March 8, 2018

Secretary Linda Seemeyer
Department of Health Services
1 W. Wilson Street, Room 650
P.O. Box 7850
Madison, WI 53703

Dear Secretary Seemeyer,

We, the undersigned organizations, are writing to share our concerns regarding the process for expanding SSI Medicaid Managed Care to an estimated 28,000 Wisconsinites with disabilities. We have appreciated the opportunity for dialogue with the Department of Health Services to provide guidance regarding the process for expanding Medicaid Managed Care, and the efforts to address previous concerns. Advocates have communicated the concerns in this letter to Jennifer Malcore and Rachel Currans Henry, and appreciate their consideration of the issues raised. However, given the short timeline, we wanted to document the concerns with this letter, and share recommendations for action.

Immediate action is needed given that the next region is Milwaukee County and may impact an estimated 12,000 people with disabilities. We ask that the department extend the timeline for enrollment in additional regions to address our concerns, and request action to address the following:

1. **Notice Issues**
   Provide notice and enrollment packets directly to potential enrollees who have a Social Security representative payee, including in the initial regions where only the representative payee received the notice, enrollment packet and other communications from the state. Currently, people with rep payees are not receiving the notices of mandatory enrollment notice, enrollment packets, or assignment letters. The materials have been sent to the representative payees of SSI recipients, rather than to the individual recipients. It is required under Medicaid law that these potential enrollees themselves receive these documents. The lack of notice is a serious concern. As a result, many individuals who have a representative payee are being auto enrolled in HMOs and may not be aware of their opportunity to choose an HMO in which their medical providers are within the network.

   We ask the department to take immediate action to correct the notice issues for the potential enrollees with Social Security representative payees.
   It is the policy of the Social Security Administration to send all notices to **both** the representative payee and the beneficiary, as verified by the following citations from the Social Security Program Operations Manual System (POMs) and also attached to this letter.
   - GN 03001.015 https://secure.ssa.gov/apps10/poms.nsf/lnx/0203001015
   - NL 00601.010 https://secure.ssa.gov/apps10/poms.nsf/lnx/0900601010

As defined by the Social Security Administration, representative payees provide financial management for the Social Security and SSI payments of beneficiaries who are incapable of managing their Social Security or SSI payments. The representative payee does not have a role in healthcare decisions, unless the SSI Medicaid recipient specifically appoints the representative payee in writing as an authorized representative for their Medicaid benefit.

- We ask the department to provide notices, enrollment packets, and assignment letters directly to all those individuals for which a required notice, packet and/or letter was sent to their representative payee, as required by Medicaid law.
- For individuals with representative payees in regions for which mailings have not yet been sent, the department should obtain the individuals' mailing addresses to use for the notice, enrollment packet and assignment letter mailings, instead of the representative payee contact information.
- For those individuals who have already been auto-assigned, materials should be sent directly to them, the auto assignment designation should be removed where it has occurred, and those individuals should then receive a 12 week enrollment period prior to auto-assignment (as discussed below) to choose an HMO.

2. **Enrollment Issues**
   a. **Extend the timeline for managed care expansion to allow sufficient time for members to receive options counselling and make an informed choice about enrollment.** Currently individuals have about 6 weeks to select an HMO. The voluntary enrollment rate in the two regions affected so far has been very low – only 38% have made an active HMO choice. Over 60% of members have **not** chosen an HMO and have been assigned an HMO without making an informed choice. This is not acceptable.

   Although the department finds this low rate of 38% of SSI members acceptable because it is comparable with BadgerCare, the needs of these populations are not comparable. By definition, the SSI Medicaid population consists of individuals who have a disability determination and severe impairments. Eligibility for BadgerCare is determined based on financial criteria and does not require any type of medical eligibility. The majority of individuals in SSI Medicaid have a significant reliance on the services funded by Medicaid to maintain their health, independence, and ability to live in the community.

   Since the majority work with multiple providers, adequate time must be provided to see which of their providers are in HMO networks. Failure to make an informed choice about an HMO can put SSI members at serious risk by causing disruptions in personal care, specialty care such as dialysis or chemotherapy, mental health services, or other vital supports, resulting in risk to the health and even the lives of members. Therefore, immediate action is needed to extend the timeline before auto-assignment. **The current 6 weeks should be extended to 12 weeks to allow members to receive the support and enrollment counselling that is needed to ameliorate these concerns.**

b. **Extend the time period for open enrollment for members to change HMOs, as well as extending the continuity of care guarantee.** After members are auto-enrolled in an HMO or have chosen an HMO, they have only 90 days to make a change, and are then locked into an HMO for nine months. Given the low rate of individuals who have made an active choice of an HMO, the high numbers of individuals being required to select an HMO during this roll out, and the significant reliance SSI members have on access to Medicaid services, the open enrollment period of 90 days should be extended by a minimum of four weeks.

   In addition, the continuity of care guarantee should also be extended an additional four weeks. The other major Wisconsin Medicaid managed care program for people with disabilities is Family Care; Family Care members can change their HMO at any time during the year. The 90 day period for SSI Medicaid is far too restrictive.

3. **Personal Care Reimbursement and Network Adequacy**
   Require HMOs to honor the legislative intent of the biennial budget personal care rate increase in their reimbursement rate for these services. Wisconsin is experiencing a crisis with access to personal care, with a shortage of workers and agencies closing due to inadequate funding. Recognizing the magnitude of this problem, the biennial budget approved last year included a 2% increase for Medicaid personal care services.

   We are concerned that Medicaid HMOs are not required to honor the 2% increase for personal care and that some HMOs choose to give a lower rate. Personal care provider agencies are already struggling and many are unable to accept a lower rate. This will further erode the provider network and put SSI Medicaid members who rely on personal care at risk. In the past, access to personal care providers has been one of the reasons cited for individuals to opt out of SSI Medicaid managed care. This has also been due to concerns about network adequacy, including access to culturally competent personal care providers who were not in the HMO networks.

   - Therefore, the Department should require all HMOs to increase their personal care reimbursement rate by 2% as approved in the biennial budget.
   - The department should also require HMOs to assure culturally competent networks, including personal care providers, and include this access in the outcomes.

Much of the communication regarding these changes and enrollment—which includes navigating which providers are available in which networks—is being conducted over the phone. We find this approach to be extremely problematic. Low-income individuals often rely on pre-paid phone plans for their telephone access. An enrollment process that demands participants consider many factors to truly weigh options and make an informed choice is time consuming, may necessitate several calls and may use up an individual's minutes without them being able to complete the task.

Participants who are hard of hearing, those without access to their own individual phone line, those with speech challenges, and people with cognitive challenges may all be negatively affected if a phone is the only mechanism available to complete enrollment. It is encouraging to learn that some HMOs are doing in-person outreach in the community to support their members. We request that all members be offered the choice of in-person options counselling.

We ask the department to extend the enrollment timeline and work with stakeholders to address these concerns. We stand ready to partner with you.

The Arc Wisconsin, Lisa Pugh, Executive Director
Community Advocates, Inc., Andi Elliot, Chief Executive Officer
Community Living Alliance, Inc., Todd Costello, Executive Director
Dayton Care Center, Nicole Johnson, B.A. Admission Discharge Coordinator
Disability Rights Wisconsin, Daniel Idzikowski
Greater Wisconsin Agency on Aging Resources, Inc., Robert J. Kellerman, Executive Director
Guest House of Milwaukee, Cindy Krahenbuhl, Executive Director
Hope House of Milwaukee, Wendy Weckler, Executive Director
IndependenceFirst, Deb Langham. Chief Operating Officer
Independent Living Resources, Inc. Kathie Knoble –Iverson, Executive Director
Jewish Family Services, John A. Yopps, President & CEO
Kenosha County Long Term Care Workforce Alliance
Mental Health America of Wisconsin, Shel Gross, Director of Public Policy
Milwaukee Mental Health Task Force, Mary Neubauer & Kelly Davis, Co-chairs
Milwaukee Shelter and Transitional Housing Task Force, Wendy Weckler, Chair
NAMI Wisconsin, Crystal Hester, MSW, Public Policy & Advocacy Director
Society's Assets, Inc, Amy Mlot, Public Relations Director
Survival Coalition of Wisconsin Disability Organizations
Whole Health Clinical Group, John Chianelli, Vice President and Executive Director
Wisconsin Board for People with Developmental Disabilities, Beth Swedeen, Executive Director
Wisconsin Coalition of Independent Living Centers, Inc., Maureen Ryan, Executive Director
Wisconsin Community Services, Clarence Johnson, Executive Director
Wisconsin Personal Services Association, Darci Knapp, WPSA President

Copy:
Heather Smith, Medicaid Director
Jennifer Malcore, Assistant Deputy Secretary
Rachel Currans-Henry, Director, Bureau of Benefits Management

Social Security Programs Operations Manual System (POMS): Citations Regarding SSA Notice for Individuals with Representative Payees

GN 03001.015 https://secure.ssa.gov/apps10/poms.nsf/lnx/0203001015
NL 00601.010 https://secure.ssa.gov/apps10/poms.nsf/lnx/0900601010

NL 10601.210
BASIC (09-15)

NL 10601.210 Who Receives Our Notices?

SSA sends notices for a wide number of programs that we administer. The programs include:

- Title II
- Title XVI
- Title VIII (Special Veterans Benefits), and
- Medicare

We send notices to people who apply for benefits and to the beneficiaries and recipients who get benefits. We also send notices to representative payees, appointed representatives, and third parties, such as employers.

GN 03001.015 Notices Required Before And After Taking A Title II Adverse Action

A. Policy - Advance Notice

An advance due process notice must be sent to the beneficiary/claimant and/or representative payee before an adverse action is taken when:

- A third party report is received which results in an adverse action, or
- An event discovered by SSA results in an adverse action.

  An advance notice of change in representative payee is NOT sent to beneficiaries living in foreign countries. The final notice in those cases must include a full explanation of appeal rights. (See GN 00505.044)

  See GN 00503.100 for the policy on sending an advance notice in representative payee situations to an adult or legally emancipated child.

1. Notice Content

If the beneficiary/claimant has a payee, send the notice to the representative payee and the beneficiary/claimant. The notice must state the:

- pending adverse action,
- reason for the action,
- the evidence used to make the determination,
- effect on benefits, and
- the number of days the beneficiary has to respond before SSA takes action.

SI 02301.300 Due Process Protections – General

D. Policy - General

1. Recipients' Rights

GK procedures provide recipients with:

- a written advance notice of an adverse action, **and**
- time to question and appeal the action before it occurs, **and**
- the right to a formal conference at the reconsideration level of appeal, **and**
- the right to continue receiving unreduced benefits **until** there is a decision at the first level of appeal.

Individuals may **not** waive written advance notice of an adverse action, but they may waive their right to payment continuation in writing (see SI 02301.310). They may also choose a case review or an informal conference instead of a formal conference (see SI 04020.020B.7.).

2. Who Receives Advance Notice

These individuals receive an advance notice:

- Legally competent adult recipients
- Representative payees
- Both members of an eligible couple when the action reduces the total couple's payment and **changes the payment amount to each** (even if the result is an increased payment to one member)
- Appointed representatives and legal guardians. (See NL 00801.001 about Supplemental Security Income (SSI) notification policy and procedures.)