

REQUEST FOR PROPOSALS



To Contract As a

Managed Care Organization

for the delivery of

Managed Long-Term Care in Selected Service Areas

RFP # 1615-DLTC-SM

January 28, 2008

Wisconsin Department of Health and Family Services



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PROPOSALS MUST BE SEALED AND ADDRESSED TO:

AGENCY ADDRESS:

Department of Health & Family Services
Division of Long Term Care – Family Care
1 W. Wilson St. Room 518
P.O. Box 7851
MADISON WI 53707-7851

**REQUEST FOR PROPOSAL
THIS IS NOT AN ORDER**

PROPOSER (Name and Address)

<input type="checkbox"/> Remove from proposer list for this commodity/service. (Return this page only.)	
Proposal envelope must be sealed and plainly marked in lower corner with due date and Request for Proposal # 1615-DLTC-SM . Late proposals will be rejected. Proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the proposal is due. Proposals dated and time stamped in another office will be rejected. Receipt of a proposal by the mail system does not constitute receipt of a proposal by the purchasing office. Any proposal which is inadvertently opened as a result of not being properly and clearly marked is subject to rejection. Proposals must be submitted separately, i.e., not included with sample packages or other proposals. Proposal openings are public unless otherwise specified. Records will be available for public inspection after issuance of the notice of intent to award or the award of the contract. Proposer should contact person named below for an appointment to view the proposal record. Proposals shall be firm for acceptance for sixty (60) days from date of proposal opening, unless otherwise noted. The attached terms and conditions apply to any subsequent award.	
Proposals MUST be in this office no later than Due April 4, 2008 4:00 PM	Public Opening <input type="checkbox"/> No Public Opening X
Name (Contact for further information) Monica Deignan, RFP Program Manager (608) 261-7807 Susan McKercher Procurement Manager (608)267-7637	
Date: January 28, 2008	
Quote Price and Delivery FOB N/A	

Description

**Managed Care Organization
for the delivery of
Managed Long-Term Care in Selected Service Areas**

Payment Terms:

Delivery Time:

We claim minority bidder preference [Wis. Stats. s. 16.75(3m)]. Under Wisconsin Statutes, a 5% preference may be granted to CERTIFIED Minority Business Enterprises. Bidder must be certified by the Wisconsin Department of Commerce. If you have questions concerning the certification process, contact the Wisconsin Department of Commerce, 5th Floor, 201 W. Washington Ave., Madison, Wisconsin 53702, (608) 267-9550.

We are a work center certified under Wis. Stats. s. 16.752 employing persons with severe disabilities. Questions concerning the certification process should be addressed to the Work Center Program, State Bureau of Procurement, 6th Floor, 101 E. Wilson St., Madison, Wisconsin 53702, (608) 266-2605.

Wis. Stats. s. 16.754 directs the state to purchase materials which are manufactured to the greatest extent in the United States when all other factors are substantially equal. Materials covered in our bid were manufactured in whole or in substantial part within the United States, or the majority of the component parts thereof were manufactured in whole or in substantial part in the United States.

Yes No Unknown

In signing this proposal we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other proposer, competitor or potential competitor; that this proposal has not been knowingly disclosed prior to the opening of proposals to any other proposer or competitor; that the above statement is accurate under penalty of perjury.

We will comply with all terms, conditions and specifications required by the state in this Request for Proposal and all terms of our proposal.

Name of Authorized Company Representative (Type or Print)	Title	Phone ()
		Fax ()
Signature of Above	Date	Federal Employer Identification No.
		Social Security No. if Sole Proprietor (Voluntary)

RFP TIMELINE

Monday January 28, 2008.....	Release of RFP
Thursday, February 7, 2008	Deadline for providing notice of participation in Proposers' Conference Call
Monday February 11, 2008	Proposers' conference call
Monday February 18, 2008	Deadline for all questions
Friday March 14, 2008.....	Publish answers to all submitted questions
Friday, April 4, 2008 (no later than 4:00 p.m.)	Due date for proposals
Friday, April 11, 2008*	Oral interviews, if necessary
Wednesday, May 14, 2008*	Announcement of intent to award
Friday, May 30, 2008*	Public announcement of awards
Thursday, July 31, 2008*	Completion of MCO certification
Friday, August 1, 2008.....	First possible effective date of contract

*Estimated Dates

Section 1: Request for Proposals (RFP) Purpose and Background

1.1 Purpose

The Department of Health and Family Services (DHFS) is requesting proposals from entities seeking certification by the Department to contract as managed care organizations for the delivery of managed long-term care to elders and adults with disabilities in specific service areas.

This solicitation is Part 1 of a three-part process that will culminate in contracts for delivery of managed long-term care. To be offered a contract through this three-part process, an entity must

Part 1: Demonstrate through its response to this RFP that it possesses or has capacity to secure sufficient resources to meet certification standards for managed long-term care organizations (see Appendix 1 – Readiness Template).

Part 2: Achieve certification as a managed long-term care organization by meeting DHFS certification standards.

Part 3: Contract with DHFS to deliver specific managed long-term care benefits (see Section 1.4.5) to specific target groups (see Section 1.4.4) in a designated service area (see Section 1.4.3). The decision to offer a contract is at the sole discretion of DHFS and will be based on the relative merits of proposers' responses to this RFP as evaluated by an evaluation committee selected by DHFS and during the subsequent certification process.

1.2 What is managed long-term care?

Managed long-term care is delivery of a defined benefit package (see Section 1.4.5) under a risk-based capitated contract to eligible elders and adults with disabilities who need long-term care services and meet the eligibility requirements for state-funded managed long-term care (see Appendix 2 – Eligibility for Managed Long-Term Care).

1.3 What is the purpose of managed long-term care?

Managed long-term care, pioneered in Wisconsin by Family Care and the Wisconsin Partnership Program, is an innovative way of delivering long-term care services. These programs were designed with the input of consumers, advocates, providers, state and local officials, and others in order to address concerns about the cost and complexity of the multiple long-term care programs and services available, inequities in availability of community and institutional services, and projections for an aging population's growing demand for long-term care. Managed long-term care is intended to provide cost-effective, comprehensive and flexible long-term care that fosters consumers' independence and quality of life, while recognizing the need for interdependence and support, with the specific goals of:

- Giving more people choices about where they live and what kinds of services and supports they receive to meet their long-term care needs;
- Improving access to long-term care services;

- Improving quality through a focus on health and social outcomes; and
- Creating a cost-effective long-term care system for the future.

Managed long-term care in Wisconsin has two major organizational components:

Aging and disability resource centers are designed to be the single recognized source for older people and people with disabilities and their families to get information and advice about a wide range of resources available to them in their local communities, including long-term care services and managed long-term care. The Department will contract for managed long-term care only in areas that are served by an aging and disability resource center. Resource centers provide:

- Information and assistance
- Long-term care options counseling
- Benefits counseling
- Emergency response
- Prevention and early intervention
- Facilitation of eligibility and enrollment in managed long-term care for applicants, including:
 - Determining functional eligibility using a standardized functional screening tool;
 - Arranging with economic support for financial eligibility determination;
 - Arranging for eligible applicants who choose managed long-term care to enroll in the managed care organization for receipt of the managed long-term care benefit.

Managed care organizations (MCOs) manage and deliver the managed long-term care benefit (see Section 1.4.5), which combines funding and services from a variety of existing programs into one flexible benefit. From the benefit, the MCO weaves together a package of services and supports that is tailored to each individual's needs, circumstances and preferences. MCOs:

- Develop a comprehensive network of providers of long-term care and health care services in the managed long-term care benefit package;
- Accept prepaid capitated payments to provide all of the services in the benefit package that each individual enrollee needs;
- Provide services and supports in the benefit package for each enrollee in accordance with a comprehensive assessment of the individual's needs, preferred outcomes and service preferences, and an individualized service plan designed by the enrollee and an interdisciplinary team to support those needs, preferences and outcomes;

- Provide ongoing care management to protect the health and well-being of enrollees and to support enrollees in achieving their desired personal-experience outcomes, which are:
 - I decide where and with whom I live
 - I make decisions regarding my supports and services
 - I decide how I spend my day
 - I have relationships with family and friends I care about
 - I do things that are important to me
 - I am involved in my community
 - My life is stable
 - I am respected and treated fairly
 - I have privacy
 - I have the best possible health
 - I feel safe
 - I am free from abuse and neglect
- Assure and continually improve the quality of care and services that members receive.

1.4 Overview of DHFS intent for this RFP

1.4.1 Who is eligible to receive the managed long-term care benefit from an MCO?

To receive the managed long-term care benefit, an individual must be aged 18 or over, and

- Be a member of one or more of the following target groups:
 - People who are frail elderly
 - People with developmental disabilities
 - People with physically disabilities
- Meet level of care (functional eligibility) and financial eligibility requirements (see Appendix 2 – Eligibility for Managed Long-Term Care); and
- Reside in an area served by the MCO.

1.4.2 Who may submit a proposal?

An MCO must be a legal entity that is legally able to enter into a risk-based contract in Wisconsin. A contract to deliver the managed long-term care benefit will be with a single entity that is responsible for all obligations specified in the contract for the service area(s) proposed.

Such entities include:

- A county under s. 2.01 Wisconsin Statutes (see Section 1.4.3 for more information);
- A group of counties acting cooperatively under s. 66.0301 Wisconsin Statutes;
- A long-term care district as defined in s. 46.2895 Wisconsin Statutes;

- A privately held managed care organization;
- An HMO or similar organization regulated by the Office of the Commissioner of Insurance;
- A federally-recognized Wisconsin Indian Tribe; or
- A group of any of the above entities working under a contractual agreement

A contract for delivering managed long-term care will be between DHFS and a single entity which assumes responsibility for complying in all ways with the contract, and assumes responsibility for any financial risk.

1.4.3 What service areas may a proposal include?

The Department's long-term goal is to expand managed long-term care statewide. Proposals will be accepted from entities seeking to begin operating an MCO during 2008 to provide the managed long-term care benefit(s) in some combination of the following Wisconsin counties: Richland, Crawford, Grant, Iowa, Juneau, Lafayette, Green and Sauk.

This RFP will result in identification of organizations with which the Department may contract to ensure that a managed long-term care benefit is available to all eligible individuals in these service areas.

Consideration will be given to proposals that phase in services to various geographic sectors of the service area over a period of not more than 24 months after the contract effective date.

Contractors will be required to develop a plan jointly with DHFS to manage enrollment into the MCO so that by 24 months after the initial contract date, the MCO has the capacity to enroll every eligible person who chooses to enroll.

Prior to a contract being signed, DHFS will require a resolution from the individual county boards in the service area stating that the county:

- Intends to transition to managed long-term care at this time; and
- Agrees that a county contribution is required according to the schedule published by DHFS, consistent with direction in the biennial budget act.

Contracts awarded as a result of this RFP process may be amended at a later date to include additional service areas.

1.4.4 What persons and target populations may a proposal include?

For purposes of this RFP, managed long-term care target groups are limited to people who are elderly and adults with developmental and physical disabilities. The Department intends to ensure that enrollment in a managed care organization is equally available to individuals from all three of these target groups. Therefore, proposers that will seek certification as MCOs that will serve all target groups are strongly preferred. However, a proposal to phase in services to the

specified target groups over a period of not more than 12 months after the contract effective date will be given consideration. The Department reserves the right to reject any proposal for an MCO that will not serve all target groups.

1.4.5 What is the managed long-term care benefit package?

1.4.5.1 Family Care as the minimum benefit package

Every proposer must plan to offer at least the Family Care benefit (see <http://dhfs.wisconsin.gov/LTCare/Generalinfo/Benpackage.htm>) _Family Care consists of a risk-based contract for the delivery of all long-term care services covered under Medicaid and under the home and community-based waiver programs.

1.4.5.2 Family Care Plus

Family Care Plus is a risk-based contract for the delivery of all Medicaid state plan services, as well as the Medicaid waiver home and community-based services. Family Care Plus will not be a benefit package option in Wisconsin until at least 2010, and perhaps later, depending on the capacity of the Medicaid Management Information System (MMIS) to support that option. However, MCOs that are awarded contracts to operate Family Care or Family Care Partnership may be offered the option of expanding their program to include Family Care Plus during the contract period covered by this RFP. Therefore, proposers are asked to submit information about any potential interest they may have of offering Family Care Plus during the next five years. As a separate attachment to your proposal submission, please include brief responses to the following:

Have you had discussions with local stakeholders about the potential of offering Family Care Plus? If so, please provide one or two sentences describing the interest of local stakeholders in Family Care Plus.

If you, as the proposing entity, and local stakeholders have some interest in potentially offering Family Care Plus in the future, what would be the earliest date you would consider doing that?

In scoring proposals, there are no points awarded for responses to these questions about potential interest in offering Family Care Plus in the future.

1.4.5.3 Family Care Partnership benefit package

A proposer may offer both Family Care and Family Care Partnership, which was formerly known as the Wisconsin Partnership Program. Family Care Partnership may be offered as the sole benefit in a service area where Family Care or Family Care Plus is already offered, or will be offered through another MCO. Family Care Partnership consists of a risk-based contract for the delivery of all Medicaid health and long-term care services and a risk-based contract directly with Medicare for the delivery of the Medicare Part A, Part B and Part D benefits. For DHFS to consider contracting with an entity to offer the Family Care Partnership benefit, the proposer must provide evidence that it has contracts directly with Medicare for the delivery of the Medicare Part A, Part B and Part D benefits. One contract must be a Medicare Advantage Dual Eligible Special Needs Plan with an institutional subset for the geographic area you are

proposing to serve, as well as the target populations. The proposer must also have evidence that it has a contract directly with Medicare as a Medicare Part D Prescription Drug Plan applicable to the geographic area and population they are proposing to serve.

1.4.5.4 Other benefit packages

While not included in this solicitation, at some point in the future DHFS may consider proposals for other combinations of services as long as the proposed benefit package includes all of the services in the Family Care benefit. In order to approve an alternative benefit package, additional state statutory and/or federal authority may be required and additional changes to state reporting and payment systems may be necessary. Because of this, a proposal to deliver any other benefit package will not be considered at this time.

1.4.6 Will DHFS contract with more than one entity in a service area?

DHFS may choose to contract with more than one entity to provide managed long-term care in any single geographic service area (see Section 1.4.3). DHFS must ensure that each organization with which it contracts has a sufficient number of potential enrollees within its service area to allow for its successful operation as a managed long-term care organization. A proposal must indicate the minimum number of enrollees it projects will be necessary to successfully deliver managed long-term care. If DHFS awards contracts to more than one proposer in a service area, it will negotiate enrollment capacity with each proposed contractor prior to certification and contracting. DHFS reserves the right to amend contracts with certified MCOs operating in one or more service areas to provide the Family Care benefit(s) in additional service areas if it is determined that this is necessary to meet the obligations of the Department in providing access to adequate choice of providers, and to long-term care services for all eligible individuals.

In single geographic areas in which DHFS contracts with more than one long-term care MCO, enrollees will have an opportunity to change MCO at least twice per year during “open enrollment periods,” and may change at other times for cause with approval of DHFS.

1.4.7 What are the prerequisites to a contract?

DHFS may offer a contract to an organization to operate a managed care organization in a specified service area if:

- It determines through this RFP process that a proposer likely has or can secure sufficient resources to meet the standards for managed long-term care organizations; and
- The organization is certified by DHFS as meeting those standards.

1.4.8 What is the duration of the contract?

DHFS will offer a contract for the duration of the calendar year in which the contract begins, with the option for annual one-year renewals, not to exceed five years in total, if the MCO continues to meet performance requirements. In the future, to coordinate RFPs across different service areas, DHFS may conduct a new RFP process prior to the end of the five-year contract period.

1.4.9 Funding

1.4.9.1 Payments to MCOs

DHFS will provide an MCO with a capitated payment for each person who enrolls. Capitation rates are determined using an actuarially sound methodology for projecting the average per-person cost of services for persons entitled to the managed long-term care benefit. For Family Care capitation rates in the current and past years see Appendix 3. For information on Wisconsin Partnership Program capitation rates see Appendix 4. See also the webcast on Rates and Risk Reserves at <http://dhfs.wisconsin.gov/ManagedLTC/grantees/webcasts/033006.htm>.) If the case mix of persons actually enrolled by an individual MCO varies significantly from the case mix projected in rate setting, rates may be retroactively adjusted to reflect actual versus projected case mix.

1.4.9.2 Effect on other funding for long-term care

Funding for other long-term care programs operated by the county or counties in the service area (Community Options Program, COP-Waiver, CIP II, CIP IA, CIP IB, Brain Injury Waiver and other county long-term care programs funded by Community Aids) for persons in the managed long-term care target groups will be transferred to the managed long-term care benefit(s) through an agreed upon implementation plan for an orderly implementation of managed long-term care, including a smooth transition of existing cases. Other Medicaid services in the benefit package (see Section 1.4.5) will also be available through managed long-term care to persons who choose to enroll. For persons who choose not to enroll, Medicaid State Plan services (card services) and, under certain circumstances, home and community-based waiver services will continue to be available from fee-for-service providers, pending any other state or federal decision that may modify this assumption at some time in the future.

SECTION 2: PROPOSAL RESPONSE

Technical Assistance

Technical assistance regarding the RFP guidelines is available upon request. Written or telephone request for technical assistance on the proposal guidelines should be addressed to:

mckersl@dhfs.state.wi.us

Department of Health and Family Services

Division of Enterprise Services

Susan McKercher, Procurement Manager – Room 750

P.O. Box 7851

MADISON WI 53701-7851

Phone: (608) 267-7637

Fax: (608) 264-9874

Written e-mail or Fax requests are preferred. To ensure receipt of your e-mail/fax place the following information in the subject line:

RFP #1615-DLTC-SM Managed Care Org Delivery of Managed LTC

Collect calls will not be accepted.

General Instructions

Proposers must submit their completed proposal electronically and in hard copy (see Section 3 for submission instructions.) The Department reserves the right to reject any proposal that is not complete. If an attachment is used to provide supporting information, number it with the number of the section or subsection to which the supporting information is applicable. For example, an organizational chart that is used to provide information in response to Section 2.1.2.1 must be labeled “Attachment 2.1.2.1”. Evaluators may not consider attached information that is unlabeled or improperly labeled.

Name and contact information of proposer: Provide the name of the organization submitting the proposal and its mailing address. Provide the name, telephone number, fax number and e-mail address of the organization’s principal contact person for this proposal. This information must be provided on form DOA 3477, (see attached forms).

Authorized signature: Signature of a person authorized to represent the proposer organization. This must be provided on form DOA 3261 which is part of this proposal document.

2.1 Proposer Information (100 points)

2.1.1 Organization authority to enter into a risk-based contract

Describe the legal entity under which the proposed contracted MCO will operate and be able to enter into a risk-based contract (see Section 1.4.2).

2.1.2 Description of proposer organization

2.1.2.1 Governance and organizational structure

Describe the governance structure of the proposer organization, identifying lines of authority and operating responsibility. Please include an organizational chart.

2.1.2.2 Contractual relationships

A contractor will be expected to be organized and operated as an independent business enterprise with revenue and expense and reserve funds that are separate from its parent organization, and have independent control over information systems and their development, contracting, procurement and personnel decisions such as hiring to keep up with capacity demands.

If you have a parent organization or a subsidiary located outside of Wisconsin, please identify this organization. Also tell us what services they provide for you, what level of accountability you have to this organization, and whether or not this organization will affect the administrative decisions of the proposer organization. If any organization outside of Wisconsin does affect administrative decisions, please explain how and to what extent this occurs and how you will assure the independence necessary to effectively service your membership.

2.1.3 Governing board requirements

Describe how the MCO will meet Wisconsin statutory requirements for a Family Care governing board, s.46.284 (6), Wis. Stats., including having a board that reflects the ethnic and economic diversity of the geographic area served by the care management organization. At least one-fourth of the members of the governing board shall be representative of the client group or groups whom the managed care organization is contracted to serve or those client's family members, guardians, or other advocates.

In a long-term care district, at least one-fourth of the members of the board shall be representative of the client group or groups whom it is the long-term care districts primary purpose to serve or those clients' family members, guardians, or other advocates.

2.2 Scope of proposal (100 points)

2.2.1 Geographic service area

Describe the geographic area in which the proposer intends to contract to provide managed long-term care. The proposer must demonstrate that the proposed service area has sufficient population so that the number of potential enrollees is able to support the proposer's business plan (see Section 2.3.3.5). Generally, an MCO that expects its enrollment will not reach 1,500 members will not be considered; however, this minimum may be waived in exceptional circumstances at the request of a proposer and at the sole discretion of DHFS. A service area, generally, may not include partial county areas; however, this requirement may be waived in exceptional circumstances at the request of a proposer and at the sole discretion of DHFS.

2.2.2 Target populations

Coverage for all three target groups is required (see Section 1.4.4). This requirement may be waived at the request of a proposer and at the sole discretion of DHFS if the Department's goal of serving all target groups can be met through contracting with multiple organizations to deliver the managed long-term care benefit. DHFS will waive this requirement only if evidence, such as a letter of intent from another entity, is submitted with the proposal showing that another entity will be submitting a proposal to serve the additional target groups. List the target groups proposed to be served and the timeline for serving each. Target groups to be served may be phased in over the initial 12 months of operation

2.2.3 Managed long-term care benefit package

Specify what program(s) you are proposing to offer (Family Care, Family Care Plus or Family Care Partnership.) See Section 1.4.5. for definitions and parameters.

2.2.4 Other services or benefits provided by the proposer

Identify any other health care services, benefits or plans that are offered by the proposer, or that the proposer anticipates offering in the future. These could include SSI managed care, Medicaid managed care for children and families, the Program for All-Inclusive Care for Elders (PACE) or any other health care service or plan. If the proposer is offering the Family Care Partnership

benefit, the proposer must provide evidence that it has a Medicare Advantage Dual Eligible Special Needs Plan with an institutional subset for the geographic area and the population they are proposing to serve, and a Medicare Part D Prescription Drug Plan for the geographic area and population they are proposing to serve

2.3 Organizational capacity to implement managed long-term care (600 points)

Points for this section are further subdivided as follows:

- Section 2.3.1: Stability and public accountability (200 points)
- Section 2.3.2: Community based experience (200 points)
- Section 2.3.3: Managed care expertise (200 points)

In this section, the proposer is asked to demonstrate that it possesses, or how it will acquire, the skills and resources needed to successfully deliver managed long-term care. This section is an initial evaluation of the proposer's potential to meet the standards necessary for DHFS to certify, prior to entering into a contract, that the organization has the capacity to deliver the managed long-term care benefit package specified in Section 2.2.3. If DHFS determines that a proposer likely has the potential to meet the necessary standards, the organization will then be required to meet certification requirements prior to entering into a contract.

Between notification that DHFS has determined that a proposer likely has the potential to meet the necessary standards and the effective date of contracting, a proposer will be expected to plan for implementation of the managed care organization and secure the resources needed for meeting certification, including:

- Developing needed business systems and information technology;
- Planning with aging and disability resource center(s) and income maintenance unit(s) to ensure efficient procedures for enrollment of persons determined eligible and who want to enroll;
- Planning with current long-term care program(s) and providers and with individual enrollees to ensure a smooth transition of responsibility and service provision to the new organization;
- Developing needed provider contracts to ensure provider network adequacy and capacity;
- Developing management and staff capacity, including interdisciplinary team capacity, to provide services immediately upon enrollment to any eligible person who applies; and
- Any other activities needed for certification by DHFS.

No later than 45 days prior to entering into a managed long-term care contract the proposer will be expected to meet all certification requirements (see Appendix 1 – Readiness Template).

On the effective date of the contract, the managed care organization will be expected to:

- Have completed all planning and resource development activities, and have in place the systems, resources and procedures needed to deliver the managed long-term care benefit(s) specified in Section 2.2.3.

Have the capacity to carry out an enrollment plan developed jointly with DHFS that will result, within 24 months from the effective date of the contract in the MCO being able to enroll, with no waiting, all persons who are eligible and choose to enroll.

2.3.1 Stability and public accountability

Competitive procurement rules required by the federal government allow private entities, as well as public entities, to compete to deliver publicly-funded managed long-term care benefits. The state procurement and certification processes will result in contracts with organizations that can be depended upon to remain in business and continue to deliver services over a long period of time. Under such contracts, MCOs are accountable for the health and safety of the individuals they serve, for the delivery of quality services and are responsive to long-term care consumers within the proposed service area.

2.3.1.1 Stability

Provide evidence that the proposer can be depended upon to remain in business and continue to deliver services over a long period of time. Include information about the history of the organization and its founding or partnering organizations as well as information about past partnerships with local government entities, stakeholders and local long-term care delivery systems.

If the proposer has past or current experience providing health or long-term care services, briefly tell us about that experience. If this experience involved a contract that was terminated, describe the circumstances under which this termination occurred, and include information regarding transition planning for members when the contract ended.

Provide evidence of commitment to the proposer organization's mission and ongoing operation by its governing board and any founding or partnering organizations. This evidence should describe how the MCO governing board will be compliant with statutory requirements for Family Care MCO governing boards, found in s.46.285(6), Wis. Stats.

2.3.1.2 Accountability

Identify the mechanisms by which the proposer makes its organization transparent, accountable and responsive to persons who receive its services and the public at large. Include information about:

- Efforts to communicate regarding your organization's performance to oversight bodies such as regional long-term care advisory committee or Aging and Disability Resource Center (ADRC) boards and other local advocacy organizations.
- Efforts to provide easy access to your organization by potential members and the general public through brochures, flyers, interactive web sites or other means.
- Efforts to assure effective communication and interactions with other systems that may serve your members, such as Adult Protective Services, mental health and substance abuse services, school systems, vocational services and primary and acute health care systems.
- Your organization's willingness to be responsive to the needs of potential future enrollees who are eligible for Family Care but currently receiving inpatient treatment for mental health or substance abuse, or currently residing in nursing homes or ICFs-MR.
- Your organization's willingness to enter into an MOU or other written agreement with the Aging and Disability Resource Centers (ADRCs) in the service area that describes the circumstances in which the MCO will serve individuals who are functionally eligible and at imminent risk of harm, hospitalization or institutionalization without the services of the MCO but whose financial eligibility is pending.

2.3.2 Experience in delivery of community-based long-term care services

Managed long-term care emphasizes providing long-term care services to people where they choose to live. When people choose to reside in nursing facilities or ICFs-MR, those facilities are primarily responsible for the care and treatment of those individuals, and for addressing health and safety needs. People residing in these facilities may be enrolled in a Family Care program, and receive additional care management and quality oversight from the MCO staff. The MCO itself will contract with licensed nursing facilities that have the capacity to provide quality care in those settings.

When individuals with health and long-term care needs choose to live in their own homes or other community-based settings, the MCO is responsible for developing a care plan to address their care and treatment needs, and provide assurances for health and safety.

2.3.2.1 Organizational expertise

Identify experience the proposer has in delivering community-based long-term care to people within the Family Care target groups, including comprehensive assessments to determine what members need to live successfully in community-based settings, and in providing services and supports to enable people to do so safely.

2.3.2.2 Organizational experience in individualizing services in managed care

The Department seeks to contract with MCOs that are person-centered and outcome-focused. This requires the ability to work with members to identify the real life results, or outcomes, they want to achieve through their health and long-term care services and supports, and keeping the member at the center of the care management team developing the care plan and determining what services and supports to put in place. Identify the expertise the proposer has in delivering person-centered services under a managed care contract.

2.3.2.3 Acquiring qualified interdisciplinary care management team staff

Care management is the core function of the managed long-term care organization. Describe the proposer's plan to obtain qualified clinical care management staff necessary to deliver the managed long-term care benefit(s) specified in Section 2.2.3 to the membership projected in the initial business plan (see Section 2.3.3.5) using the interdisciplinary team models currently required by Family Care or Family Care Partnership. This includes having specialized knowledge of the conditions of the target populations served by the MCO, a knowledge of community alternatives for those target populations, and knowledge of the full range of long-term care resources.

Also, describe the staff to member ratios you anticipate for the professionals on your interdisciplinary teams.

2.3.2.4 Interdisciplinary care management team staff training

Identify the proposer's plan for assuring care managers have knowledge and competencies in:

- Identifying outcomes;
- Person-centered planning;
- Cost-effective care planning; for instance, use of the State’s resource allocation decision-making methodology (RAD);
- Supporting opportunities for self-direction and self-directed supports;
- Functional limitations and service needs of the managed long-term care target groups;
- The range and availability of community-based long-term care services and supports;
- Identifying and dealing with mental health and substance abuse among the long-term care target groups.
- How to effectively function as a member of an interdisciplinary team.
- Internal MCO systems and processes to support service authorization and care planning.

2.3.3 Organizational capability for managed care

Managed long-term care requires experience in capitated risk-based contracting.

2.3.3.1 Organizational experience in managed care

Describe the proposer’s experience in managed long-term care in each of the business areas identified in Appendix 1 – Readiness Template.

2.3.3.2 Acquiring qualified business management staff

Describe the proposer’s plan to obtain dedicated or additional staff and other resources to ensure it has the business systems and quality management systems necessary for successful operation of a managed long-term care organization, including:

- Strategic planning;
- Provider network management;
- Budgeting, accounting and financial management;
- Information management;
- Claims processing;
- Quality management; and
- Executive and supervisory staff to support the care management functions.

2.3.3.3 Provider network

The provider network is one measure of a proposer’s ability to meet the needs of its members. Prior to entering into a managed long-term care contract a proposer will have to have a provider network that DHFS has certified is adequate. Provide evidence that the proposer has a workable plan and the resources to, by the time the contract is entered into, build a comprehensive network of providers with the capacity to deliver the proposed managed long-term care benefit(s) specified in Section 2.2.3 to the membership projected in the initial business plan (see Section 2.3.3.5).

Please address the following:

- Your methodology to project network capacity needs, including projected enrollment by target group;
- Specific expertise that must be included in the network, including evidence-based services for mental health and substance abuse services for persons with cognitive deficits, behavioral difficulties and brain injuries; inclusion of “waiver” services such as vocational supports and respite;
- Consideration of geographic access factors;
- Consideration of workforce needs related to direct care workers; and
- Consideration of cultural competency.

2.3.3.4 Solvency and risk

An MCO will be required to have cash reserves that are sufficient to:

- Assure that the organization has adequate cash flow to hire staff and subcontract with providers that will be necessary to deliver the proposed benefit(s) specified in Section 2.2.3;
- Allow the organization to manage fluctuation in enrollment, capitation payments and other receipts and fluctuation in the cost of delivering services in the benefit package based on individual needs of enrollees;
- Ensure that the organization has sufficient liquid reserves to continue to meet the individual needs of enrollees for a minimum of three months in the event that the managed long-term care contract is terminated by DHFS or by the managed long-term care contractor, as estimated through the incurred but not reported (IBNR) calculation and satisfied through funds invested for the mandatory reserve requirement and maintained for ongoing operations; and
- Assure that the organization has a reasonable expectation of ongoing solvency.

Please address the following as relevant:

- Any organization that specifies in Section 2.2.3 that it intends to provide a benefit package that includes primary and/or acute health care services is required to demonstrate that it is licensed as an HMO or other insurance entity in good standing by the Office of the Commissioner of Insurance, or otherwise provide evidence that will satisfy this requirement at the time of contracting;
- Any organization other than a county, group of counties or Long-term care district acting jointly may also be required at the time of the initial contract to be licensed as an HMO or other insurance entity in good standing by the Office of the Commissioner of Insurance;
- A county, a tribe or band, or any combination of counties or tribes or bands acting together to contract to deliver the Family Care benefit as a long-term care district or under Wisconsin State Statute 66.0301, or a private entity contracted to deliver the Family Care benefit, will be required to meet working capital, risk reserve and solvency fund requirements as specified in the Family Care contract (see <http://dhfs.wisconsin.gov/LTCare/StateFedReqs/FC-RC-CMO-Contracts.htm>);
- A county, group of counties or long-term care district contracting to provide the Family Care benefit will need to have a plan to reach all solvency requirements within three years of the date of the initial contract. A private entity will need to have a plan to reach all reserve and solvency requirements at the time of the initial contract.

Provide evidence that the proposer will have adequate working capital, risk reserves and solvency protection including the sources of such funds, consistent with the points outlined immediately above, for the delivery of the managed long-term care benefit(s) proposed in Section 2.2.3. A private entity should provide a copy of their most recent audited financial statements and their most recent interim financial statements, demonstrating the strength of their financial position and ability to support proposed operations of both the proposing entity as well as for the consolidated entity if a relationship exists.

2.3.3.5 Business plan

All proposers must submit an initial three-year (36 month) business plan starting with the anticipated initial contract date. This plan will project that, if awarded a managed long-term care contract, the proposer will be financially stable, as demonstrated by projected positive net income, within two years of initial contract award, and remain financially stable thereafter. Omission of a business plan may result in rejection of a proposal.

For purposes of this RFP process the initial business plan should minimally include:

- Projected enrollment by target group. See Appendix 5 for information on the population currently receiving services from, or on the waiting list for services from, the home and community based waivers.
- Anticipated capitation rate(s) required to provide the benefit package specified in Section 2.2.3 and narrative to support the assumptions underlying the anticipated rate.
- Assumptions underlying the projected expenses that will be experienced during ramp-up.

- Complete budget projections, including balance sheet, income statement, statement of cash flow, and budget narrative including:
 - Any other anticipated revenue (e.g. Medicare payments or cost share)
 - Projected staffing costs for:
 - Management and administrative staff
 - Interdisciplinary team staff to serve anticipated growth in enrollment
 - Other internal staff
- Projected cost of purchased services and supports including administrative services
- Projected cost of any risk sharing, reinsurance or stop-loss insurance
- For any plan proposing to offer acute and primary care, documents supporting that the plan is currently in good standing with the Office of the Commissioner of Insurance (OCI), or provide documentation that the plan will be in good standing with the OCI at the start of any contract that results from this RFP.
- The source and amount of any cash, risk or solvency reserves
- Cash flow in relation to anticipated revenues and expenditures including any projected costs of building or maintaining reserves
- A self-assessment of the business strength and weaknesses that will support entering into, or expanding, current operation to provide and assume risk for managed long-term care services.

Information on service utilization for the current waiver population for calendar years 2004–2006 is also available upon request. To request a data set of this information, please contact Tom Lawless at (608) 261-7810 or LawleTM@dhfs.state.wi.us

2.4 Coordination with outreach and access services (50 points)

2.4.1 Aging and disability resource centers

Provide evidence that any ADRCs within the proposed service area have been informed of the proposer's intent to respond to this RFP. Please send us one copy of a letter used to notify ADRCs of your intent to respond, and a list of other organizations you have contacted by letter, including the organization's name, address, and the date on which you contacted them. If there is currently no ADRC in the proposed service area or part of the service area, provide evidence that there is an organization ready and willing to apply to the Department to become an ADRC.

2.4.2 Eligibility and enrollment

Provide evidence that the income maintenance units in the counties within the proposed service area have been informed of the proposer's intent to respond to this RFP. Please send us one copy of a letter used to notify an income maintenance unit and a list of other units you have contacted by letter, including the name of the unit, and the date on which you contacted them.

2.5 Coordination with related programs and services (50 points)

2.5.1 Existing community-based service programs

Provide evidence that the current COP / Waiver agency or agencies in the proposed service area have been informed of the proposer's intent to respond to this RFP. Please send us one copy of a letter used to notify a COP/Waiver agency and a list of other agencies you have contacted by letter, including the agency's name, address and the date on which you contacted them.

2.5.2 Existing managed long-term care organizations

Provide evidence that any existing managed long-term care organizations already operating in the proposed service area have been informed of the proposer's intent to respond to this RFP. This includes MCOs serving the SSI population, the Medicaid long-term care population, and Medicare Special Needs Plans serving individuals also eligible for Medicaid and/or designated as an institutional Special Needs Plan. Please send us one copy of a letter used to notify these organizations of your intent to respond, and a list of other organizations you have contacted by letter, including the organization's name, address, and the date on which you contacted them.

2.5.3 Other related county-operated programs and services

Provide evidence that the following county agencies within the proposed service area have been informed of the proposer's intent to respond to this RFP. Please send us one copy of a letter used to notify them, and a list of the other agencies also sent letters including the agency name, address, and the date on which you contacted them.

- o Adult protective services
- o Public health services

- County aging units and agencies providing services to elders including congregate or home-delivered meals or other nutrition services, senior companionship, transportation services, etc.
- Alcohol and other drug abuse services
- Mental health services
- Children’s long-term care services
- Emergency food, shelter and energy assistance services
- Other services to children and families

2.5.4 Other related regional programs and services

Provide evidence that regional agencies that provide other related services within the proposed service area have been informed of the proposer’s intent to respond to this RFP, including:

- Area Agencies on Aging
- Independent Living Centers
- Hospitals, clinics and other regional health care providers

Please send us one copy of a letter used to notify these organizations of your intent to respond, and a list of other organizations also contacted by letter including the agency name, address, and the date on which you contacted them.

2.6 Stakeholder involvement (100 points)

2.6.1 Efforts to involve stakeholders in proposal development

Provide evidence that consumers, advocates, service providers, aging and disability resource centers and other county human/social service agencies have been involved in the development of this proposal.

2.6.2 Plans for future efforts to involve stakeholders

Describe the proposer’s plan for soliciting input from consumers, advocates, service providers, aging and disability resource centers and other county human/social service agencies in the future.

SECTION 3: PROPOSAL SUBMISSION INSTRUCTIONS

3.1 Deadline for delivery

Complete submission materials must be received no later than 4:00 p.m. on April 4, 2008.

3.2 Place of delivery

Submission materials must be addressed to and received at:

MLTC Proposal
DLTC / BLTS / Managed Care Section
1 W. Wilson St., Room 518
P.O. Box 7851
Madison, WI 53707-7851

3.3 Manner of delivery of proposal submission

Submission materials may be delivered in person or by US mail or other delivery service with signature confirmation of receipt by the date and time noted in Section 3.1 to the address given in 3.2. For proposals delivered in person, postal or other delivery services, the signature confirmation will serve as proof of receipt. Hard copy proposals will be date stamped at the time of receipt. Receipt of a proposal by the State mail system does not constitute receipt of a proposal by the named office in Section 3.2 for purposes of this RFP. Proposers are cautioned to allow sufficient time for delivery by the U.S. Post Office because it can sometimes take several days to receive mail from outlying areas. Any proposals, which are received by the office named in Section 3.2 after the closing date and time, will not be reviewed and will be returned to the vendor. No exceptions will be allowed. Supplemental and clarifying information will not be accepted from a proposer after the deadline for submittal of proposals, unless requested by the Department.

3.4 General submission instructions

3.4.1 Completeness

The Department reserves the right to reject any proposal that is not complete.

3.4.2 Paper document submission

Proposers must also submit 10 paper copies of:

1. Completed response to Section 2.
2. Copies of any attachments (see Section 3.4.4) used to provide supporting information. Label attachments at the top of the first page using the following naming convention: "MLTC - [name of organization in Section 2.1] - Attachment [section or subsection number to which the attachment is applicable]".
3. Required forms (see section 3.7.4).

PDF is the preferred format for paper documents. Documents involving financial material must be submitted in Excel format.

Paper submissions are the official response.

3.4.3 Electronic document submission

Proposers must also submit a compact disc (CD) that contains:

1. An electronic copy of their proposal. Name the completed electronic document, “MLTC - [name of organization in Section 2.1]”. For example, “MLTC - ABC Inc”.
2. Electronic copies of any attachments (see Section 3.4.4) used to provide supporting information. Name electronic attachments using the following naming convention: “MLTC - [name of organization in Section 2.1] – attachment [section or subsection number to which the attachment is applicable]”. For example, an organizational chart that is used to provide information in response to Section 2.1.2.1 must be named, “MLTC - ABC Inc - attachment 2.1.2.1”.

The electronic copy of the DOA 3261 (see section 3.8.4) does not need to be signed. However, the paper copy of this form must contain a signature.

3.4.4 Submission of attachments

Attachments may be used to provide supporting information. The sum of all attachments may not exceed 25 pages in total. Evaluators will not be required to consider attached information that exceeds the maximum length or is unlabeled or improperly named.

3.4.5 Incurring costs

The State of Wisconsin is not liable for any cost incurred by proposers in replying to this RFP.

3.4.6 Withdrawal of proposals

Proposals shall be irrevocable until contract award unless the proposal is withdrawn. Proposers may withdraw a proposal in writing at any time up to the proposal closing date and time or upon expiration of 5 days after the due date and time if received by the RFP project manager. To accomplish this, the written request must be signed by an authorized representative of the proposer and submitted to the RFP project manager. If a previously submitted proposal is withdrawn before the proposal due date and time, the proposer may submit another proposal at any time up to the proposal closing date and time.

3.4.7 Waiver of informalities

The Department of health and Family Services, Division of Disability and Elder Services, reserves the right to accept or reject any or all responses to the RFP, waive minor informalities and to accept only the most qualified proposals in the judgment of the Division. The

determination of whether an RFP condition is substantive or a mere formality shall reside solely with the Division of Disability and Elder Services.

3.4.8 Notification of intent to award

All vendors who respond to this RFP will be notified in writing of the State’s intent to award the contract(s) as a result of this RFP.

After notification of the intent to award is made, and under the supervision of agency staff, copies of all proposals will be available for public inspection from 8:00 a.m. to 4:30 p.m. Monday through Friday (except holidays) in the Division of Disability and Elder Services, Room 518, 1 W. Wilson Street, Madison, Wisconsin 53703. Vendors should schedule reviews with Patricia McCollum at (608) 266-5449.

3.5 Proposal scoring and Award Process

The Evaluation Committee’s scoring will be tabulated according to the final points awarded for each proposal. Sections 2.2.1; 2.3.3.4, and 2.3.3.5 will be scored by a team of 3 financial experts and all other technical proposal criteria will be scored by a team that includes a minimum of three subject experts. Scores by each team will be tabulated and compiled (financial and technical) for a final score. Those proposals meeting the requirements of the RFP will move to the next phase.

All vendors who respond to this RFP will be notified in writing whether they will qualify to move to the next phase.

The proposals will be scored using the following criteria:

- 1. Proposer information100 points (10%)
- 2. Scope of Proposal100 points (10%)
- 3. Organizational capacity600 points (60%)
 - a. Stability and public accountability 200 points
 - b. Community based experience 200 points
 - c. Managed care expertise 200 points
- 4. Coordination with outreach and access.....50 points (5%)
- 5. Coordination w/ related services.....50 points (5%)
- 6. Stakeholder involvement100 points (10%)

- Total:1,000 points (100%)

Proposals from certified Minority Business Enterprises may have points weighted by a factor of 1.00 to 1.05 to provide up to a five percent (5%) preference to these businesses (Wis. Stats., 16.75(3m)).

3.6 Appeals process

Notices of Intent to Appeal and appeals must be made in writing. Written appeals must fully identify any contested issues and should identify statute(s) and Wisconsin Administrative Code provisions that are alleged to have been violated.

The written notice of Intent to Protest the contract award must be filed with the Secretary, Wisconsin Department of Health and Family Services, One West Wilson Street, Room 650, Post Office Box 7850, Madison, Wisconsin 53707 and received in his office no later than five (5) working days after the notice of intent to award is issued. The full, final written protest must be received in the Secretary's Office no later than ten (10) working days after the notice of intent to award is issued.

The decision of the Secretary of the Department of Health and Family Services may be appealed to the Secretary of the Department of Administration within five (5) working days of issuance, with a copy of the appeal to the procuring agency, providing the appeal alleges a violation of statute(s) or a provision of Wisconsin Administrative Code.

3.7 Standard terms and conditions

The State of Wisconsin reserves the right to incorporate standard State contract provisions into any contract negotiated with any proposal submitted responding to his RFP. A copy of Standard Terms and Conditions (DOA-3054) and Supplemental Standard Terms and Conditions for Procurements for Services (DOA-3681) are posted on the Wisconsin VendorNet System with this RFP. Failure of the successful proposer to accept these obligations in a contractual agreement may result in cancellation of the award.

3.8 General Proposal Information

3.8.1 VendorNet registration

The State of Wisconsin's purchasing information and vendor notification service is available to all businesses and organizations that want to sell to the state. Anyone may access VendorNet on the Internet at <http://vendornet.state.wi.us> to get information on state purchasing practices and policies, goods and services that the state buys, and tips on selling to the state. Vendors may use the same Web site address for inclusion on the bidders list for goods and services that the organization wants to sell to the state. A subscription with notification guarantees the organization will receive an e-mail message each time a state agency, including any campus of the University of Wisconsin System, posts a request for bid or a request for proposal in their designated commodity/service area(s) with an estimated value over \$25,000. Organizations without Internet access receive paper copies in the mail. Increasingly, state agencies also are

using VendorNet to post simplified bids valued at \$25,000 or less. Vendors also may receive e-mail notices of these simplified bid opportunities.

3.8.2 Proposers' conference call / written questions

A proposers' conference will be conducted via conference call from 1:00–3:00 p.m. on February 11, 2008. To participate, please use one of the following numbers and then enter the passcode when cued to do so.

Number: 608-265-1000

Toll Free: 800-462-1257

Passcode: 2992 (followed by the # sign)

In order to assure adequate lines are available for the call, notify the Department that you plan to participate in the call by the end of business on February 7, 2008. Notification should be made to: Patricia McCollum at 608/266-5449 or mccolpa@dhfs.state.wi.us.

Written questions may be submitted in advance of the call to Patricia McCollum at:

DLTC – Family Care
1 W. Wilson St. Room 518
P.O. Box 7851
MADISON WI 53707-7851

An official response to verbal conference call questions and all written questions will be published at the Wisconsin VendorNet System Web Site on March 14, 2008. All written questions are due by February 18, 2008 to the address noted above

3.8.3 Reasonable accommodations

The Department will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities upon request. If you think you need accommodations at the proposers' conference, contact Susan McKercher, Procurement Manager, at (608) 267-7637 (voice) or e-mail: mckers@dhfs.state.wi.us.

3.8.4 Required forms

DOA 3477 Vendor Information Sheet
DOA 3261 Request for Proposal Form

VendorNet attachments to the RFP

DOA 3027 Designation of Confidential and Proprietary Information
DOA 3054 Standard Terms and Conditions
DOA 3681 Supplemental Standard Terms and Conditions

APPENDIX 1 – READINESS TEMPLATE

DLTC Management Planning Tool for LTC Expansion “Readiness Template”

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (Including IT)
Strategic Planning	<p>The 3-year MCO business plan approved prior to contract effective date, including:</p> <ul style="list-style-type: none"> – Timeline for providing required risk reserve, solvency requirements, and working capital (if not licensed as an HMO). <p>Organizational design and governance:</p> <p>Existence of legal (contracting) entity that will carry the financial risk and be responsible for quality, including:</p> <ul style="list-style-type: none"> – Governance board with membership able to provide appropriate oversight. – Organization chart w qualified and full-time CEO, CFO, and Quality Manager. <p>Documentation of how MCO will coordinate with adult protective service and counties’ 51/55 systems.</p> <p>Evidence of consumer and other stakeholder involvement in strategic planning.</p>	<p>Establishment of a separately identifiable restricted investment reserve account in a financial institution and Business Solvency Plan, with timeline and financing strategy.</p> <p>Consumer and Stakeholder Participation:</p> <ul style="list-style-type: none"> – Identify stakeholders and provide opportunities for consumers and stakeholders to participate in planning process. – Provide training/support to enhance meaningful consumer and stakeholder participation. – Create mechanisms for consumers and reps to participate in quality management and appeals and grievance processes. <p>Develop policies and procedures for best practices (designing quality into the organization).</p> <p>Legal and Operational Platform for Regionalized Governance satisfactory to all planning partners, including:</p> <ul style="list-style-type: none"> – Mission and values statements. – Operating and risk sharing agreements. – By-laws and business protocols. – Steering and oversight committees, including consumer and stakeholder members. <p>Organizational needs assessment (strengths, weaknesses, opportunities, barriers) for administrative, care management, IT and financial management tools and competencies to carry out managed long-term care, including:</p> <ul style="list-style-type: none"> – Strategies to learn management techniques. – Identification of essential IT and competencies. – A claims payment / business system adequate for <ul style="list-style-type: none"> – Encounter reporting – Service authorization and benefit coordination – Utilization management – Fiscal monitoring analysis – Managing enrollment – Provider network monitoring and contracting
Information/ Knowledge Management	An information management plan that supports each business process’s specific information management and information technology (IT)	<p>Identification of essential IT and reporting tools and competencies to carry out managed long-term care</p> <p>Plan for control of data:</p>

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (Including IT)
	needs.	<ul style="list-style-type: none"> - Data governance - Documentation - Data integration rules, - data security - Data retention - Policies and procedures for disaster recovery. - Current and future HIPAA/HIT requirements
Budgeting and Projections	Initial 3-year budget approved as part of business plan.	Identification of data sources and the analytical method used to project the budget.
Managing Enrollment	Approved Access Plan. ADRC and ES readiness requirements are documented separately.	Participate in Access Plan development with ADRC and ES. CMO enrollment processes in place to accept new enrollments, assign care teams, make sure needed services are in place on day of enrollment, develop initial care plan w/in 10 days. (FC)
Managing Enrollment and Capitation	Policies and procedures to manage enrollment and capitation developed prior to implementation.	<p>Reconcile enrollment reports and capitation payments with member enrollment, disenrollment and LOC effective dates.</p> <p>Process for resolving discrepancies between the State enrollment reports and the MCO's enrollment records.</p> <p>Recertification processes in place to maintain enrollee eligibility – functional screens, interface with ES.</p> <p>Management of cost share receivables, process for interventions if cost share payments not timely, process to refer for loss of eligibility if interventions are not successful.</p>
Care Management and Care Planning ----- Service Authorization -----	<p>Adequate and trained care management teams in place.</p> <p>Approved Service Authorization Policy (RAD) in place (dif. for FC / WPP).</p> <p>Policies and procedures for SDS in place.</p>	<p>Strategy and timeline to achieve employed and/or subcontracted care management teams..</p> <ul style="list-style-type: none"> - Training in the needs of the target groups, service authorization policies and utilization management, care management techniques including outcome assessment, risk management and negotiation skills. - Training plan developed and in place. <p>Process for prior authorization of services, clerical support and integration with fiscal systems.</p>

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (Including IT)
Utilization Management	Appropriate interdisciplinary plans for benefit package provided are in place.	
Member Grievances and Appeals Process	Policies and procedures and MCO structure in place.	
Service Provision ----- Provider Network ----- Contract Management ----- Provider Relations	State review and certification of adequacy of service capacity prior to implementation. Process for determining future provider network needs is in place. Have negotiated and executed cost-effective provider contracts.	Identification of service needs among potential enrollees, assessment of the capacity of the local provider pool to meet these needs (gap analysis); planning with potential providers to achieve a satisfactory workforce and provider pool in regard to capacity, quality and options for consumers; and establishment of minimum provider competencies. This planning must address the needs of consumers who are interested in self-directed supports. Develop contracts and put in place (contract language must be approved by DHFS). Train providers in philosophy of managed LTC, claims processes, etc. Process to ensure an adequate number of personnel 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. Provider capacity monitoring and management.
Claims Processing	Demonstrated ability to submit acceptable encounter data. An encounter data worksheet is posted on http://dhfs.wisconsin.gov/LTCare/Partners/EncounterReporting.htm Proposers that receive a letter of intent to award a contract from the Department must complete this worksheet within 5 business days of receipt of the letter. The requirement to complete the encounter data worksheet applies to any new organization that has not submitted data using the encounter application; any existing organization that is adding new programs or expanding their line of business; and any	Acquire or develop claims processing capacity. Considerations include: <ul style="list-style-type: none"> - Customer Service functions, - Customized Check/EOB printing - Communications with members - Reporting requirements, - QA/audit, - High cost \$ claim procedures, - Cost containment procedures, - Coordination of benefits - Processes for adjustments, corrections, and claims that cannot be adjudicated - Reconciliation with service authorizations - Encounter submissions, tie-outs

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (Including IT)
	<p>existing organization that has not had their encounter data audited.</p> <p>Policies and procedures to handle provider appeals.</p>	
Financial Management and Reporting	<p>Full-time, qualified fiscal manager with appropriate certification, such as a CPA.</p> <p>Ability to manage and effectively utilize sophisticated information systems.</p> <p>Accounting policies and procedures in place, including for use of GAAP accrual accounting practices.</p> <p>Cost allocation plan.</p> <p>Ability to implement an IBNR model</p> <p>Ability to produce financial statements that tie out to claims.</p>	<p>Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable.</p> <p>Cost allocation: Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies).</p> <p>Procedures for monitoring consumer cost sharing collections.</p> <p>Methodology for analyzing (fiscal) risk.</p> <p>Monitor and analyze budget versus actual variances.</p> <p>Process to identify “outliers” (members whose claims exceed expected costs).</p> <p>IBNR methodology; process to monitor accuracy and reliability of the methodology.</p> <p>Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable.</p> <p>Maintenance of solvency protections.</p> <p>Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies).</p>
Utilization Review	<p>Demonstrated ability to produce reports that clearly communicate utilization information and trends to all levels of the MCO.</p> <p>Process by which utilization information will be shared with IDTs and other parts of the MCO, and how IDTs and others will be given help in analyzing that information.</p>	<p>Process for reconciliation and reporting on services authorized versus services used; service utilization reports.</p> <p>Process to communicate changes in practice patterns and health care delivery identified through utilization management reviews.</p> <p>Process to review and evaluate high volume / high risk indicators, practice guidelines and protocols, unusual occurrences, clinical outcomes, and services provided. How are these reviews used to minimize risk?</p>
Quality Management	<p>QM organizational structure, including:</p> <ul style="list-style-type: none"> – A senior manager with resource-deployment authority is designated as responsible for QM program. – A full time qualified professional is in place 	<p>Design QM program that will:</p> <ul style="list-style-type: none"> – Assure quality of both provided and purchased services; – Monitor performance and Detect problems; – Determine causes of problems; – Prioritize quality-improvement activities;

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (Including IT)
	<p>to coordinate the quality program.</p> <ul style="list-style-type: none"> – QM activities have individuals or units with clearly assigned responsibility for them. – Mechanisms for active participation from consumers, staff, and others. – Must have clear operational links to and support from other functional areas. <p>DHFS- approved Quality Program/Plan, adopted by gov. board, including:</p> <ul style="list-style-type: none"> – Includes annual goals based on findings from previous QM activities; – Describes quality-monitoring processes and activities; – Describes at least one performance improvement project. 	<ul style="list-style-type: none"> – Determine effective remediation; – Follow up to verify problems are fixed; and – Carry out improvement efforts even in absence of identified problems. <p>MCO ensures that assessments and care plans are timely and of high-quality—without checking or prior approval from DHFS.</p> <p>MCO determines, documents, and reports its own performance (e.g., immunization rates)</p> <p>MCO plans and carries out tightly focused improvement projects.</p>

NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.

APPENDIX 2 – ELIGIBILITY FOR MANAGED LONG-TERM CARE

A2.1 Eligibility for the Family Care benefit

A2.1.1 General conditions of eligibility

- (a) *Age*. The person will attain at least the age of 18 years during the application month.
- (b) *Residency*. The person is a resident of a county in which the managed long-term care benefit is available through a managed care organization.
- (c) *Target group*. The person has a physical disability, a developmental disability or infirmities of aging.
- (d) *Cost sharing*. The person pays any cost sharing obligations required as a condition of post eligibility treatment of income.
- (e) *Other non-financial conditions*. The person meets the nonfinancial conditions of eligibility for medical assistance under s. HFS 103.03 (2) to (9).
- (f) *Divestment*. The person is not currently ineligible for medical assistance under the provisions of ss. 49.453 and 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 because he or she divested assets.

A2.1.2 Functional eligibility

The person has a long-term or irreversible condition and meets the requirements for one of the following levels of care:

1. *Nursing home functional capacity level*. A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screen:
 - a. The person cannot safely or appropriately perform 3 or more activities of daily living.
 - b. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living.
 - c. The person cannot safely or appropriately perform 5 or more IADLs.
 - d. The person cannot safely or appropriately perform one or more ADL and 3 or more IADLs and has cognitive impairment.
 - e. The person cannot safely or appropriately perform 4 or more IADLs and has cognitive impairment.
 - f. The person has a complicating condition that limits the person's ability to independently meet his or her needs as evidenced by meeting both of the following conditions:
 - 1) The person requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range of medical or social interventions due to a multiplicity of conditions.
 - 2) The person has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.
2. *Non-Nursing Home functional capacity level*. A person is functionally eligible at the non-nursing home level if the person is at risk of losing his or her independence or functional

capacity unless he or she receives assistance from others, as is evidenced by a finding from application of the functional screen that the person needs assistance to safely or appropriately perform either of the following:

- a. One or more ADL.
- b. One or more of the following critical IADLs:
 - 3) Management of medications and treatments.
 - 4) Meal preparation and nutrition.
 - 5) Money management.

A2.1.3 Financial eligibility

The person is eligible for medical assistance under ch. 49, Stats., and chs. HFS 101 to 108.

A2.2 Eligibility for the Wisconsin Family Care Partnership Program benefit

A2.2.1 Acceptance of the Family Care Partnership MCO managed Medicare benefit

For a person who is eligible for Medicare, the person must accept managed Medicare benefits from the Family Care Partnership MCO in order to be eligible to enroll in the Family Care Partnership MCO to receive the Medicaid managed long-term care benefit.

A2.2.2 General conditions of eligibility

- (a) *Age*. The person will attain at least the age of 18 years during the application month.
- (b) *Residency*. The person is a resident of a county in which the managed long-term care benefit is available through a managed care organization.
- (c) *Target group*. The person has a physical disability, a developmental disability or infirmities of aging.
- (d) *Cost sharing*. The person pays any cost sharing obligations required as a condition of post eligibility treatment of income.
- (e) *Other non-financial conditions*. The person meets the nonfinancial conditions of eligibility for medical assistance under s. HFS 103.03 (2) to (9).
- (f) *Divestment*. The person is not currently ineligible for medical assistance under the provisions of ss. 49.453 and 49.454 (2) (c) and (3) (b), Stats., and s. HFS 103.065 because he or she divested assets.

A2.2.3 Functional eligibility

The person has a nursing facility level of care as documented on the long-term care functional screen.

A2.2.4 Financial eligibility

The person is eligible for medical assistance under ch. 49, Stats., and chs. HFS 101 to 108.

APPENDIX 3 – FAMILY CARE MCO CAPITATION RATES

2008		
CMO County	Nursing Home	Non-Nursing Home
Fond du Lac	\$ 2,324.17	\$ 691.71
La Crosse	\$ 2,238.09	\$ 656.11
Milwaukee	\$ 2,220.56	\$ 724.55
Portage	\$ 2,496.02	\$ 666.28
Richland	\$ 2,355.28	\$ 713.47
Community Care, Inc. (Serves Kenosha and Racine Counties)	\$ 2,957.33	\$ 689.33

[2008 Rate Report](#) (PDF, 396 KB)

2007		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 2,233.20	\$ 691.35
La Crosse	\$ 2,186.22	\$ 691.35
Milwaukee	\$ 2,093.20	\$ 691.35
Portage	\$ 2,505.63	\$ 691.35
Richland	\$ 2,256.00	\$ 691.35
Community Care, Inc. (Serves Kenosha and Racine Counties)	\$ 2,670.23	\$ 691.35

[2007 Rate Report](#) (PDF, 300 KB)

[Report for Kenosha and Racine Counties](#) (PDF, 254 KB)

2006		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 2,157.53	\$ 691.35
La Crosse	\$ 2,022.50	\$ 691.35
Milwaukee	\$ 2,055.01	\$ 691.35
Portage	\$ 2,410.74	\$ 691.35
Richland	\$ 2,140.30	\$ 691.35

[2006 Rate Report](#) (PDF, 286 KB)

2005		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 2,120.74	\$ 691.35
La Crosse	\$ 1,828.82	\$ 691.35
Milwaukee	\$ 2,055.01	\$ 691.35
Portage	\$ 2,320.75	\$ 691.35
Richland	\$ 2,140.30	\$ 691.35

[2005 Rate Report](#) (PDF, 216 KB)

2004		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 1,881.07	\$ 674.49
La Crosse	\$ 1,764.17	\$ 674.49
Milwaukee	\$ 1,810.61	\$ 674.49
Portage	\$ 2,255.32	\$ 674.49
Richland	\$ 1,970.98	\$ 674.49

[2004 Rate Report](#) (PDF, 928 KB)

2003		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 1,948.00	\$ 657.40
La Crosse	\$ 1,809.00	\$ 657.40
Milwaukee	\$ 1,765.09	\$ 657.40
Portage	\$ 2,390.60	\$ 657.40
Richland	\$ 2,004.24	\$ 657.40

[2003 Rate Report](#) (PDF, 251 KB) Note: Final 2003 comprehensive rates listed above reflect annual retrospective rate adjustment made in April 2004.

2002		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 1,897.04	\$ 640.74
La Crosse	\$ 1,748.84	\$ 640.74
Milwaukee	\$ 1,720.63	\$ 640.74
Portage	\$ 2,491.01	\$ 640.74
Richland	\$ 1,941.49	\$ 640.74

2001		
CMO County	Comprehensive	Intermediate
Fond du Lac	\$ 1,844.30	\$ 628.79
La Crosse	\$ 1,709.12	\$ 628.79
Milwaukee	\$ 1,721.77	\$ 628.79
Portage	\$ 2,516.51	\$ 628.79
Richland	\$ 1,910.15	\$ 628.79

2000	
CMO County	Comprehensive
Fond du Lac	\$ 1,651.32
La Crosse	\$ 1,583.86
Milwaukee	\$ 1,466.64
Portage	\$ 2,435.57

APPENDIX 4 – FAMILY CARE PARTNERSHIP CAPITATION RATES

SNF/ICF Skilled Nursing Facility/Intermediate Care Facility									
Calendar Year	CC	CCHP	CCHP	CCHP	EC	CARE WI (ECHP)	HPCL	PHP	PHP
	PACE	Milwaukee	Racine	Racine/ Kenosha	PACE	WPP		Elderly	PD
1999	\$2,428.62	\$2,428.62	NA	NA	\$2,465.41	\$2,465.41	\$3,281.28	\$2,219.12	\$2,976.84
2000	\$2,438.49	\$2,438.49	NA	NA	\$2,465.41	\$2,465.41	\$3,522.33	\$2,373.97	\$3,358.69
2001	\$2,660.32	\$2,660.32	NA	NA	\$2,778.82	\$2,778.82	\$3,781.81	\$2,668.26	\$3,424.97
2002	\$2,873.50	\$2,873.50	\$2,892.18	NA	NA	\$2,819.43	\$3,804.02	\$2,819.28	\$3,512.23
2003	\$2,938.76	\$2,938.76	\$2,853.12	NA	NA	\$2,829.63	\$4,669.65	\$2,820.60	\$3,247.00
2004	\$2,989.10	\$3,007.84	\$2,850.83	NA	NA	\$2,722.29	\$4,546.44	\$2,738.57	\$3,197.02
2005	\$2,980.06	\$3,028.57	\$2,930.21	NA	NA	\$2,816.47	\$4,581.04	\$2,856.67	\$3,209.49
2006	\$2,916.71	\$2,916.05	\$2,941.74	NA	NA	\$2,830.65	\$4,044.19	\$2,865.11	\$3,134.87
2007	\$2,919.66	\$3,047.26	NA	\$2,774.37	NA	\$2,913.88	\$4,044.19	\$2,940.58	\$3,154.02
2008	\$2,792.31	\$2,831.26	NA	\$2,901.87	NA	\$2,775.95	\$3,857.41	\$2,923.85	\$3,411.53

ISN IntensiveSkilled Nursing									
Calendar Year	CC	CCHP	CCHP	CCHP	EC	CARE WI (ECHP)	HPCL	PHP	PHP
	PACE	Milwaukee	Racine	Racine/ Kenosha	PACE	WPP		Elderly	PD
1999	\$3,427.95	\$3,427.95	NA	NA	NA	\$3,428.70	\$5,098.72	\$3,109.74	\$4,363.52
2000	\$3,513.54	\$3,513.54	NA	NA	NA	\$3,521.48	\$5,336.20	\$3,504.83	\$4,646.38
2001	\$3,861.61	\$3,861.61	NA	NA	NA	\$3,814.59	\$5,313.88	\$3,604.08	\$4,749.95
2002	\$4,125.80	\$4,125.80	\$4,107.03	NA	NA	\$3,814.59	\$5,313.88	\$3,703.72	\$4,800.22
2003	\$4,585.92	\$4,585.92	\$4,320.49	NA	NA	\$3,970.68	\$5,398.34	\$3,976.51	\$5,398.96
2004	\$4,685.22	\$4,811.42	\$4,410.09	NA	NA	\$4,014.58	\$5,375.43	\$4,035.54	\$5,273.85
2005	\$4,766.47	\$4,867.64	\$4,365.90	NA	NA	\$4,103.83	\$5,456.17	\$4,092.04	\$5,085.23
2006	\$4,328.50	\$4,176.88	\$4,184.89	NA	NA	\$4,071.97	\$5,962.05	\$3,939.44	\$5,628.39
2007	\$4,551.56	\$4,654.64	NA	\$4,152.63	NA	\$4,061.43	\$5,962.05	\$3,946.94	\$5,304.00
2008	\$3,758.00	\$3,757.25	NA	\$3,704.65	NA	\$3,643.39	\$4,730.73	\$3,813.39	\$4,572.93

Key:

CCHP: Community Care Health Plan, Inc. (formerly Community Care for the Elderly, CCE)

CARE WI: (formerly ECHP (Elder Care Health Plan, Inc.))

HPCL: Health Plan for Community Living, Inc. (formerly Community Living Alliance, CLA)

PHP: Partnership Health Plan, Inc. (formerly Community Health Partnership, CHP)

CC PACE: Community Care, Inc. PACE Program

Appendix 5

Waiver and Waitlist Counts by County by Target Groups in December 2006

As reported in HSRS through April 2007

County	Waiver Recipients by TG* DEC 2006				Wait List by TG** DEC 2006		
	Wvr DD	Wvr PD	Wvr FE	Total Wvr	WL Elderly	WL Disabled	Total WL
BARRON	149	13	92	254	112	118	230
BAYFIELD	37	25	74	136	19	40	59
BUFFALO	44	9	46	99	32	9	41
BURNETT	48	6	57	111	7	43	50
CHIPPEWA	170	24	97	291	20	19	39
CLARK	119	19	70	208	22	30	52
COLUMBIA	154	29	95	278	155	192	347
CRAWFORD	53	23	58	134	17	17	34
DODGE	141	29	95	265	65	114	179
DOUGLAS	111	81	213	405	189	140	329
DUNN	94	19	57	170	7	25	32
EAU CLAIRE	244	36	61	341	18	23	41
GRANT	101	43	89	233	78	52	130
GREEN	55	42	129	226	75	52	127
GREEN LAKE	52	5	31	88	46	11	57
IOWA	39	8	31	78	9	20	29
JACKSON	85	22	83	190	4	11	15
JEFFERSON	343	56	149	548	140	84	224
JUNEAU	43	15	51	109	84	62	146
LAFAYETTE	44	8	30	82	14	31	45
MARATHON	364	65	285	714	281	155	436
MARQUETTE	31	16	44	91	36	27	63
MONROE	112	30	91	233	57	67	124
OZAUKEE	170	27	98	295	88	39	127
PEPIN	23	14	40	77	37	10	47
PIERCE	92	30	67	189	26	22	48
POLK	93	16	65	174	54	57	111
SAUK	154	56	149	359	138	113	251
SAWYER	42	12	54	108	72	65	137
SHEBOYGAN	280	114	246	640	133	98	231
ST. CROIX	141	47	55	243	67	123	190
ST. CROIX RNIP	2	0	1	3			-
TREMPEALEAU	87	58	156	301	56	45	101
VERNON	66	13	42	121	65	20	85
WASHBURN	63	20	74	157	35	64	99
WASHINGTON	228	59	196	483	68	104	172
WAUKESHA	578	120	444	1142	555	286	841
WAUSHARA	56	17	83	156	49	57	106
WOOD	220	42	240	502	236	113	349

* Waiver Target Groups are determined as follows:

- 1) Individuals age 65 and greater are in the Frail Elderly target group.
- 2) Individuals less than age 65 who are in CIP 1A, CIP 1B, or BIW are in the DD target group.
- 3) Individuals less than age 65 who are in CIP II or COP-W are in the PD target group.

* Wait List Target Groups are as follows:

- 1) Individuals age 65 and greater are in the Elderly target group.
- 2) Individuals less than age 65 are in the Disabled target group.