring the overall health of each MCO organization.

- 6.6.3.4 Business Plans Submission; Business Plans for all MCOs must be submitted to the Department and must be updated if there are any material changes in the strategic direction of the MCO.
- 6.6.3.5 Financial Statements Submission / Access; Financial reporting for all MCOs are due to the Department in accordance with GAAP.
- 6.6.3.6 Financial Audits; Financial audits for all MCOs are due to the Department to show a reasonable assurance that the organization's financial statements are free from material misstatement in accordance with GAAP. The audit report should demonstrate to the Department that the MCO's internal controls, and related reporting systems in operation by the MCO, are sufficient to ensure the integrity of the financial reporting systems.
- 6.6.3.7 Tracking Expenditures; The Department tracks and analyzes certain expenses to ensure they are appropriate (e.g. administration expenses).
- 6.6.4 Communication Management
 - 6.6.4.1 Public Relations; The DHS works to build rapport with voters and the general public, including managing the flow of information between Family Care and the public. A set of management, supervisory, and technical functions that foster Family Care's ability to strategically listen to, appreciate, and respond to those persons whose mutually beneficial relationships with the organization are necessary if it is to achieve its missions and values. This management function focuses on two-way communication and fostering of mutually beneficial relationships between Family Care and the public.
 - 6.6.4.2 Stakeholder Relations; The DHS works to build rapport with those that are impacted by the Family Care activities including the members and the taxpayers.
 - 6.6.4.3 Federal Relations (obtain authorization and approval); The DHS manages approval of waivers, contracts and rates and compliance with federal requirements while maintaining relationships with federal stakeholders.
 - 6.6.4.3.1 Federal Relationship (advocacy, policy consultation)
 - 6.6.4.3.2 Federal Reporting
 - 6.6.4.3.3 Contract Rates Submission; This includes the development and approval of contracted rates for the Family Care members.
 - 6.6.4.3.4 Waiver Renewals; The DHS seeks appropriate federal authority from CMS regional Office Administrator for renewal of waivers: c, b, combinations, 1115, and Medicaid State Plan.

6.6.4.3.5 Contract Compliance

- 6.6.5 Fiscal Operations; OFCE financial operations provides enrollment and capitation administration for programs which includes responsibility for establishing eligibility criteria, monitoring enrollment, determining capitation rates, issuing capitation payments, and reconciling enrollments to capitation payments. Systems used are CARES, MMIS, and DSS DW (the data warehouse).
- 6.6.5.1 Budget, Trend Factors, Projected Service Costs; OFCE and the Office of Policy Initiatives and Budget (OPIB) function cooperatively to monitor Family Care and Family Care Partnership program budgets to assure expenditure targets are met, analyze and report trends to management, and plan for biennial budget requests.
- 6.6.5.2 Capitation Administration; This includes establishing capitation rates in the MMIS, ensuring correct payments are made to the MCOs for the correct time periods, ensuring MCOs receive payments for the correct members, assisting MCOs with their reconciliation processes.
- 6.6.5.3 Rate Development; The DHS ensures Family Care and Family Care Partnership programs have a common structure, formula, process and management of actuarially sound capitation rates that incorporate emerging health and long-term care business practices; reflect state-of-the-art use of data; meet industry and regulatory best practices; and forecast and inform the Department's future long-term care managed care business.
- 6.6.5.4 Develop and Maintain ADRC Cost Model; Summarized data from ADRCs' information and assistance systems are used to determined funding levels for each ADRC.
- 6.6.6 Incident Tracking; The DHS monitors and resolves incidents, complaints, and grievances that are reported directly to the Department or were reported through other channels.
- 6.6.6.1 Client Incident Tracking and Reporting; This includes recording an event, incident, or course of action or inaction that is either associated with suspected abuse, neglect, other crime, or a violation of client rights; or that resulted in serious harm to the health or well-being of a member.
- 6.6.6.2 Complaints, Appeals and Grievances; The Department must have a system in place for members that include a DHS grievance process that maintains and implements due process procedures to review and resolve complaints, grievances, and appeals made by the member regarding program or provider services. Grievances may be initiated through the ADRC or the MCO. The Department must have access to these cases for review and involvement or resolution, as appropriate.

- 6.6.7 Business Operating Management
 - 6.6.7.1 Policy and Procedure Development; The federal government mandates policies and requirements of federally supported health care programs. DHS develops program policy based on federal requirements.
 - 6.6.7.2 Communications Development; This includes maintenance and distribution of all information, including publications, websites, and list server communications.
 - 6.6.7.3 Financial and Budget Management (risk, liability); Short-term and long-term decisions made based on analysis performed on current and projected revenues and expenditures. The management of this function includes the development and submission of a line-item budget, budget narrative and expenditure report.
 - 6.6.7.4 Enterprise Content Management; Technologies, strategies, methods and tools used to capture, manage, store, preserve, and deliver content and documents related to an organization and its processes.
 - 6.6.7.5 Workflow and Communication Management; The MCOs participate in systematic planning, implementing, monitoring, and revision of all the channels of communication and sequence of activities within individual organizations, and between organizations. This also includes the organization and dissemination of new communication directives connected with an organization.
- 6.6.8 Data Collection and Verification; This DHS process is defined to collect, verify, and store data in a secure environment and provide access to data using secure web portals and state supported business intelligence tools. It includes building and maintaining a business intelligence infrastructure and standards according to enterprise data governance policies, and maintaining the enterprise data warehouse for data storage and business intelligence. This infrastructure includes, but is not limited to, PPS, FSIA, Encounter, WITS, MMIS, and CARES.
- 6.6.9 Data Storage and Business Intelligence; This warehouse resides at DHS and includes functional screen data, CARES financial data, encounter data, eligibility data, etc.

6.7 General Questions

- 6.7.1 How does your system solution(s) support the core functions performed by the ADRCs, the MCOs, and DHS outlined above?
- 6.7.2 How does your system solution(s) support the other non-core functions performed by the ADRCs, the MCOs, and DHS outlined above?
- 6.7.3 How does your system solution(s) support the need for connectivity and/or integration between organizations and the functions they perform?

- 6.7.4 How does your system solution(s) support variation in platforms, software versions and hardware infrastructure?
- 6.7.5 How does your system solution(s) support end-user turnover and diverse levels of knowledge and skills with technology?
- 6.7.6 Describe your system as it relates to all the applicable State and Federal standards.
- 6.7.7 Describe the composition or organization of your system solution(s), specifically address the functional modules or sub-components of the system.

6.8 Question(s) Regarding ADRC Functions

- 6.8.1 How does your system solution(s) support the need for system flexibility and change in program requirements by the ADRC and the Department?

6.9 Question(s) Regarding MCO Functions

- 6.9.1 How does your system solution(s) support the need for system flexibility and change in program requirements by the MCO and the Department?

6.10 Question(s) Regarding DHS Functions

- 6.10.1 How does your system solution(s) support the need for system flexibility and change in program requirements by the Department?

6.11 Company Information

- 6.11.1 Introduce your organization (e.g., parent, age, size, number of customers, offices, number of employees, etc.). Please include ownership structure.
- 6.11.2 Identify contact name(s) that we may use for questions we might have concerning this information and the products and services you offer.
- 6.11.3 List any relevant web sites for your company and its offerings.
- 6.11.4 Describe your software product and/or services strategies, including markets served. Include information regarding any strategic partnerships or alliances with other technology or service organizations.
- 6.11.5 Identify major customers that use your software and/or services and are willing to serve as a reference. Please provide the appropriate contact information.

6.12 Pricing Information

- 6.12.1 Describe your pricing and/or funding model.
- 6.12.2 Provide sample invoices or billing statements.

Appendix A - Acronyms and Definitions

The following abbreviations are used throughout this Request for Information (RFI).

ADRC	Aging and Disability Resource Center
BLTS	Bureau of Long-Term Support
CARES	Client Assistance for Reemployment and Economic Support
CMS	Centers for Medicare and Medicaid Services
DHCAA	Division of Health Care Access and Accountability
DHS	Wisconsin Department of Health Services
DLTC	Division of Long-term Care
DQA	Division of Quality Assurance
DSS	Decision Support System
DW	Data Warehouse
EHR	Electronic Health Record
EMR	Electronic Medical Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Family Care
FSA	Financial Services Agency
FSIA	Functional Screen Information Access
GAAP	Generally Accepted Accounting Principles
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	US Department of Health and Human Services
ICA	Independent Consulting Agency
IM	Income Maintenance
IRIS	Include, Respect, I Self-direct
IT	Information Technology
MA	Medical Assistance
MCI	Master Client Index
MCO	Managed Care Organization
MCP	Member Centered Plan
MDS	Minimum Data Set
MLTC	Managed Long-term Care
MMIS	Medicaid Management Information System
OCI	Office of the Commissioner of Insurance
OFCE	Office of Family Care Expansion

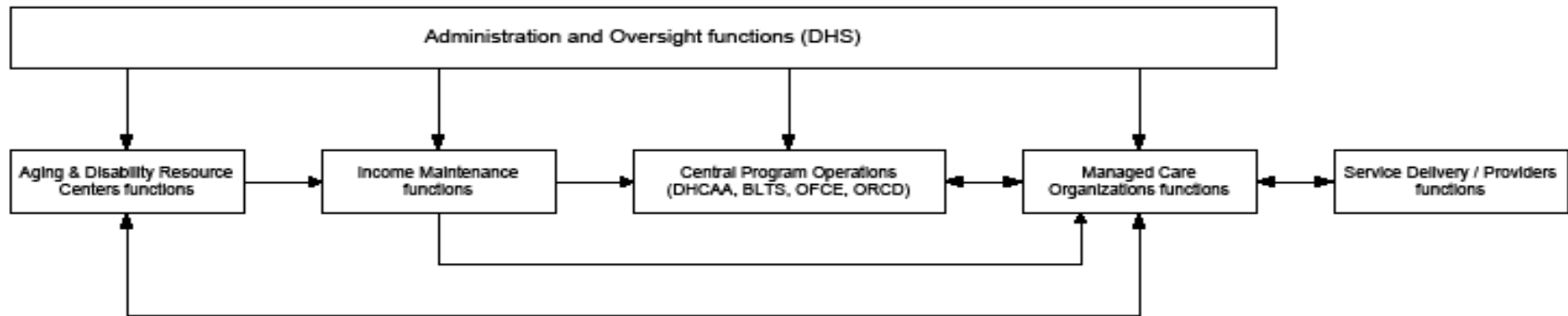
OPIB	Office of Policy Initiatives and Budget
ORCD	Office of Resource Center Development
PACE	Program of All-inclusive Care for the Elderly
PBM	Pharmacy Benefit Management / Pharmacy Benefit Manager
PPS	Program Participation System
RFI	Request for Information
RFP	Request for Proposal
SDS	Self-Directed Supports
SSI	Supplemental Security Income
TPA	Third Party Administrator
WITS	Wisconsin Incident Tracking System

The following definitions are used throughout the RFI.

Atypical services	non-medical or non-health related services, which may be included in community based service programs
Business operations	ongoing recurring activities involved in the running of a business for the purpose of producing value for the stakeholders
Department	the Wisconsin Department of Health Services
Enrollee	a person enrolled in a Long-term Care Managed Care program
Medicaid	Wisconsin Medicaid
Member	a person enrolled in a Long-term Care Managed Care program
Member share	payments received from a person enrolled in a Long-term Care Managed Care program, to be applied to their obligation for cost share, room and board, spend down, or other voluntary contributions made toward the cost of their care
Recipient	a person enrolled in a Long-term Care Managed Care program, and generally refers to a person receiving services through the managed care program
State	the State of Wisconsin
Waiver(s)	the federal government has issued a waiver of Medicaid policy for the purposes of program administration in specified areas

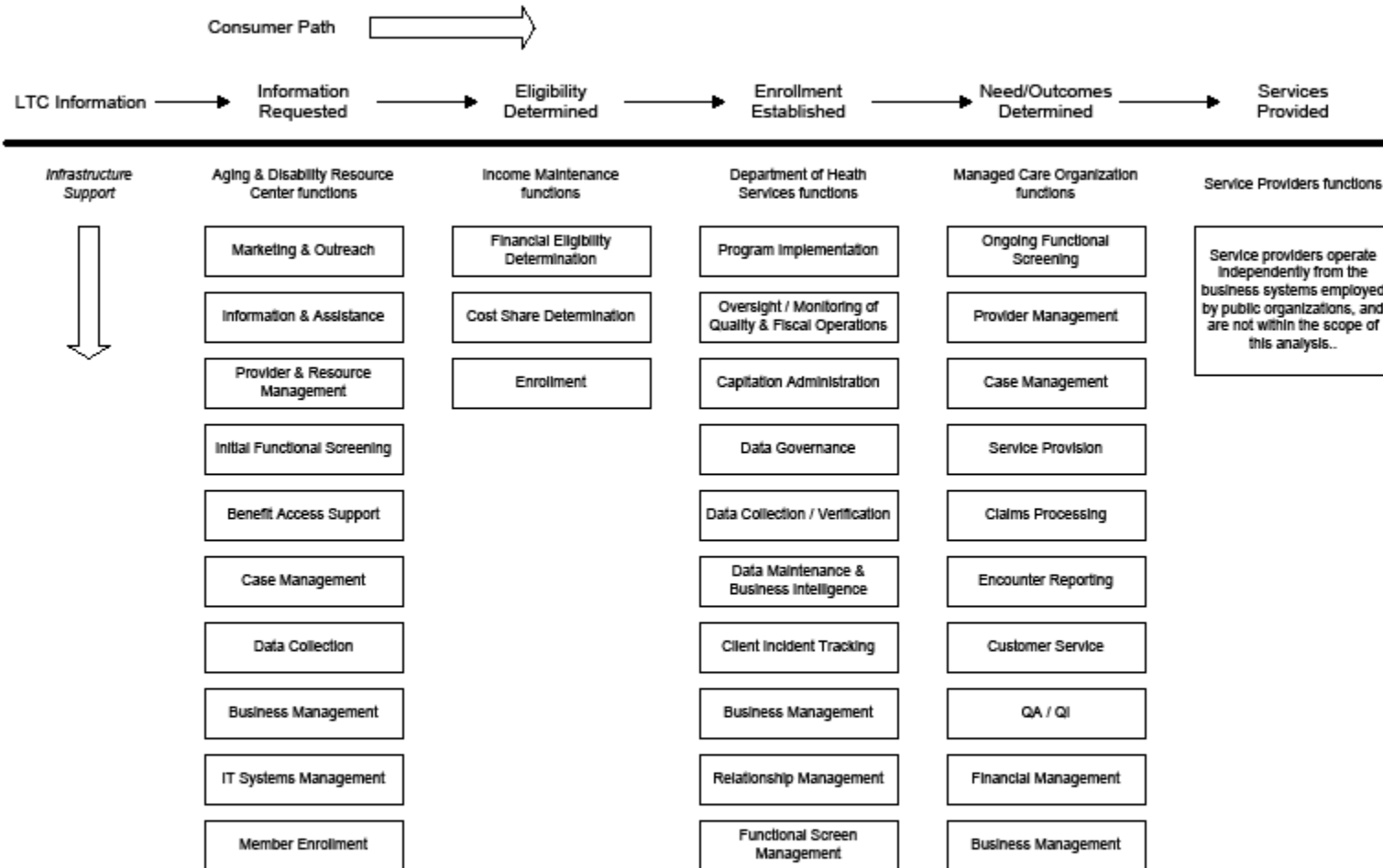
Appendix B - Long Term Care Program View - Summary Level

High Level Business Functions to Support Long-term Care Programs



Appendix C - Long Term Care Consumer View - Functional Level

Long Term Care Service Delivery Process



Appendix D – DHS Organization Chart

