By Supervisors Holloway and Mayo

A RESOLUTION

supporting the Workforce Mobility Act that would restore funding to Wisconsin public transit systems that were reduced ten percent in the 2011-2013 State Budget Bill

WHEREAS, the 2011-2013 State Budget Bill cut funding for public transit by ten percent, which represented an annual reduction of $6.85 million to the Milwaukee County Transit System (MCTS); and

WHEREAS, the 2012 Budget for MCTS included route and segment reductions in order to meet the lower operating support provided by the State; and

WHEREAS, the 2012 Transit/Paratransit Budget (Org. 5600) anticipates $7.7 million in Congestion Mitigation and Air Quality (CMAQ) funding as part of a three-year allocation of $16.9 million (95 percent will be allocated in the first two years) that has helped avert even more drastic cuts to the transit system; and

WHEREAS, State Senators King and Larson and Representatives Pasch and Hintz are introducing legislation entitled the Workforce Mobility Act to provide workers in communities across Wisconsin dependable, accessible transportation to their jobs; and

WHEREAS, of the 140,000 rides provided daily by MCTS, approximately 39 percent are commuters traveling to and from work; and

WHEREAS, according to the Legislative Fiscal Bureau, a recent re-estimate of the transportation fund indicates that an additional $32.9 million remains available for use, of which the proposed legislation would allocate $9.6 million to restore the recent budget cuts; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby supports the Workforce Mobility Act, or similar legislation, that would restore funding to the Milwaukee County Transit System and other transit systems throughout the State; and

BE IT FURTHER RESOLVED, that the Director of Intergovernmental Relations is authorized and directed to communicate Milwaukee County's support of this legislation to State policymakers and related officials.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 1/26/12

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: A resolution supporting the Workforce Mobility Act that would restore funding to Wisconsin public transit systems that were reduced ten percent in the 2011-2013 State Budget Bill

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Approval of this resolution will require an expenditure of staff time, but will not require an appropriation of funds.

Department/Prepared By Steve Cady, Fiscal and Budget Analyst

Authorized Signature Stephen J. Cady

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

State of Wisconsin
2011 – 2012 LEGISLATURE

LRB–3899/1
EVM:sbb&wlj:rs

2011 BILL

AN ACT ***to amend*** 85.20 (4m) (a) 6. cm., 85.20 (4m) (a) 6. d., 85.20 (4m) (a) 7. b. and 85.20 (4m) (a) 8. b. of the statutes; **relating to:** funding for the urban mass transit operating assistance program and making an appropriation.

Analysis by the Legislative Reference Bureau

Under current law, DOT provides state aid payments to local public bodies in urban areas served by mass transit systems to assist the local public bodies with the expenses of operating those systems. There are five classes of urban mass transit systems. Four classes are defined by reference to the annual operating expenses of the system or the population of the area in which the system operates. The total amount of state aid payments to these four classes of mass transit systems is limited to an annual amount specified in the statutes. The fifth class is for certain commuter or light rail systems. There is no specified amount payable to the rail mass transit system class. This bill increases funding for state aids to the four classes of mass transit systems for which a yearly amount of aid is specified.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 85.20 (4m) (a) 6. cm. of the statutes, as affected by 2011 Wisconsin Act 32, is amended to read:

85.20 **(4m)** (a) 6. cm. From the appropriation under s. 20.395 (1) (ht), the department shall pay $66,585,600 for aid payable for calendar year 2010~~,~~ and $68,583,200 for aid payable for calendar year 2011~~, and $61,724,900 for aid payable for calendar year 2012~~ and thereafter, to the eligible applicant that pays the local contribution required under par. (b) 1. for an urban mass transit system that has annual operating expenses of $80,000,000 or more. If the eligible applicant that receives aid under this subd. 6. cm. is served by more than one urban mass transit system, the eligible applicant may allocate the aid between the urban mass transit systems in any manner the eligible applicant considers desirable.

SECTION 2. 85.20 (4m) (a) 6. d. of the statutes, as affected by 2011 Wisconsin Act 32, is amended to read:

85.20 **(4m)** (a) 6. d. From the appropriation under s. 20.395 (1) (hu), the department shall pay $17,496,400 for aid payable for calendar year 2010~~,~~ and $18,021,300 for aid payable for calendar year 2011~~, and $16,219,200 for aid payable for calendar year 2012~~ and thereafter, to the eligible applicant that pays the local contribution required under par. (b) 1. for an urban mass transit system that has annual operating expenses in excess of $20,000,000 but less than $80,000,000. If the eligible applicant that receives aid under this subd. 6. d. is served by more than one urban mass transit system, the eligible applicant may allocate the aid between the urban mass transit systems in any manner the eligible applicant considers desirable.

SECTION 3. 85.20 (4m) (a) 7. b. of the statutes, as affected by 2011 Wisconsin Act 32, is amended to read:

85.20 **(4m)** (a) 7. b. For the purpose of making allocations under subd. 7. a., the amounts for aids are $25,099,500 in calendar year 2010~~,~~ and $25,852,500 in calendar year 2011~~, and $23,267,200 in calendar year 2012~~ and thereafter. These amounts,

to the extent practicable, shall be used to determine the uniform percentage in the particular calendar year.

SECTION 4. 85.20 (4m) (a) 8. b. of the statutes, as affected by 2011 Wisconsin Act 32, is amended to read:

85.20 **(4m)** (a) 8. b. For the purpose of making allocations under subd. 8. a., the amounts for aids are $5,681,600 in calendar year 2010~~,~~ and $5,852,200 in calendar year 2011~~, and $5,267,000 in calendar year 2012~~ and thereafter. These amounts, to the extent practicable, shall be used to determine the uniform percentage in the particular calendar year.

SECTION 5. Fiscal changes.

(1) TIER B TRANSIT OPERATING AIDS. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hr) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $646,300 for the first fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hr) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $2,585,300 for the second fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids.

(2) TIER C TRANSIT OPERATING AIDS. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hs) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $146,300 for the first fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids. In the schedule

under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hs) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $585,200 for the second fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids.

(3) TIER A–1 TRANSIT OPERATING AIDS. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (ht) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $1,714,600 for the first fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (ht) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $6,858,300 for the second fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids.

(4) TIER A–2 TRANSIT OPERATING AIDS. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hu) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $450,500 for the first fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of transportation under section 20.395 (1) (hu) of the statutes, as affected by the acts of 2011, the dollar amount is increased by $1,802,100 for the

second fiscal year of the fiscal biennium in which this subsection takes effect to increase funding for mass transit aids.

(END)

COUNTY OF MILWAUKEE
District Attorney's Office
Inter-Office Communication

Date: January 13, 2012

To: County Board of Supervisors

From: District Attorney's Office

Subject: 2012 Revenue Deficit in the District Attorney's Victim/Witness Program

Pursuant to County Board Resolution 86-666, I am reporting a potential 2012 revenue deficit in the district attorney's victim/witness program. The district attorney's 2012 adopted budget estimates that the Wisconsin Department of Justice, Office of Crime Victim Services (OCVS), will reimburse the county for approximately 51 percent of the costs of the victim/witness program. OCVS recently advised us that the state reimbursement rate could be as low as 41 to 42 percent of costs, resulting in a 2012 revenue shortfall of as much as $225,000 to $250,000.

There are two principal reasons for the revenue shortfall. First, last fall we reported to the County Board that we were projecting a 2011 revenue surplus of approximately $165,000 in the district attorney's victim/witness program because state reimbursement during state fiscal year 2011, which ran from July 1, 2010, to June 30, 2011, was approximately 60 percent of the costs of the program, compared to a budgeted reimbursement rate of approximately 52 percent of costs. County Board file number 11-385.

When a court sentences an offender, the court imposes a victim/witness surcharge of $67 for each misdemeanor offense and $92 for each felony offense. Wis. Stat. § 973.045. The victim/witness surcharge is the main source of funding for the state victim/witness program, but the surcharge also funds the Sexual Assault Victim Services (SAVS) grant program. OCVS administers both programs. OCVS recently discovered that the state reimbursement rate for the victim/witness program in state fiscal year 2011 was inflated in part because victim/witness surcharge revenue that should have been directed to the SAVS program was mistakenly credited to the victim/witness program. The victim/witness program must repay that money to the SAVS program, which will reduce the state reimbursement for the victim/witness program in state fiscal years 2012 and 2013.

Second, the Wisconsin Department of Justice (DOJ) and other state agencies are required by the 2011-13 state budget to lapse expenditure authority to the general fund in each year of the biennium. DOJ is proposing, as part of its state fiscal year 2012 plan, to lapse victim/witness program funding of $517,309 to the general fund, consisting of $451,300 in victim/witness surcharge revenue and $66,009 in general purpose revenue. An objection was filed to the state agencies' state fiscal year 2012 lapse plan, so the state Joint Finance Committee will hold a hearing on the request. The Intergovernmental Relations Division is representing the county's interests, and the Wisconsin

District Attorneys Association is representing the interests of the state's district attorneys in maintaining existing services to crime victims and witnesses. Later this year, DOJ and other state agencies must submit an expenditure lapse plan for state fiscal year 2013.

In summary, the need to repay the SAVS fund and the Joint Finance Committee's approval of DOJ's biennial lapse plans could lower the state reimbursement rate for the victim/witness program to 41 or 42 percent of costs, resulting in a 2012 revenue deficit of $225,000 to $250,000.

Respectfully Submitted,

John T. Chisholm
District Attorney

Cc: County Executive
DAS Fiscal

COUNTY OF MILWAUKEE

INTEROFFICE COMMUNICATION

Date: January 26, 2012, 2012

To: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors
Supervisor Luigi Schmitt, Chairman, Intergovernmental Relations Committee

From: Pamela Bryant, Interim Fiscal and Budget Administrator

Re: Impact of State Funding Lapse on Milwaukee County Youth Aids Allocation

Information has been requested by the Committee regarding the impact of the State funding lapse on Milwaukee County's Youth Aids allocation. The 2012 Youth Aids allocation for Milwaukee County is $33,260,076 as established by the 2012 contract with the Wisconsin Department of Corrections. The Total Youth Aids Allocation consists of a base allocation and other formula-driven allocations. The 2012 base allocation includes two negative adjustments of $3,635,982 for the Act 32 funding lapse and $1,443,448 for the FY2012 funding lapse which were not included in the 2011 original base allocation. The 2011 original Youth Aids allocation, however, was reduced in 2011 by $1,817,989 due to Act 32. The impact of the reduction to the base allocation is presented below:

	BASE ALLOCATION	FORMULA ALLOCATION	TOTAL YOUTH AIDS ALLOCATION
2011*	$ 27,030,532	$ 9,154,978	$ 36,185,510
2012	$ 23,769,091	$ 9,490,985	$ 33,260,076
11-'12 CHANGE	$ (3,261,441)	$ 336,007	$ (2,925,434)

*The 2011 original Youth Aids allocation was $38,003,499. The 2011 original Youth Aids base allocation was reduced due to Wisconsin Act 32 by $1,817,989 for a 2011 Youth Aids allocation for $36,185,510.

DEPARTMENT OF HEALTH & HUMAN SERVICES
DISABILITIES SERVICES DIVISION

Milwaukee County

Héctor Colón • DHHS Director
Geri L. Lyday • DSD Administrator

To: County Board Chairman Lee Holloway
From: Geri L Lyday, Administrator, Disabilities Services Division
Stephanie Sue Stein, Director, Department on Aging
Date: January 24, 2012
Subject: Review of DHS "Long Term Care Sustainability" proposed modifications to Family Care program

The Disabilities Services Division and the Department on Aging have reviewed the draft Long Term Care Sustainability proposals from the Wisconsin Department of Health Services (DHS). Our feedback comes from the perspective of our dual roles as operators of the Aging and the Disability Resource Centers and as advocates for people who comprise our target populations, a role required in our Wisconsin Aging and Disability Resource Center (ADRC) contracts.

Our responses are attached and include Attachment 1 from the Disabilities Services Division Disability Resource Center and Attachment 2 from the Department on Aging, Aging Resource Center.

Geri L. Lyday, Administrator
Disabilities Services Division

Stephanie Sue Stein
Director, Department on Aging

Cc Chris Abele, County Executive
Supervisor James "Luigi" Schmitt, Chairman Intergovernmental Relations Committee
Supervisor Peggy Romo West, Chairperson Health and Human Needs Committee
Amber Moreen, Chief of Staff, County Executive
Terrence Cooley, Chief of Staff, County Board
Hector Colon, Director, Department of Health and Human Services
Roy de la Rosa, Director, Intergovernmental Relations
Kelly Bablitch, Assistant Director, Intergovernmental Relations
Carol Mueller, Committee Clerk, Intergovernmental Relations Committee

Milwaukee County Disabilities Services Division comments regarding DHS "Long Term Care Sustainability" proposed modifications to Family Care program

The Disabilities Services Division reviewed DHS's draft Long Term Care Sustainability proposals. Our feedback comes from two perspectives. We considered the proposed modifications that directly relate to the role and responsibilities of resource centers. As part of our ADRC State contract-required role to provide advocacy on behalf of people with disabilities and systems advocacy "related to the long term care delivery system," we also offer feedback from that perspective.

Living Well at Home and in the Community

- The DRC does not receive sufficient funds in its State contract to hire the staff necessary to carry out the proposed additional responsibilities such as medication compliance, nursing home diversion (responding within 7 days of admission), falls prevention, chronic disease self-management, short-term community intervention and care transitions. Current staff would be unable to take on these additional responsibilities.
- The lack of safe, accessible and affordable housing is a huge problem in Milwaukee County. It is unrealistic to expect the DRC to "secure affordable housing" for individuals with disabilities who don't need residential care but are struggling to remain at home.
- We question whether automated in-home medication dispensing systems would work for individuals with cognitive disabilities without proper monitoring and assistance with preparation.

Youth in Transition

- DHS references the experience of Dane County in developing community employment opportunities for youth with disabilities after graduation from high school. Milwaukee County's employment environment is significantly different from Dane County's and this would need to be recognized through additional resources to address Milwaukee's challenges.
- The proposed modifications assume a lot about the support network of families if it is preferred that a youth remain with parents or family until he or she has community employment. Such family supports are not always the case in Milwaukee.
- The specific roles of the resource centers and the managed care organizations need to be clearly identified.
- The DRC would need additional resources, like the MIG Grant "Transitioning Services for Youth in the Disability Resource Center of Milwaukee Project" grant which is no-longer available but had provided critical resources for Youth in Transition programming, to have staff to serve as a "transition team" working with DVR,UWM, school districts, employment service agencies, parents and employers.
- MPS is a significant partner in Youth in Transition programming and they are clearly stretched to the limit fiscally. They have already cut collaborative programs such as the special Mobile Urgent Treatment Team (MUTT) for the Wraparound Milwaukee program for children with mental health needs.
- Working with the Children's Long-Term Care system to begin transitional planning and discussion of community employment is a good idea and the DRC has done this in select situations but would require additional staff to accomplish this more completely.

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Employment Supports

- The DRC supports the proposed modifications regarding assuring a continuum of employment supports in all Family Care programs.
- It is unclear who would complete the proposed Infrastructure Grant Funding activities. If these additional responsibilities were to be provided by resource centers then more funds would be needed.
- We support the funding of Work Incentive Specialists and hope that Milwaukee County is considered one of the 10 Family Care districts to be served by the Specialists. We question if 10 will be sufficient for the entire state.

Family Care Benefits

- Shifting from public supports to "natural supports" or families makes a huge assumption that an individual with disabilities has a family able and willing to provide supports, with resources, and not already burned-out from years of care.
- Using "natural supports" may be easier once a resource center is at entitlement and no longer has a wait list and can work with an individual and/or family sooner before families are desperate for service.
- The DRC is concerned about how the MCOs will implement the focus on natural supports. What will be in place to assure that individuals with disabilities and their families are not taken advantage of? Families should not be leveraged or feel "threatened" to provide support beyond their means. A family member should not have to unwillingly quit a job to provide care.
- The DRC is concerned about how these proposed modifications will be implemented and the timeline.
- The DRC strongly supports the proposed crisis intervention and stabilization modifications but notes that law enforcement should be included in the collaborations.

Family Care Administrative and Program Efficiencies

- Case management should be tailored to the needs of the individual who should have role in determining how much case management support he or she would need.
- The DRC agrees having more flexibility in using nurses to focus on those with more medical needs. We do not support not assigning and not evaluating a member's medical needs but support relaxing the inflexible requirement regarding the number of nurse visits.
- The frequency of oversight in facilities that consistently meet licensure standards should not be reduced. Licensure focuses on compliance with facility standards while the interdisciplinary team provides needed quality oversight as it relates to the individual.
- Increased competition by allowing additional MCOs increases the staff resources needed in resource centers because of increased enrollment and dis-enrollment counseling. The DRC knows this first-hand and has never received funding from DHS in recognition of the additional workload.
- The DRC is concerned that the proposed modifications significantly tip the balance in favor of a more cost-driven approach to delivery of services rather than need-driven.

IRIS and Self-Directed Supports

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- The DRC supports the proposed modifications for IRIS for the most part.
- Promoting use of technology to "move away from 24/7 one-to-one staffing" is very concerning for what it is saying for people who really need 24/7 supports.
- We assume that reference to including "an active guardian" in determining the amount of support an individual needs to self-direct does not mean that everyone has to have an appointed guardian.
- A tool to help assess if an individual can self-direct and what they are able to self-direct would be helpful.
- The DRC supports developing a "robust support broker system" since our experience has been that IRIS program staff is not always knowledgeable about local supports and services.

Residential Services

- The DRC is very concerned about the proposed modification which would require that options counseling be provided "to transition IRIS participants from restrictive to integrated settings in the community within 12 months of this change." The DRC would need additional resources to provide options counseling to these additional individuals.
- Acuity should not necessarily drive where an individual lives. Some individuals with significant disabilities can live in an apartment with appropriate supports. The residential setting should not be driven by an individual's physical condition but by their needs and abilities.
- Developing a continuum of more affordable, integrated, accessible and safe housing options in Milwaukee County should be the first sequential step in the proposed modifications related to residential services. Many individuals in Milwaukee are currently living in marginal situations which are unsafe, not accessible, and crowded.
- Independence for young adults graduating from high school should be encouraged and they should not be forced to live with their parents because of cost.

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Attachment 2

Milwaukee County Department on Aging comments regarding DHS "Long Term Care Sustainability" proposed modifications to Family Care program

The following analysis is in response to the proposed efficiencies to Family Care concentrating on those that will especially affect Frail Elders.

They fall into three categories/papers:

1. Residential Options: There are lots of issues in this paper.

- The first is making a residential benefit open only to persons who meet some level of acuity.
- The level or meaning of acuity is not defined.
- Persons with Alzheimer's Disease or other dementias often do not have physical acuity. They are often in the most need of residential care.
- What happens to persons who have no family or natural support.
- What happens to persons living in abusive situations.
- The Department spent two years trying to get a uniform payment system for residential care and stopped due to the myriad of issues involved in such an undertaking.
- So who will set and how will they set an upper limit of payment.
- The scope of services will eliminate amenities- what does that mean?
- What happens when people chose to move to Assisted living and then use all of their money - will MCO's move them?
- Where - or will they be directed to move on their own?
- Health and Safety are the two reasons given for approving residential care - Those are very broad categories left to the vagaries of MCO's - why doesn't the screen decide that?
- Who is going to re educate the entire residential care industry and consumers?

2. Benefits

- Who is going to compile and keep up with the cost of all benefits available in service areas.
- Why should cost be discussed with consumers who really have clear need of care - is the onus of cost containment being shifted to the guilt of persons who need long term care services and are poor?
- Persons are to be counseled to use their own resources - What Resources? I don't know any Medicaid beneficiaries with resources.
- Families are not asked to supplement any other Medicaid services - including Nursing Home Care- why only Family care?

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3. Living Well at Home

This whole section assigns responsibilities and duties to ADRC's who ARE NOT funded to carry out these tasks. Such as:

- Deploy staff to Nursing homes and residential settings within 7 days of admission for the purpose of diversion--What staff?
- Deploy staff for short tern community intervention- What staff?
- Carry out coordination with hospitals- with what staff?
- Carry out evidence based prevention- when prevention is no longer funded.
- ADRC's are not constructed to carry out these duties and would need substantial funds to do so.

And finally - the assumption in the **Administrative** section that MCO competition holds down cost is blatantly untrue- when other MCOs entered Milwaukee County their capitation was and remains higher than Milwaukee County's.

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MEMORANDUM

Date: January 25, 2012

To: Chairman Lee Holloway, Milwaukee County Board of Supervisors

From: Maria Ledger, Director, Department Of Family Care

Subject: Informational report on the 2011-2013 Long Term Care Sustainability Plan

Per your request, this report provides a brief analysis on the 2011-2013 Long Term Care Sustainability Plan prepared by the State Department of Health Services (DHS).

DHS states this plan is " . . . a package of reforms and savings measures that will help make the program sustainable on an ongoing basis in the future while keeping consistent with the interests of current and future program participants."

The Reforms by Focus Area are as follows:

- Employment Supports
- Family Care Administrative and Program Efficiencies
- Family Care Benefits
- IRIS and Self-Directed Supports
- Living Well at Home and in the Community
- Residential Services
- Youth in Transition

Employment Supports

The proposed modifications in the area of employment would benefit both the MCO and members in the following ways**:**

- Improve Family Care members' access to DVR services and funding through a statewide pilot that will leverage 80% federal matching funds, to facilitate prioritization of Family Care members to receive services to support community employment.

- Medicaid Infrastructure Grant (MIG) funding ($1.6 million carryover) will allow for continued technical assistance and support from the Pathways office in the areas of youth in transition, Vocational Futures Planning model, supported employment network development and improved employment data collection:

- Work Incentive Benefits Counseling, currently very scarce in Milwaukee County, will help MCO participants decrease barriers to community employment by addressing the impact of earning money on their eligibility for needed benefits.

- There are proposed changes to the Medical Assistance Purchase Plan (MAPP) which allows working individuals to purchase Medicaid. These changes will allow MCO members with higher earnings to remain enrolled in Medicaid. These proposed changes will increase the State Income Maintenance workers tracking responsibilities of cost share.

- This proposal would support and encourage the MCO to register as an Employment Network in order to collect federal reimbursements under the Ticket to Work Act. This proposal will require a labor-intensive tracking process to capture payments. The MCO has explored this option through our Integrated Employment workgroup and has not found the efforts to be worth the funding that would result, given the current enrolled member population. Ticket to work is usually most successful with individuals who would not necessarily have met the functional eligibility for Family Care.

Family Care Administrative and Program Efficiencies:

The proposed modifications in the areas of Family Care Administrative and Program Efficiencies would impact members in the following ways:

- Under the heading of "**Streamline and Improve Care Management"** DHS states that their goal is to assure that care management is tailored to the needs of each individual, using a strength-based assessment process that identifies and utilizes natural supports when addressing member outcomes when planning for services and supports.

- It is important to note care management is already person-centered and should only be provided to the extent needed to meet member outcomes. The Milwaukee County MCO does regular chart audits to insure that all documented care management is appropriate.

- Another proposed reduction of care management is for members in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance. Our concern is the number of community relocations will be drastically reduced. In CY 2011, the Milwaukee MCO relocated 552 individuals from Nursing Homes. 268 of these individuals went to community residential placements (AFH, CBRF, RCAC, SIL) and 284 returned to their homes. These moves to more independent setting required the care and coordination of care managers and nurses of the Interdisciplinary teams (IDTs).

The proposed modifications in the areas of Family Care Administrative and Program Efficiencies would impact the MCO in the following ways:

- If MCO authority to institute "checks and balances" to ensure that care plans reflect cost-effective choices is strengthened and MCOs implement a secondary review for high-cost products and services, it would be beneficial to have a DHS representative not only provide education to Administrative Law Judges but also attend Fair Hearings to co-represent the MCO. This would be markedly different than having the State's External Quality Review Organization (EQRO) present at hearings representing members.

- The Milwaukee MCO has asked for years that the State work with persons in legacy waiver programs in advance of the transition to managed LTC programs to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

Family Care Benefits:

The proposed modifications in the Family Care Benefits would impact members in the following ways:

- Currently, Family Care members can only be referred for disenrollment if they do not pay their cost share (All cost shares are calculated by State Income Maintenance Staff. Payment of cost shares by Family Care members is a condition of Family Care eligibility). If Family Care members live in an assisted living facility, they must pay the cost of Room and Board in that facility. Room and Board is not a covered benefit under Family Care. There is currently no way for MCOs to refer members for disenrollment if they do not pay their room and board. Some members will be much more diligent in paying their room and board if there is a consequence to their failure to pay.

The proposed modifications in the Family Care benefits would impact the MCO in the following ways:

- If DHS clarifies that program payments for social activities are limited to activities directly related to the long term care needs of the eligible person, it would be beneficial if this were communicated to stakeholders, advocates and Administrative Law Judges.

- As an MCO we have requested re-consideration of Over the Counter medications and supplies (OTCs) as a benefit in Family Care. DHS has considered this opinion but due to legislative language they are unable to remove this benefit without having cost consequences with medication remedials. We maintain that the costs that occur due to the burden of provision of this service outweigh these costs and would continue to advocate this be left out of the FC benefit package.

- Individuals who reside in group homes, nursing homes, adult family homes, etc. who do not pay their room and board impose a financial burden on the MCO. Further, their refusal to pay their room and board is unfair to the many members who do pay their bills timely. The Milwaukee MCO welcomes any mechanism that can be put in place to assist us in addressing this issue.

IRIS and Self-Directed Supports

Although the description of this focus area is to strengthen program integrity and accountability of the IRIS program and ensure that self-direction in IRIS *and Family Care* (italics added for emphasis) maximize natural supports and the ability of consumers to choose the most integrated, community-based and cost-effective services, there is no mention is this section of the opportunity for members to self-direct all or some of their services within Family Care.

Over 40% of the Milwaukee County MCO members self direct their services.

There is no discussion in this focus area of the proposed requirement to limit the use of more restrictive residential settings in IRIS (including 8-bed CBRFs, 3-4 bed AFHs, RCACs, and assisted living facilities) to no more than needed to address participant health or safety needs *on a short-term basis*. This initiative seems to discriminate against persons with higher levels of care by prohibiting them from self-directing these services that meet their needs.

Per member per month (PMPM) costs of current IRIS participants ($4159.30 PMPM) are already significantly higher than those of Family Care participants ($3187.82 PMPM). The MCOs must be allowed to serve individuals with a wide range of needs. This is how every other insurance model works and to do so differently in this case will negatively impact Family Care to failure by requiring it to serve only the neediest individuals out of a pool of people who are already disabled, frail elderly or both.

Residential Services

The proposed modifications in the areas of residential services would impact members in the following ways:

- Specifying acuity-based guidelines for utilization of more restrictive residential settings must take into account the level of natural supports available to the member. Families do not have a legal obligation to care for either their adult children or elderly family members. Furthermore, not every family is capable of caring for someone. If a member is not fortunate enough to have an intact and supportive family system, they should not be penalized by being "locked out" of certain levels of services, as long as those services are the right fit to meet their needs.

- The Milwaukee County MCO has already developed an innovative program to support More Integrated, Cost-Effective Options in Place of 24/7 Staffing. By implementing this model, which we refer to Supportive Independent Living (SILs) we have been able to successfully maintain 327 members in their own homes and apartments in partnership with agencies that arrange and support a range of services that support person-centered outcomes and self-directed care. 39 of these individuals moved from more restrictive settings to SILs.

The proposed modifications in the areas of residential services would impact the MCO in the following ways:

- Providing options counseling to transition IRIS participants from restrictive to integrated settings in the community and allowing members who do not wish to move to transition to a program that permits more restrictive residential settings (i.e. Family Care) results in adverse selection for the managed care programs. Why must MCOs be solely responsible for individuals with high care needs who may not have sufficient natural supports to enable them to live more independently in the community? In addition, IRIS should have the same responsibility as MCOs to work with newly enrolled members to "right size" services.

Living Well at Home and in the Community

MCOs currently fulfill many of the following responsibilities for their members and will continue to:

- Improve Medication Compliance,
- Counsel new residents and their families in nursing home and assisted living about services in the community, arrange those services and help existing institutionalized Medicaid residents leave a facility for services at home,
- Expand the number of high-risk persons participating in evidence-based prevention programs to reduce hospitalization and/or need for long-term care,
- Expand the number of high-risk persons with multiple chronic diseases that participate in peer-led chronic disease self-management,
- Arrange for short-term practical community interventions to support people with modest means to remain at home,
- Screen vulnerable individuals to identify those diagnosed with Alzheimer's disease or other dementia, to delay institutional placement by an average of 18 months and,
- Assist seniors and persons with disabilities leaving hospitals and making a transition to home

Youth in Transition

The proposed modifications in the area of Youth in Transition would impact members in the following ways:

- Improving our members' access to DVR services and funding through a State-wide pilot which will leverage 80% federal matching funds, to facilitate prioritization of Family Care members to receive services to support community employment.

The proposed modifications in the area of Youth in Transition would impact the MCO in the following ways:

- The MCO has created a specialized training for IDTs along with tools and resources they may need. Our Integrated Employment workgroup and Best Practice Team mentoring in this area are available to all of our IDTs for ongoing support and assistance. Our provider network includes agencies that offer supported employment and Independent Living Services for members to maximize their self-determination and independence.

- The MCO currently has Policies and Guidelines to focus on Integrated Community Employment during the care planning process to facilitate a smooth school to work transition.

- The MCO welcomes the opportunity to participate in statewide school pilots designed to identify best/promising practices designed to expand community employment for youth in transition (note: youth between the age of 18 and 21 may still be attending High School while enrolled in Family Care)

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEC 13 2011

Mr. Brett Davis
Medicaid Director
Division of Health Care Access and Accountability
1 West Wilson Street
P.O. Box 309
Madison, Wisconsin 53701

Dear Mr. Davis:

The Centers for Medicare & Medicaid Services (CMS) is currently reviewing the State of Wisconsin's proposed amendments to the Wisconsin Family Care and Self-Directed Supports Waiver Programs (CMS control numbers 0367.R02.01, 0368.R02.02, 0484.R01.0, and 0484.R01.01).

Please note that these types of waiver amendments, even if potentially approvable, may receive only a prospective approval date. Until specific approval of an amendment is received, the State is required to continue to operate the waiver as described in the currently-approved 1915(c) waiver application (see 42 CFR §430.25(h)(1)).

Because the currently approved waiver includes an entitlement to waiver services, we are instructing the State to operate the waiver as it was approved by CMS. Therefore, we are directing the State to identify any individuals not currently enrolled onto the Family Care or Self-Directed Supports waivers since the July 1, 2011 implementation of the newly instituted enrollment caps, and immediately enroll those individuals in the waiver programs. This includes individuals living in any counties who had or would have had an entitlement to the waivers as of July 1, 2011, and includes individuals who were or would have otherwise been selected for enrollment from other participating counties.

During our review, we will continue to evaluate:

- the potential implications of the amendments on the State's compliance with Maintenance of Effort (MOE) requirements under sections 1902(a)(74) and 1902(gg) of the Social Security Act, added by section 2001(b) of The Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152;

- whether appropriate tribal consultation occurred as required consistent with section 1902(a)(73) of the Social Security, added by section 5006(e) of the American Recovery and Reinvestment Act of 2010, P.L. 111-5; also see Presidential Executive Order 13175 (2000), Executive Memorandum on Tribal Consultation (November 5, 2009) and HHS Tribal Consultation Policy (December 14, 2010); and

- whether the amendments raise other issues, comments or concerns that the State must address before CMS can consider approval.

We look forward to hearing from the State regarding its plan for immediate identification and enrollment of the individuals described above.

If you have further questions or concerns, please contact me at (312) 353-1133 or Ralph Lollar, Director, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, at 410-786-0777.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Beth Wroblewski, DHS
Pris Boroniec, DHS
Mindy Morrell, CMCS

2011-2013
Long Term Care Sustainability

Employment Supports

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Employment Supports
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Ensure a continuum of employment supports in Family Care, IRIS, PACE and Partnership.

Main Message Points

- The federal waivers that support Family Care and IRIS require active treatment, including participation in employment and employment-related services for waiver participants.
- Recent CMS guidance highlighted the importance of competitive work and the goal to promote integrated, community-based employment options with an emphasis on person-centered planning.
- Approximately12% of long-term care recipients in Wisconsin participate in competitive-wage, integrated employment and Wisconsin ranks 32nd in the percentage of adults with developmental disabilities in Medicaid who are in supported, community-based employment.
- Research has shown that employment results in cost savings, less reliance on public benefits, and more money going back into the local community.
- Community Rehabilitation Programs (CRPs), in addition to workshop-based services, currently provide 65% of community-based employment supports funded by the Division of Vocational Rehabilitation.
- Given recent federal guidance, opportunities also exist to increase community-based employment for people with disabilities that are supported by Medicaid-funded waiver programs.

Proposed Modifications

1. **Division of Vocational Rehabilitation (DVR) Pilot.** Establish a statewide pilot program to support community-based employment to leverage 80% federal matching funds and the infrastructure and programming in DVR for integrated employment to prioritize services for people with disabilities in Family Care and IRIS.

2. **Infrastructure Grant Funding.** As allowed under grant provisions, allocate $1.6 million of carryover funding from the Medicaid Infrastructure Grant (MIG) to complete activities to:
   - Continue to work with CRPs to create more community-based employment supports.
   - Provide assistive technology and supports for youth with disabilities
   - Continue implementation of Project SEARCH, school to work and initiatives to use natural supports
   - Provide assistance for Vocational Futures Planning and MCO network development
   - Finalize guidance on asset development to assist persons to develop sustainable cash assets and saving
   - Provide support to employers to employ persons with disabilities
   - Improve the Disability Employment Data Infrastructure to:
     - Complete data collection activities to identify expenditures and measure employment outcomes
     - Finalize comprehensive data use agreements between DHS, DVR and DPI

3. **Work Incentive Benefits Counseling.** Ensure work incentive benefits counseling service is available and participation encouraged for LTC participants with an integrated employment goal.
   - Ensure availability of Work Incentive Benefits Specialists and Counseling Services as part of ADRC services. Explore opportunities to:
     - Fund up to 10 specialists to serve a regional system corresponding to Family Care districts.
     - Provide mandatory training, initially and ongoing, to economic support workers on the purpose of the Medicaid Purchase Plan and its effective administration.
   - Add Work Incentive Benefits Counseling Services as a specific service for participants in the Medical Assistance Purchase Plan (MAPP).
   - Explore opportunities for Work Incentive Benefits Counseling providers to be credentialed with the state Work Incentive Benefits Specialist Association.

4. **Improve policies for the Medical Assistance Purchase Plan (MAPP).** Analyze possible changes to the MAPP premium formula to support higher participant earning, saving and financial stability:
   - Consider elimination of the current distinction between earned and unearned income in the premium calculation;
   - Establish an effective definition of "employed" for eligibility purposes that is consistent with national policy and ensures that "in-kind" payments for work-like activities for people of working age (under age 65) does not qualify as employment;
   - Provide for participation in MAPP when substantial work ceases at age 65 or later by creating a definition of "employed" specific to this population;
   - Consider implementation of minimum premiums for all participants with countable income above 150% FPL;
   - Define a maximum premium for participants that removes the disincentive toward higher earnings; and
   - Focus outreach on the SSI 1619(b) population to encourage MAPP participation and create provisions for an "individualized threshold" similar to 1619(b) within MAPP.

5. **MCOs and IRIS Consultant Agencies leverage provision of employment services to collect federal reimbursements under the Ticket to Work program.** Encourage and support LTC management organizations (MCOs and ICAs) to register as Employment Networks (ENs) under the Ticket to Work Act:
   - Provide Technical Assistance to LTC agencies in registering for EN status;
   - Include LTC agencies in "Smartworks" pilot in 2012; and
   - Implement service payment strategies transferring SSA reimbursements to providers that generate quicker and higher quality integrated employment outcomes.

Effect of these changes:

- Wisconsin will leverage state funding to secure federal vocational rehabilitation funding at an improved match rate in order to support employment for people with disabilities.
- The benefits of key initiatives under MIG funding will conclude and Wisconsin will assure that successful initiatives can be replicated in the long term care system.
- Work incentives counseling will be available to assist and promote employment options for people with disabilities.
- The MAPP plan will be strengthen and key definitions of employment will be clarified.
- MCOS and IRIS Consultant Agencies will support and promote employment of people with disabilities.

2011-2013
Long Term Care Sustainability

Family Care Benefits

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Family Care Benefits
Projected Savings:	$9 million GPR
Proposed Implementation Date:	Spring 2012

Description: Implement strategies to assure that supports and services are tailored to the needs of the individual by focusing on strength-based care plans and by maximizing the use of natural supports.

Main Message Points:

- Individuals must meet functional and financial eligibility standards to enroll in Family Care. In assuring that functional needs are properly determined, people can be referred to the most appropriate benefits within Family Care and to alternative systems of care.
- Individuals who meet eligibility requirements and enroll in Family Care managed care organizations (MCOs) have access to a broad range of services, including services traditionally provided under home and community-based waiver programs, long term care Medicaid card services (supportive home care, care management, home health, employment supports, adult day services, medical supplies, physical therapy, transportation services) and nursing home services. Strength-based assessment processes identify the supports needed to address member outcomes and include the natural supports in a person's life to assure that public funding augments, rather than supplants unpaid supports.

Proposed Modifications

1. **Balance Cost Effectiveness with Choice.** Strengthen the care management planning process to require that members be presented with information regarding care options and the cost of those options to promote cost-effective decisions about care management.
   - Require care managers to disclose costs associated with service options to members as part of the care planning process.
   - Revise member informing materials to articulate the importance of cost effectiveness when care planning.
   - Allow MCOs to communicate to members that State-paid capitation rates reflect an average of overall costs for all members and not budget amounts for each individual member.
   - Revise policies and procedures to reinforce this strategy, emphasizing that care and services should be provided in the least restrictive and most cost effective environment necessary to meet the needs to the member.
   - Facilitate training to MCOs to ensure appropriate use of strength-based care management and of Resource Allocation Decision-making (RAD) guidelines so that a member's needs are properly identified and build upon natural supports.

2. **Focus on Strength-Based Care Plans and a Continuum of Supports.** Maximize the use of family caregivers and other natural supports and build capacity within communities to increase utilization of natural supports. Assure a

- Reduced and automated paperwork and documentation to eliminate duplication;
- Simplification of the RAD;
- Reduced submissions to DHS to only federally required documentation;
- Evaluation of the impact that the Annual Quality Reviews (AQR) or other reviews in contributing to duplicative or unnecessary work on behalf of the MCOs; and
- Increased use of IT systems in place of paperwork and processes.

- Minimize contractual barriers in Partnership that currently limit the role of Nurse Practitioners as an extension of the Primary Care Physician and ensure that the roles of the Nurse Practitioner and the Nurse are not duplicative.

2. **Streamline Care Management in Residential and Institutional Settings.** Develop standards and strategies for interdisciplinary team oversight to reduce duplication and enhance care management when a member is in a residential care setting, including:
   - Reduce the frequency of oversight in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance;
   - Reduce the number of different teams involved with oversight of members within a single facility; and
   - Increase collaboration with facility staff.

3. **Strengthen Oversight of Service Authorization.** Strengthen MCO authority to institute "checks and balances" to ensure that care plans reflect cost-effective choices.
   - Provide flexibility to establish written protocols to guide interdisciplinary teams (IDTs) in determining acceptable services/products, subject to DHS approval and require that written guidelines do not in any way modify the range of services authorized in the waiver.
   - Revise member informing materials to emphasize that any products/services paid for with public funds must be related to the long term care outcome for the member.
   - Communicate and stress the importance of input from all members of the care planning team to ensure that the care plan reflects cost-effective choices.
   - Allow MCOs to implement a secondary review for high-cost products and services.

4. **Administrative Initiatives.**
   - Streamline reporting requirements and required paperwork to ensure that member outcomes are identified and supported and that member health and safety is ensured.
   - Review current reporting requirements, eliminate unnecessary paperwork, and determine what is necessary to meet DHS requirements for health and safety as well as any requirements established in the waiver or by CMS.

5. **Appeals.** Streamline and simplify the appeals process to ensure timely decision-making for consumers and MCOs**.**

6. **Business Plan Requirements and Administrative Oversight.** Streamline Business Plan requirements to reduce unnecessary administrative burden on MCOs and DHS.

7. **Member Handbooks and Provider Network Directories.** Minimize administrative burden and costs associated with providing written copies of Member Handbooks and Provider Directories except when requested.

8. **Provider Contracts/Relations.** Require that MCOs:
   - Share proposed contractual changes at least 30 days in advance of implementation, facilitate disclosure of specific changes proposed in provider contracts, and work collaboratively with providers to maintain networks during negotiations;
   - Make timely payments to providers; and
   - Explore opportunities across MCOs to standardize protocols, claims processing and data reporting for providers to the extent possible.

9. **Streamline and Improve the Consistency of Claims Processing and Other IT Functions.** Explore opportunities to leverage IT systems and contracts to improve the uniformity and consistency of data collection, to enhance program

management and program integrity, and to reduce costs.

10. **Increase Competition in MCO Service Areas.** Foster competition within Family Care by allowing existing MCOs organized through Long Term Care Districts to compete in additional counties and service areas, subject to the approval of their Board.

11. **Future Expansion Counties.** Work with persons in legacy waiver programs in advance of the transition to managed LTC programs and IRIS through strength-based care management and the RAD to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

12. **Best Practices and Self-Directed Supports.** Incorporate MCO best practices and enhanced use of self-directed supports in future Family Care MCO procurements.

Effect of this change:

- Reduce administrative burden and administrative costs.
- Improve the efficiency and cost-effectiveness of MCO operations.
- Increase quality and ensure more cost-effective support of people's outcomes.
- Streamline and improve care management practices at the MCO level.
- Eliminate duplication and streamline administrative processes.

2011-2013
Long Term Care Sustainability

Family Care Administrative and Program Efficiencies

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Family Care Administrative and Program Efficiencies
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Implement strategies to streamline program and administrative processes in Family Care to better align operations with current and future needs, to improve management, and to reduce program costs.

Main Message Points:

- As of January 2012, ten managed care organizations (MCOs) provide LTC benefits through Family Care, PACE and Partnership. Of these, six are Family Care MCOs, three are Family Care/Partnership MCOs, and one serves people enrolled in Partnership/PACE.
- Most areas of the state are served by one MCO; however enrollees in Milwaukee County have a choice of two MCOs, along with PACE and Partnership.
- The current care management model of an interdisciplinary team within Family Care is intended to ensure that people's individual needs are assessed from multiple perspectives including social work and nursing services. However, there are concerns that the model as specifically defined in contract requirements and as implemented may result in duplication of efforts or more care management than needed by some people.

Proposed Modifications

1. **Streamline and Improve Care Management.** Assure that care management is tailored to the needs of each individual, using a strength-based assessment process that identifies and utilizes natural supports when addressing member outcomes when planning for services and supports.
   - Use a strengths-based assessment process, including building upon natural supports in a person's life to assure that publically-funded supports strengthen rather than supplant unpaid supports and that the service authorization process leads to cost savings while maintaining strong quality outcomes.
   - Modify contractual and procedural requirements to reduce administrative overhead and eliminate care management paperwork.
   - Permit MCOs to develop protocols that account for acuity, level of care and natural supports in order to provide the right amount of care management that is unique to each person's assessed needs.
   - Retain access to registered nurses (RNs) for all members, but allow MCOs to not routinely assign RNs or to provide that the nurse be the primary point of contact for some members, such as medically complex frail elders.
   - Promote a strength-based assessment process by MCOs to:
     - Focus on the skills people have;
     - Identify natural supports; and
     - Account for these strengths when developing the formal care plan.
   - Reduce administrative paperwork and processes, including:
     - Streamlined notice of action and appeals process;

- Reduced and automated paperwork and documentation to eliminate duplication;
- Simplification of the RAD;
- Reduced submissions to DHS to only federally required documentation;
- Evaluation of the impact that the Annual Quality Reviews (AQR) or other reviews in contributing to duplicative or unnecessary work on behalf of the MCOs; and
- Increased use of IT systems in place of paperwork and processes.

- Minimize contractual barriers in Partnership that currently limit the role of Nurse Practitioners as an extension of the Primary Care Physician and ensure that the roles of the Nurse Practitioner and the Nurse are not duplicative.

2. **Streamline Care Management in Residential and Institutional Settings.** Develop standards and strategies for interdisciplinary team oversight to reduce duplication and enhance care management when a member is in a residential care setting, including:
   - Reduce the frequency of oversight in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance;
   - Reduce the number of different teams involved with oversight of members within a single facility; and
   - Increase collaboration with facility staff.

3. **Strengthen Oversight of Service Authorization.** Strengthen MCO authority to institute "checks and balances" to ensure that care plans reflect cost-effective choices.
   - Provide flexibility to establish written protocols to guide interdisciplinary teams (IDTs) in determining acceptable services/products, subject to DHS approval and require that written guidelines do not in any way modify the range of services authorized in the waiver.
   - Revise member informing materials to emphasize that any products/services paid for with public funds must be related to the long term care outcome for the member.
   - Communicate and stress the importance of input from all members of the care planning team to ensure that the care plan reflects cost-effective choices.
   - Allow MCOs to implement a secondary review for high-cost products and services.

4. **Administrative Initiatives.**
   - Streamline reporting requirements and required paperwork to ensure that member outcomes are identified and supported and that member health and safety is ensured.
   - Review current reporting requirements, eliminate unnecessary paperwork, and determine what is necessary to meet DHS requirements for health and safety as well as any requirements established in the waiver or by CMS.

5. **Appeals.** Streamline and simplify the appeals process to ensure timely decision-making for consumers and MCOs**.**

6. **Business Plan Requirements and Administrative Oversight.** Streamline Business Plan requirements to reduce unnecessary administrative burden on MCOs and DHS.

7. **Member Handbooks and Provider Network Directories.** Minimize administrative burden and costs associated with providing written copies of Member Handbooks and Provider Directories except when requested.

8. **Provider Contracts/Relations.** Require that MCOs:
   - Share proposed contractual changes at least 30 days in advance of implementation, facilitate disclosure of specific changes proposed in provider contracts, and work collaboratively with providers to maintain networks during negotiations;
   - Make timely payments to providers; and
   - Explore opportunities across MCOs to standardize protocols, claims processing and data reporting for providers to the extent possible.

9. **Streamline and Improve the Consistency of Claims Processing and Other IT Functions.** Explore opportunities to leverage IT systems and contracts to improve the uniformity and consistency of data collection, to enhance program

management and program integrity, and to reduce costs.

10. **Increase Competition in MCO Service Areas.** Foster competition within Family Care by allowing existing MCOs organized through Long Term Care Districts to compete in additional counties and service areas, subject to the approval of their Board.

11. **Future Expansion Counties.** Work with persons in legacy waiver programs in advance of the transition to managed LTC programs and IRIS through strength-based care management and the RAD to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

12. **Best Practices and Self-Directed Supports.** Incorporate MCO best practices and enhanced use of self-directed supports in future Family Care MCO procurements.

Effect of this change:

- Reduce administrative burden and administrative costs.
- Improve the efficiency and cost-effectiveness of MCO operations.
- Increase quality and ensure more cost-effective support of people's outcomes.
- Streamline and improve care management practices at the MCO level.
- Eliminate duplication and streamline administrative processes.

2011-2013
Long Term Care Sustainability

Living Well at Home and in the Community

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Living Well at Home and in the Community
Projected Savings:	$54.5 million GPR
Proposed Implementation Date:	Spring 2012

Description: Increase the availability of timely and easy access to less intensive and more flexible supports to help people and their caregivers to remain healthy and safe at home and in the community without the need for more comprehensive LTC supports and services.

Main Message Points

- Aging and Disability Resource Centers (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. In particular, ADRCs:
  - Serve as the single point of access for publicly-funded LTC, providing eligibility determination and enrollment counseling.
  - Provide options counseling to identify other available programs and resources for those not eligible for Family Care, IRIS, PACE or Partnership.
  - Offer intervention activities such as programs to review medications or nutrition, teach people how to manage chronic conditions like diabetes or heart disease, or engage people in programs to eliminate home hazards and prevent falls.
- In identifying resources and making informed decisions about long term care, seniors and persons with disabilities can conserve their personal resources, maintain self-sufficiency, and delay or prevent the need for potentially expensive long term care.

Proposed Modifications

1. **Medication Compliance.** Provide automated, in-home medication dispensing systems for frail seniors, persons with disabilities, and high-risk persons on Medicaid to keep people living independently in the community and to reduce emergency room visits, inpatient hospital stays and nursing home and LTC residential admissions from non-compliance and errors in dispensing prescription medications.
   - Utilize existing data and analytical tools to systematically identify at-risk individuals on Medicaid with multiple medical conditions, multiple medications, some form of cognitive impairment, a history of negative health outcomes from not taking medications, and need for assistance in a relatively high number of activities of daily living.
     - Medication compliance by frail seniors is typically below 15%, but rises to about 98% with automated dispensing.
     - Research shows that up to 23% of nursing home admissions are due to medication non-compliance by seniors, while over 10% of hospital admissions are due to medication non-compliance.
   - Facilitate access to secure in-home medication dispensing systems with personal resources for seniors and persons with disabilities who are at risk of entering a residential or institutional placement or of becoming eligible for more costly LTC programs.

- Automated dispensing reduces the need for services in more intensive LTC settings; the inability to follow medication therapy is sufficient reason for admission in these settings.

- Use supportive home care workers, families, nurses, and pharmacists to load prescriptions in machines.
  - The device holds a month's supply of prescribed drugs;
  - Visually and audibly notifies the person when it is time to take their medication;
  - Dispenses medications at the correct time of day, in correct combinations, in correct quantities, and with correct instructions (e.g., take with food); and
  - Sends warning alerts to caregivers over the phone line, continuously tracks medication compliance, and provides data for care management.
- Implement the pilot within three months on a voluntary basis, and generate net savings quickly from avoidable hospital, ER and LTC placements in residential and institutional settings.
  - Proactively identify 40,000 Medicaid beneficiaries through predictive modeling of the high risk of hospitalization/institutionalization of those who are at extremely high risk of medication non-compliance due to a high number of active prescriptions, multiple morbidities, age, prior adverse events from non-compliance and other risk factors, such as cognitive impairment or functional limitations.
  - Certify qualified providers to provide automated dispensing, with savings used to fund implementation and ongoing costs for Medicaid eligibles and with competitive rates for those at risk of becoming eligible for LTC programs.
  - Explore the opportunity of a grant with the CMS Innovation Center to share the costs and savings from Medicare beneficiaries in the demonstration pilot.
- Provide additional supports, such as ensuring home-delivered meals for individuals that need adequate nutrition for effective medication management.

2. **Nursing Home and Assisted Living Intervention and Diversion.** Counsel new residentss and their families in nursing home and assisted living about LTC services in the community, assist them in arranging those services and help existing institutionalized Medicaid residents leave a facility for services at home.
   - Deploy staff in nursing home and residential facilities to provide information within seven days of admission to residents who are on Medicaid and those likely to become eligible for Medicaid within six months to conduct an assessment and discuss LTC options at home and in the community.
   - Intervene early in a stay, focusing mainly on those who continue to have available housing and willing support systems, providing assistance to remain in their own homes or delay or prevent residential or institutional placement.
   - Similar initiatives in Washington, Oregon and New Jersey have demonstrated savings of 35% to 60% from reduced nursing home admissions over a 10 to 15 year period.

3. **Falls Prevention.** Expand the number of high-risk persons participating in evidence-based prevention programs to reduce hospitalization and/or need for long-term care.
   - Reduce falling among older people in every county to reduce by 20% hospitalization and long-term injury among older people due to falls.
   - Develop outreach to health systems and to people to promote referrals and participation in falls prevention by 25% each year.
   - Support occupational and physical therapy participation in falls prevention.
   - Work with health systems and MCOs to develop additional programs for members.

4. **Chronic Disease Self-Management.** Expand the number of high-risk persons with multiple chronic diseases that participate in peer-led chronic disease self-management.
   - Support outreach to adults with chronic illness to participate in a seven-week peer-directed class in self-management of chronic conditions in order to improve health and well-being.
   - Increase participation by 25% each year in every county.
   - Focus efforts on diabetic and cardio-pulmonary conditions.
   - Work with health systems, MCOs, and other federal and state initiatives to promote referrals and to develop

additional programs.

5. **Short-term Community Intervention.** Arrange for short-term practical community interventions to support people with modest means to remain at home.
   - Problem solve with elders and people with disabilities who are at risk of moving to residential settings by arranging volunteer help; low cost technologies; minor home repair and cleaning or other affordable solutions to problems with the current home environment.
   - Identify and mobilize social supports and community connections to reduce isolation and risk for people living alone.
   - Secure affordable housing and arrange for low-cost services for elders, people with disabilities and their families that do not need residential care but who are struggling to maintain independence at home.
   - Conserve individuals' personal funds for people that do not require residential care by advising about purchasing in-home or community-based services.

6. **Alzheimer's Disease and Other Dementia.** Screen and treat vulnerable individuals to identify those diagnosed with Alzheimer's disease or other dementia, to delay institutional placement by an average of 18 months.
   - Conduct a brief screen at ADRCs to identify persons at risk.
   - Refer those who may be at risk for dementia to diagnostic clinics (21 available around the state) that are affiliated with Alzheimer's Institute.
   - Using the evidence-based model of Memory Care connections, connect individuals and families with social supports, education, caregiver support and respite.
   - Provide contact and help to caregivers using the evidence-based Mittleman model.
   - Engage persons with dementia and caregivers in a program of moderate physical and mental exercise to reduce isolation, improve function, and provide respite (LEEP model).

7. **Care Transitions.** Assist seniors and persons with disabilities leaving hospitals and making a transition to home.
   - Pilot the evidence-based Coleman model of effective hospital transitions with several major hospitals or health systems.
     - Provide for individuals who are screened at discharge as at risk of returning to the hospital by providing a transition "coach" to facilitate effective transition for the person and caregiver.
     - Using a combination of home visits and telephone contacts, monitor compliance with the discharge plan for up to three months.
     - Measure effectiveness and cost-savings and determine how to finance expansion of the model, if successful in Wisconsin.
   - Strengthen relationships between ADRCs and hospital discharge units to improve information and assistance about community resources.
   - Pilot the Peer Link model which uses certified peer specialists to assist with transitions from the hospital to the community for individuals with mental health concerns and which has shown a 46% decrease in hospitalizations for members in the program.

Effect of this change:

- Delay or prevent people's entry to long term care.
- Assist more people to manage within their own personal resources.
- Avert unnecessary hospitalizations, ER visits, and nursing home placements, reducing public and private expenditures for primary, acute and LTC.
- Ensure that caregivers receive critical support to be able to maintain their role as a caregiver while remaining healthy.

2011-2013
Long Term Care Sustainability

Residential Services

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Residential Services
Projected Savings:	$14 million GPR
Proposed Implementation Date:	Spring 2012

Description: Ensure that people with long-term care needs are safe and cared for in their own homes and community settings as long as possible, with services provided in residential settings only when it is the least restrictive and most integrated location to meet the person's needs.

Main Message Points

- The cost of care provided in residential settings, which includes Adult Family Homes (AFHs), Community-Based Residential Facilities (CBRFs), Residential Care Apartment Complexes (RCACs) and Assisted Living, is a significant cost driver in Family Care, IRIS, PACE and Partnership:
  - In Family Care, care provided in residential settings represents 53% of costs for members with a developmental disability, 41% of costs for members with a physical disability, and 60% of costs for frail elders.
  - For members with a developmental disability, the lowest one-third cost group expends about $200 per member per month (PMPM) for supportive care in their own home. In contrast, the highest one-third cost group expends $4,387 PMPM for home care provided in residential settings. Similar differences also occur for persons with physical disabilities and for frail elders.

- The most integrated, community-based, and cost-effective setting to receive LTC services for most people is in their own home or apartment in the community. To support these principles, this initiative is designed to:
  - Provide information and counseling on care in residential settings, including assisted living;
  - Use technology and other community-based services to support people in their own homes;
  - Align access and payment for residential care with members' functional needs leveraging flexibility identified by the Centers for Medicare and Medicaid Services (CMS) to set utilization criteria to control waiver costs;
  - Require that self-directed care be provided in settings in which the consumer directs the provision of care; and
  - Ensure the right support, in the right amount, at the right time, allowing people to be supported to live in their own homes and natural settings as long as possible while assuring health and safety.

Proposed Modifications

1. **Establish Criteria for Residential Care as an Allowable Service within the Family Care Benefit Package.**
   - Specify acuity-based guidelines for utilization of more restrictive residential settings.
   - Ensure that members with low acuity do not generate a rate to support costly, more restrictive residential settings.
   - Establish an upper payment limit for members in assisted living that do not have exceptional needs.
   - Require that LTC services and Medicaid-supported personal care support living at home, and not to provide housing or substitute care. Utilize residential settings for individuals whose health and safety cannot reasonably be met in natural residential settings such as homes or apartments.

2. Limit the Use of Restrictive Residential Settings that are Inconsistent with Self-Direction in IRIS.

- Limit the use of more restrictive residential settings in IRIS (including 8-bed CBRFs, 3-4 bed AFHs, RCACs, and assisted living facilities) to no more than needed to address participant health or safety needs on a short-term basis. This is consistent with the IRIS Advisory Committee recommendations to assure that a person is in a setting consistent with full self-direction.
- Provide options counseling to transition IRIS participants from restrictive to integrated settings in the community within 12 months of this change, and allow members who wish do not wish to move to transition to a program that permits more restrictive residential settings.
- Assist IRIS participants with information on potential service providers and guidance on how to select providers to deliver self-directed care in less restrictive residential settings.
- Educate providers on self-direction and encourage providers to develop options that allow for maximum consumer control.

3. Emphasize the Importance of Natural Supports within Family Care and IRIS.

- Require a comprehensive assessment of members' informal support networks to assure that Medicaid does not supplant that support.
- Build on best practices which show that people with unpaid supports, in addition to publically-funded supports, are safer and more included within their community.

4. Ensure Informed Decision-Making Regarding the Use of Assisted Living.

- Maximize the use of personal resources to support LTC and reduce the number of people that enter publicly-funded LTC from assisted living facilities.
- Work with Aging and Disability Resource Centers (ADRCs) and Assisted Living facilities to help consumers and their families to make informed choices about the most cost-effective long term care options, using a standard Consumer Bill of Rights and Responsibilities to ensure that people understand:
  - The options for caregiver support and services in their own home, including the availability of medication management technology, falls prevention, and assistance with care management;
  - The estimated impact of moving to assisted living on their personal finances;
  - The criteria for living in such a setting when public funds are utilized; and
  - If private funds are exhausted, that a move may be required if care in the assisted living facility is not consistent with acuity-based guidelines or LTC residential rates for public programs.
- Define the scope of services for which public funding would be used to support care (e.g., exclude amenities).
- Publish assisted living facility rates to assist consumers in understanding how quickly their personal resources would be spent and whether public funding may be available if they become eligible for Medicaid LTC services.
- Require facilities to notify people if they do not accept public rates within their facility.

5. Align the IRIS Program Rates to be Comparable to Allowable for Residential Services within Family Care.

- Establish rate bands to ensure alignment of IRIS acuity measures and rates with local MCOs services and rates.
- Require that members who transfer to IRIS to retain their provider receive a budget allocation that is comparable to the rate offered by the MCO.

6. Support More Integrated, Cost-Effective Options in Place of 24/7 Staffing.

- Implement supported living within Family Care and IRIS to ensure that people receive care in their own homes and apartments in partnership with an agency that will arrange and support a range of services that support person-centered outcomes and self-directed care, including:
  - Leverage technologies, such as alert systems and rapid response, for supports for people with an intermittent and/or unpredictable need for supports.
  - Use assistive technology and home modification devices to promote independence in accomplishing daily activities.
  - Utilize medication management systems to assure accurate use of prescription drugs and to monitor instances when the person needs an on-sight visit for professional staff to meet their needs.
  - Promote MCO and IRIS consumer efforts to develop cost-effective models for providing 24/7 in-home care

that is not based on shift work or per-hour work.
  - Establish a clear definition of supported living arrangements and provide the necessary infrastructure to facilitate the use of such supports.

7. Develop more cost effective housing options for people with long term support needs.

- Support more affordable housing initiatives, and explore options to develop individualized, integrated, accessible, affordable and safe housing for people living independently but with intermittent support needs.
- Provide affordable housing options for support staff to live proximate to the people in need of support.
- Support efforts to identify and develop cost-effective settings for people to live and receive care.
- Support efforts to locate compatible roommates, identify home/apartment settings to share living expenses and increase access to support.
- Increase use of and support for natural, unpaid supports in people's lives.
- Transition Family Care from primarily using licensed, regulated settings to supporting people in their own homes or apartments with services from a provider who is not also the homeowner.
- Leverage the recently-approved grant of $330,000 to build sustainable partnerships in housing to:
  - Create a new and innovative partnership between DHS and WHEDA to evaluate HUD Section 811 opportunities to develop affordable housing projects;
  - Create a new Section 811 independent housing referral process utilizing the LTC infrastructure;
  - Establish a new housing counseling curriculum for agencies serving members in the community; and
  - Educate developers on the benefits of Section 811 program reforms and opportunities for LTC clients.

8. Utilize Enhanced Federal Match through Money Follows the Person (MFP) to Relocate and Divert Individuals from Institutions (Nursing Facilities and ICFs-MR) to More Integrated Settings in the Community.

- Ensure that consumers/families sign up for MFP before the transition to the community:
  - Require ADRC and institutional staff to inform residents of the availability of MFP prior to relocation.
  - Ensure that individuals who agree to participate are assisted in completing the quality of life survey prior to transitioning from the institution.
  - Explore opportunities to allocate a portion of enhanced federal funding to MCOs that relocate or divert individuals to the community.
- Enhance the system to track and follow-up with individuals who agree to participate in MFP.
- Require institutional facilities, ADRCs, MCOs and counties to fully cooperate with MFP.
- Maximize the use of 100% federal funding for MFP administrative costs.

9. Outreach to Ensure Understanding of Community Supports. Ensure outreach to physicians, nurse practitioners, hospital and nursing home social workers, and other medical and social service professionals to increase understanding of supports available within the community.

Effect of this change:

- Support the most integrated, community-based, and cost-effective setting for LTC supports and services which, for most people, is in their own home or apartment.
- Provide information and counseling to help seniors and their families make better and less costly long term care choices.
- Limit the growth in future Family Care, IRIS, PACE and Partnership costs by providing care in more cost-effective home and community settings.
- Ensure the right support, in the right amount, at the right time, allowing people to be supported to live in their own homes and natural settings as long as possible while assuring health and safety.

2011-2013
Long Term Care Sustainability

IRIS and Self-Directed Supports

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Strengthen the IRIS Program and Self-Directed Supports
Projected Savings:	$1.3 million GPR
Proposed Implementation Date:	Spring 2012

Description: Strengthen program integrity and accountability of the IRIS program and ensure that self-direction in IRIS and Family Care maximize natural supports and the ability of consumers to choose the most integrated, community-based and cost-effective services.

Main Message Points

- The IRIS Program has experienced significant growth with almost 6,000 people currently enrolled since it was first available on July 1, 2008. As required under federal waivers, IRIS provides an alternative choice to managed LTC in Family Care.
- IRIS is unique from Family Care through its use of:
  - A combination of waiver funding and Medicaid fee for service "card" services;
  - An individual budget allocation and flexibility to develop a person-centered plan; and
  - An IRIS consultant to assist in defining outcomes and identifying paid and informal services and supports.
- The goal of the IRIS Program is to ensure consumer-directed planning to maximize independence, support meaningful participation in the community, and promote individual responsibility and self-determination.

Proposed Modifications

1. **IRIS Program Integrity and Accountability.** Implement safeguards to ensure the appropriate expenditure of state and federal funds, as recommended by the Legislative Audit Bureau, and modify the program design, infrastructure and organizational support for IRIS to ensure program integrity and accountability.
   - Through a competitive procurement for IRIS consultant and claims payment services, ensure development of:
     - A comprehensive, consumer accessible, integrated information technology platform, with capacity to:
       - Support individual budget allocations;
       - Incorporate guidelines and estimation tools into budget development;
       - Link to Support Brokers to create cost-effective, community-based supports and services; and
       - Perform monthly and annual reconciliations of individual budget allocations;
     - Web-based access to individualized budgets and monthly expenditures; and
     - Program management and monitoring tools, including fraud and abuse prevention and detection capabilities.
   - Ensure quality oversight and management by dedicating state staff positions to support IRIS operations, quality management and program integrity functions.

2. **Strengthen Self-Direction in IRIS.** Implement changes to the IRIS program based on the experience and guidelines of the *National Center for Self-Direction* to maximize self-determination, including initiatives to:
   - Reduce complexity, bureaucracy and centralization of IRIS and create greater transparency and a more participant-friendly process in the IRIS program.

- Support individuals to understand and implement the principles of self-direction.
- Assure that IRIS participants receive the necessary continuum of support through their IRIS experience.
- Ensure appropriate, cost-effective supports, leveraging natural and community resources, whenever possible.
- Avoid cost-shifting and promote cost-effective choices in accessing Medicaid fee-for-service benefits.
- Streamline administrative structures and requirements and ensure choice and local access to claims processing for participants, if possible.
- Assure that IRIS staff are knowledgeable regarding local services, supports and resources.
- Assure that each step of the IRIS process is conducted in a timely manner.
- Provide IRIS participants with clear and complete information about self-direction and the parameters of the program, including the expectation that people will utilize natural unpaid supports and establish the most cost-effective plan necessary to meet their needs.
- Streamline the initial service planning process for IRIS participants to:
  - Develop tools to triage IRIS participants to determine the amount of support needed to self-direct and to include an active guardian or other decision-making support if the person needs assistance in consumer-direction.
  - Assist in the initial service planning process to create an appropriate support plan that builds around natural supports to the greatest extent possible.
  - Develop a robust support broker system and peer-to-peer mentoring to enable people to secure assistance when needed.
  - Provide tools to promote independence and personal responsibility, such as a web portal for service and budget management, an hours/payment estimating tool for supportive home care, and tools/guidelines to ensure appropriate use of customized goods and services.
  - Provide information on potential services and providers and guidance on how to select a service provider.
  - Bring service plan approval closer to the participant in order to ensure participant flexibility in plan development and implementation.
- Develop processes to allow for more flexibility to adjust payments, plans and budgets from month to month.
- Identify options to allow for more flexible and cost-effective staffing.
- Identify technology and home modification options to ensure health and safety while reducing the need for staff.

3. **IRIS Budget Allocation Alignment.**
   - Leverage budget allocation improvements to ensure accurate individual budgeting, review plans to ensure that program allocations are fairly determined for persons within IRIS and as compared to Family Care.
   - Evaluate allocations for people that enrolled prior to July 2010, and during their annual review work with participants to bring costs in alignment with those enrolled after that date, creating better alignment of costs for people who have selected IRIS with those receiving services through Family Care.
   - Assure that paid supports are focused and do not supplant informal and natural community-based supports.
   - Develop community supports and enhanced training for crisis intervention and stabilization to keep people in the community, and not in more intensive settings.
   - Promote the use of technology and intermittent supports to move away from 24/7 one-to-one staffing whenever feasible to meet a person's needs.
   - Use information technology to provide budget and payment control to participants through a web-based system of budget and expenditure tracking, service payment authorization and direct payment for recurrent services.
   - Assure that participants have access to a monthly budget ledger and complete annual reconciliation to support self-direction, personal responsibility, and accountability.

4. **Assure that IRIS Participants, not Providers, Direct their Services and Supports.**
   - Ensure that providers do not inappropriately limit choice, take control of funds, or raise costs for participants.
   - Require consumers/guardians to play an active role, and limit delegation of decision-making to providers.
   - Limit the use of residential options for those whose assessment does not support such settings.
   - Ensure alignment of reimbursement in IRIS that is consistent with that provided under Family Care.
   - Promote use of employment supports to foster integrated work outcomes, as recommended by federal guidelines.
   - Educate providers on self-direction and encourage options that allow for maximum consumer control.

- Assure that supports are focused and do not supplant informal and natural community-based supports.

Effect of this change:

- Assure program integrity and accountability in the operations and management of the IRIS Program.
- Strengthen the framework of IRIS to better support choice, self-determination and more cost-effective options.
- Align budget allocations to be more consistent within IRIS and with Family Care.
- Support people in the most integrated, community-based and cost-effective settings.

2011-2013
Long Term Care Sustainability

Youth in Transition

Category:	Ensuring the Cost-Effectiveness and Fiscal Sustainability of Wisconsin's Long Term Care (LTC) Programs
Focus Area:	Long Term Care – Youth in Transition
Projected Savings:	$500,000 GPR
Proposed Implementation Date:	Spring 2012

Description: Develop and maintain community employment and living settings for youth that transition from children's to adult services, and address the needs of families so they can continue to work after their child graduates from school.

Main Message Points

- The transition of young adults with disabilities from high school into the adult service system provides a critical opportunity to support community employment with earnings and community living settings.
  - By establishing a timeline, policies and supports for youth in transition, more cost-effective employment and housing is possible, ensuring the fiscal sustainability of Family Care and IRIS.
  - By focusing on employment first, youth can attain a sense of achievement and purpose and leverage paid employment to support their financial stability (including housing) and their social opportunities.
- The most integrated, community-based, and cost-effective strategies to support youth in transition include options to:
  - Ensure graduation at age 20-21 with a high school diploma and placement in integrated work in the community.
  - Provide support to maintain work, including supported employment services, transportation, and vocational support, utilizing natural supports wherever possible.
  - Incorporate best practices to match youth with positions where they can work independently with the least amount of paid support, using alternative work schedules, as needed, and natural inclusion in the work environment.
  - Ensure the transition to community-based living settings.
- The experience of graduates with developmental disabilities in Dane County in the Spring of 2011 indicates that 29 of 33, or 88%, worked in community employment at a median hourly wage of $7.25. At 15 hours worked each week, graduates earned an average of $477 per month. The average cost of a graduate in supported employment with blended funding from LTC and DVR funding totaled $13,700 per year or $1,142 per month.
- These provisions are designed to support youth in transition to develop the skills needed to achieve community connections, employment and living arrangements that are the least restrictive/most inclusive settings possible.

Proposed Modifications

1. **Establish Policy Guidelines and Criteria to Promote Community Employment and Living.** For youth in transition (ages 18 – 25 years) in Family Care and IRIS focus first on ensuring community employment and supports to live at home with one's family, and subsequently develop options to ensure housing in the community. Specify that the LTC service package include:
   - ***Employment related services***
     - Service coordination
     - Self-directed support broker services
     - Customized and supported employment services
     - Futures planning

- Job coaching
- Assistive technology and home modifications, when necessary for employment and community participation
- Daily living skills training
- Consumer education and training
- Non-medical transportation for school and work and community participation (leveraging natural supports)

- ***Family Support-related services***
  - Consumer/family education and training
  - Respite care
  - Supportive home care
- ***Medicaid card services***, to the extent such services are allowable
- ***Utilization of Services from DVR, DPI, and schools*** to assess, plan and develop community employment options prior to graduation and as youth transition from school to adult services.

2. **Division of Vocational Rehabilitation (DVR) Pilot.** Establish a statewide pilot program to support community-based employment to leverage 80% federal matching funds and the infrastructure and programming in DVR for integrated employment to prioritize services for youth with disabilities in Family Care and IRIS.

3. **School Services, Counseling, and Career Planning.**
   - Encourage youth with disabilities to access public school benefits to which they are entitled to between the ages of 18 – 21 years of age.
   - Expand and promote disability and work incentive benefits counseling so that youth with disabilities and their families are aware of the opportunities for being employed while retaining access to important public benefits.
   - Develop career planning tools that staff in the Children's Long-Term Care system can use in working with families to develop an early expectation and vision for paid work in the community.
   - Provide family-oriented training on the transition process and facilitation of skills development for their youth.
   - Expand, publicize and promote disability benefits counseling for youth in transition.
   - Explore incentives to providers to promote more integrated and cost-effective community outcomes.

4. **"Let's Get to Work" Grant.** Leverage $1.8 million over five years in recently-approved grant funding to the Wisconsin Board for People with Developmental Disabilities, with the support of DHS, DVR, DPI and numerous stakeholders to develop and implement provisions to initiate statewide school pilot sites to test a set of evidence-based practices to expand competitive employment in community settings and to disseminate policies and practices based on the pilots.

Effect of this change:

- Utilize the most integrated, community-based, and cost-effective living and employment settings for youth in transition.
- Focus first on employment for youth leaving school, using earnings to support living expenses.
- Through a pilot with DVR, negotiate a statewide rate to contribute the full amount allowed for youth in transition to support the move from school to paid employment.

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3698/3
TJD:wlj&med:jf

2011 ASSEMBLY BILL 477

January 18, 2012 - Introduced by Representatives KAUFERT, KESTELL, VAN ROY, BROOKS, DOYLE, A. OTT, ZIEGELBAUER, BERNIER, WYNN, RICHARDS, STONE, STEINBRINK, RIPP, TRANEL, MOLEPSKE JR, GRIGSBY, ENDSLEY, FIELDS, STASKUNAS, JORGENSEN, PASCH, PETRYK, DANOU, SINICKI and SPANBAUER, cosponsored by Senators MOULTON, VUKMIR, CARPENTER, HARSDORF, ERPENBACH, WANGGAARD, JAUCH, RISSER, C. LARSON and HOLPERIN. Referred to Committee on Aging and Long-Term Care.

AN ACT ***to affect*** 2011 Wisconsin Act 32, section 9121 (1g) (title), (b) and (c), 2011 Wisconsin Act 32, section 9121 (1g) (a) 4., 6. and 7., 2011 Wisconsin Act 32, section 9121 (1g) (a) (intro.), 1. to 3. and 5. and 8., 2011 Wisconsin Act 32, section 9121 (2g), 2011 Wisconsin Act 32, section 9121 (3g), 2011 Wisconsin Act 32, section 9121 (3g) (bm) (title) and 2011 Wisconsin Act 32, section 9121 (5); **relating to:** removing cap on enrollment of Family Care and other long-term care programs.

Analysis by the Legislative Reference Bureau

Under current law, Family Care, Family Care Partnership, the Program of All-Inclusive Care for the Elderly (PACE), and the self-directed services option known as IRIS (collectively known as long-term care programs) provide community-based, long-term care services to individuals who meet certain functional and financial criteria and who are either frail elders or adults with physical or developmental disabilities. In a county where a long-term care program is available, the 2011-2013 biennial budget act (2011 Wisconsin Act 32) caps the enrollment in long-term care programs until June 30, 2013, for a resource center service area at the number of individuals enrolled in those programs in that service area on June 30, 2011, with exceptions for certain individuals relocating from an institutional facility. This bill removes the cap on enrollment in long-term care programs.

Family Care currently is not available in all counties. The 2011–2013 biennial budget act prohibits the Department of Health Services (DHS) from contracting with entities to administer Family Care in a county that does not administer Family Care as of July 1, 2011, unless DHS determines that administering Family Care in that county would be more cost–effective than the current long–term care service delivery mechanism. This bill eliminates the prohibition on expansion of Family Care.

The 2011–2013 biennial budget act allocates moneys for DHS to provide services and support items offered through Family Care to individuals who are on a waiting list for a long–term care program and who are in urgent need of long–term care services, as determined by DHS. This bill eliminates that funding allocation.

Currently, as required by the 2011–2013 biennial budget act, DHS must study various aspects of the cost–effectiveness of the long–term care programs. This bill does not alter that requirement.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 2011 Wisconsin Act 32, section 9121 (1g) (title), (b) and (c) are repealed.

SECTION 2. 2011 Wisconsin Act 32, section 9121 (1g) (a) 4., 6. and 7. are repealed.

SECTION 3. 2011 Wisconsin Act 32, section 9121 (1g) (a) (intro.), 1. to 3. and 5. and 8. are renumbered 2011 Wisconsin Act 32, section 9121 (3g) (am) (intro.) and 1. to 5., and 2011 Wisconsin Act 32, section 9121 (3g) (am) (intro.) and 4. (intro.), as renumbered, are amended to read:

[2011 Wisconsin Act 32] Section 9121 (3g) (am) *Definitions*. (intro.) In this subsection ~~and subsections (2g) and (3g)~~:

4. (intro.) "Long–term care program" means any of the following that are available in a county ~~on June 30, 2011, or the effective date of this subdivision, whichever is later~~:

SECTION 4. 2011 Wisconsin Act 32, section 9121 (2g) is repealed.

SECTION 5. 2011 Wisconsin Act 32, section 9121 (3g) is renumbered 2011 Wisconsin Act 32, section 9121 (3g) (bm).

SECTION 6. 2011 Wisconsin Act 32, section 9121 (3g) (bm) (title) is created to read:

[2011 Wisconsin Act 32] Section 9121 (3g) (bm) (title) *Study.*

SECTION 7. 2011 Wisconsin Act 32, section 9121 (5) is repealed.

(END)

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3761/1
TJD:wlj&med:rs

2011 SENATE BILL 380

January 17, 2012 - Introduced by Senators MOULTON, VUKMIR, CARPENTER, HARSDORF, ERPENBACH, JAUCH, WANGGAARD, RISSER and C. LARSON, cosponsored by Representatives KAUFERT, KESTELL, VAN ROY, BROOKS, DOYLE, A. OTT, ZIEGELBAUER, BERNIER, RICHARDS, STEINBRINK, RIPP, TRANEL, MOLEPSKE JR, GRIGSBY, STONE, ENDSLEY, WYNN, FIELDS, STASKUNAS, JORGENSEN, PASCH, SINICKI, PETRYK, DANOU and SPANBAUER. Referred to Committee on Public Health, Human Services, and Revenue.

AN ACT ***to affect*** 2011 Wisconsin Act 32, section 9121 (1g) (title), (b) and (c), 2011 Wisconsin Act 32, section 9121 (1g) (a) 4., 6. and 7., 2011 Wisconsin Act 32, section 9121 (1g) (a) (intro.), 1. to 3. and 5. and 8., 2011 Wisconsin Act 32, section 9121 (2g), 2011 Wisconsin Act 32, section 9121 (3g), 2011 Wisconsin Act 32, section 9121 (3g) (bm) (title) and 2011 Wisconsin Act 32, section 9121 (5); **relating to:** removing cap on enrollment of Family Care and other long-term care programs.

Analysis by the Legislative Reference Bureau

Under current law, Family Care, Family Care Partnership, the Program of All-Inclusive Care for the Elderly (PACE), and the self-directed services option known as IRIS (collectively known as long-term care programs) provide community-based, long-term care services to individuals who meet certain functional and financial criteria and who are either frail elders or adults with physical or developmental disabilities. In a county where a long-term care program is available, the 2011-2013 biennial budget act (2011 Wisconsin Act 32) caps the enrollment in long-term care programs until June 30, 2013, for a resource center service area at the number of individuals enrolled in those programs in that service area on June 30, 2011, with exceptions for certain individuals relocating from an institutional facility. This bill removes the cap on enrollment in long-term care programs.

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SECTION 4. 2011 Wisconsin Act 32, section 9121 (2g) is repealed.

SECTION 5. 2011 Wisconsin Act 32, section 9121 (3g) is renumbered 2011 Wisconsin Act 32, section 9121 (3g) (bm).

SECTION 6. 2011 Wisconsin Act 32, section 9121 (3g) (bm) (title) is created to read:

[2011 Wisconsin Act 32] Section 9121 (3g) (bm) (title) *Study.*

SECTION 7. 2011 Wisconsin Act 32, section 9121 (5) is repealed.

(END)

A RESOLUTION
In opposition to LRB 3621 which
calls for turning over County
Unclaimed Funds money to
municipalities of origin

WHEREAS, LRB 3621/1 calls for changing the procedure for processing unclaimed funds due to the citizens of Milwaukee County by turning these funds over to the municipality of origin; and

WHEREAS, unclaimed funds are not about municipal funds, they are unclaimed monies due to the citizens of the county; and

WHEREAS, LRB3621 Legislative Bill ignores the reasons why the legislature established the existing statutory unclaimed funds process in the first place; and

WHEREAS, under current State Statutes, the county acts as a disinterested party that functions on behalf of the public to publicize and make an independent good faith effort to return unclaimed funds to their rightful owners; and

WHEREAS, the county's unclaimed funds process is a long and expensive ten-year procedure - with the counties holding the assets and paying the costs of the procedure; and

WHEREAS, In the process of handling unclaimed funds and attempting to find their rightful owners, this county publishes the unclaimed funds listing three times in the Milwaukee Journal or Daily reporter, maintains an available 24-7 look-up and claims forms on the county web site, puts copies of the listings and claim forms in local libraries ready reference desks, and sends out press releases for publication in all local papers. The county keeps detailed unclaimed funds accounts for ten years to prevent duplicate claims and allows citizens to file claims for a period of ten years after publication; and

WHEREAS, counties function as a central location for the public to go for all unclaimed local government funds in the county. The legislature established this practice because if the county did not do so, 20 local units of government would separately do so – thus making people go through the chaos of checking 20 different listings and locations to try to find their money and, if so, the service to the public in this regard would suffer; and

WHEREAS, because the county represents a larger base of all affected taxpayers in the larger community, all resident taxpayers of all the municipalities already, through the county, share in any resulting unclaimed funds that result from this process; and

WHEREAS, LRB 3621 proposes changing the existing process of the county holding the money that is due to county citizens and, instead turns it over to each municipality within 6 months. This change would result in leaving unfunded all the county's paperwork costs, publication and listings costs, and tracking and accounting costs for those funds; and

WHEREAS, while transferring the money that is due to private citizens into the municipality of origin would add new, previously unbudgeted funds to municipal coffers that is not the case for counties. In counties, it would create a hole in the counties' budgets by the loss of these funds and the lack of funding for the process of publicizing and accounting for unclaimed funds monies returned to the municipalities – a hole would have to be covered by and additional property taxes levies to make up for that loss; and

WHEREAS, the county would then have diminished revenue and be forced to recover these costs with a new separate line item tax – thus forcing the county to take money out of the taxpayers' pockets to make up for this loss; and

WHEREAS, all-in-all these proposed changes would result in taking more money out of the taxpayers' pockets not less. It would essentially create a taxing game of musical pockets, putting some money in taxpayers' municipal tax pockets but taking out still more tax money from anther county taxpayers' pocket to make up for it – all with an overall negative impact on the taxpayers; and

WHEREAS, presently, the counties do all the paperwork to notify municipalities and collect the funds. Counties compile all unclaimed funds money and organize it into a central unclaimed funds listing. Counties publicize the individual amounts and the names of the last known claimant in local newspapers, in libraries, and on county websites. Counties process all the refund applications, verifications, and refund checks. And counties also keep ongoing records for a ten year claim period; and

WHEREAS, LRB3621 instead proposes that counties continue to take on all the expenses of processing unclaimed funds and claims; nevertheless, LRB3621 requires that additional paperwork be added to track/balance the separate origin of municipality-submitted private citizens unclaimed funds

and, at the end of a 6-month period, counties must send those private citizens funds to each municipality of origin – and still leaving the county with the responsibility of redeeming unclaimed money claims for another nine and a half years; and

WHEREAS, LRB3621 would unfund many county unclaimed funds-related costs by, after a six month period, transferring unclaimed funds amounts of Milwaukee County citizens to municipalities of origin. Such a move would result in two new line-item taxes to the taxpayers: one to recover the costs of processing, publicizing, accounting costs, paying for municipal unclaimed funds publication, handling claimants recovery and forms and refunds, and another to recoup the hole in county budgets resulting from withdrawing these funds from counties. Thus creating another costly State mandate; and

WHEREAS, LRB3621 would create disparate treatment for State unclaimed funds and county unclaimed funds. It would do so by requiring the counties to return citizen's unclaimed funds to the municipality of origin, while the State unclaimed funds program would not, likewise, return unclaimed funds to the counties of origin (uncashed payroll checks, county/municipality named checks, etc.); now therefore

BE IT RESOLVED THAT Milwaukee County does hereby oppose LRB3621 because it is an unfunded mandate for treatment of unclaimed funds and that withdrawing these funds will create a deficit in current county budget processes; and

BE IT FURTHER RESOLVED, that Milwaukee County's director of Intergovernmental Relations is hereby directed to oppose LRB3621 or its successive AB or SB bill number, if LRB3621 is introduced for consideration in the State legislature.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 01/23/2012

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Unclaimed Funds

FISCAL EFFECT:

☐ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☒ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure		
	Revenue	0	1,188,299
	Net Cost	0	1,188,299
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

In 2011, Milwaukee County took in $2,103,303 in total unclaimed funds, of this amount, $1,188, 299 was submitted by the suburbs. This bill wold effectively maintain our costs in dealing with these unclaimed funds but eliminate the reveneus from the suburban unclaimed funds. This year that loss would amount to $1,188,299

I. Fiscal Summary:

This Contract Participation Agreement would reduce Milwaukee County Unclaimed funds revenues by approximately $1 million every other year

This fiscal note was prepared by the Milwaukee County Treasurer.

DD FISCAL NOTE for unclaimed funds resolution LRB3621 Jan 2012

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Daniel J. Diliberti, Milwaukee County Treasurer

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☒ Yes ☐ No

State of Wisconsin
2011 – 2012 LEGISLATURE

LRB–3612/1
MES:med:rs

2011 BILL

AN ACT ***to renumber*** 59.66 (2) (title); and ***to renumber and amend*** 59.66 (2) (a) 1., 59.66 (2) (a) 2., 59.66 (2) (am), 59.66 (2) (b) and 59.66 (2) (c) of the statutes; **relating to:** authorizing cities, villages, and towns to retain certain unclaimed funds in a public treasury.

Analysis by the Legislative Reference Bureau

Under current law, in every odd–numbered year, each officer of a municipality and county and each clerk of every court of record must provide a report to the county treasurer listing all persons for whom the officer or clerk holds money or security that has not been claimed for at least one year. The county treasurer must then publish a legal notice in a newspaper or other publication once a week for three consecutive weeks (class 3 notice) containing the names and last–known addresses of the owners of unclaimed money or security with a value of at least $10. If the money or security is not claimed within six months, the county treasurer takes possession of the money or security that, was in the possession of both county and municipal officers, and the clerks of courts, and deposits it in the county's general fund. If the money is not claimed within ten years, the money or property becomes the property of the county.

Under this bill, if the money or security is not claimed within six months of the completed publication, a county treasurer takes possession of the money or security that was in the possession of the county officers and clerks of courts and deposits it in the county's general fund, and a municipal treasurer takes possession of the money or security that was in the possession of municipal officers and deposits it in the municipality's general fund. Also under the bill, if the money is not claimed

within ten years, the money or property becomes the property of the county or municipality.

For further information see the ***local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 59.66 (2) (title) of the statutes is renumbered 66.0610 (title).

SECTION 2. 59.66 (2) (a) 1. of the statutes is renumbered 66.0610 (1) (a) and amended to read:

66.0610 **(1)** (a) On or before January 10 of every odd−numbered year, each officer of a municipality and county, and each clerk of every court of record, shall file with the county treasurer of that person's county a written report under oath giving the names and the last−known addresses of all persons for whom any such officer or clerk holds money or security, and which has not been claimed for at least one year, and showing the amount of the money or the nature of the security in detail. A duplicate report shall also be mailed to the department of financial institutions. Upon receiving the reports the county treasurer shall ~~cause to be published~~ publish a class 3 notice, under ch. 985, on or before February 1 of the same year, which contains the names and last−known addresses of the owners of the unclaimed money or security that has a value of at least $10, and shall state that unless the owners call for and prove their ownership of the money or security, within 6 months from the time of the completed publication, the county treasurer will take possession or control of the money or security held by the county treasurer, county officer, or clerk of every court of record, and the municipal treasurer will take possession or control of the money or security held by the municipal treasurer or a municipal officer. At the end of the 6 months from the time of the completed publication, the county treasurer shall

also take possession or control of all money or security of persons for whom ~~an~~ a county officer ~~of a municipality and county~~, and each clerk of every court of record, holds money or security, and the municipal treasurer shall also take possession or control of all money or security of persons for whom a municipal officer holds money or security, and which has not been claimed for at least one year, if the money or security has a value of less than $10.

SECTION 3. 59.66 (2) (a) 2. of the statutes is renumbered 66.0610 (1) (b) and amended to read:

66.0610 **(1)** (b) In counties with a population of 500,000 or more, the county treasurer shall distribute to as many community−based newspapers as possible, that are published in the county, a copy of the notice that is described in ~~subd. 1.~~ par. (a). The county treasurer shall distribute these copies of notices at the same time that he or she causes the notices to be published.

SECTION 4. 59.66 (2) (am) of the statutes is renumbered 66.0610 (2) and amended to read:

66.0610 **(2)** Any money or security of which ~~the~~ a county or municipal treasurer has taken possession or control under ~~par.~~ sub. (1) (a) ~~1.~~ and has had in his or her possession or control for more than one year shall, to the extent possible, be deposited in the county's or municipality's general revenue fund. Money or security that is deposited under this ~~paragraph~~ subsection may remain in the county's or municipality's general revenue fund or may be used by the county or municipality until the money or security is paid or delivered to its owner, or becomes the property of the county or municipality, under ~~par. (b)~~ sub. (3).

SECTION 5. 59.66 (2) (b) of the statutes is renumbered 66.0610 (3) and amended to read:

66.0610 **(3)** If within 10 years from the time any such money or security is delivered to ~~the~~ a county or municipal treasurer the owner of the money or security proves to the satisfaction of the treasurer the owner's right to the possession of the money or security, it shall be paid or delivered to the owner. If no such proof is made, then at the end of the 10−year period the money or property shall become the property of the county or municipality. Nothing in this ~~subsection~~ section shall be construed to deprive the owner of any such property of the owner's right to proceed by court action for the recovery of such money or security from ~~the~~ a county or municipal treasurer.

SECTION 6. 59.66 (2) (c) of the statutes is renumbered 66.0610 (4) and amended to read:

66.0610 **(4)** Any person violating this ~~subsection~~ section shall, upon conviction, be fined not less than $50 nor more than $200 or imprisoned for not less than 30 days nor more than 6 months.

SECTION 7. Initial applicability.

(1) This act first applies to the next succeeding January 10 of an odd−numbered year, except that if this subsection takes effect after October 1 of an even−numbered year, the act first applies to the January 10 of the odd−numbered year which occurs after the next succeeding January 10 of an odd−numbered year.

(END)