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November 26, 2001

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

Under the terms of a contract with the Legislative Audit Bureau, the Lewin Group has completed its second report on implementation of the Family Care Pilot program. Its first implementation report was released in November 2000. The Legislature authorized the Family Care program—a redesign of Wisconsin's long-term care system for the elderly and adults with physical and developmental disabilities—in 1999 Wisconsin Act 9. Act 9 also directed the Audit Bureau to contract with an organization other than an agency of the State to evaluate the pilot program. In addition to the enclosed report, the Lewin Group will provide a report on the program's impact and cost-effectiveness, as well as additional reports on program implementation, in the 2001-03 biennium.

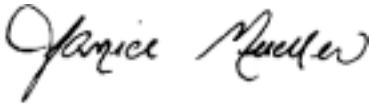
The Family Care program is being piloted in nine counties. Jackson, Kenosha, Marathon, and Trempealeau counties operate Resource Centers, which provide information and referral services to both consumers and providers of long-term care services. Fond du Lac, La Crosse, Milwaukee, Portage, and Richland counties operate both Resource Centers and Care Management Organizations (CMOs), which coordinate care and manage capitated payments for those determined to be eligible for the Family Care benefit. Expenditures for the Resource Centers and CMOs totaled $32.2 million in calendar year 2000; expenditures are expected to increase in 2001 as enrollment is projected to increase from 2,875 individuals in March 2001, the first quarter in which all five CMOs were operational, to 5,100 individuals by the end of 2001.

The Lewin Group notes that since November 2000, the Department of Health and Family Services and the pilot counties have made considerable progress in implementing Family Care, although the counties are at different stages in terms of program processes, capacity, and enrollment. In January 2002, the counties will implement a final program element, an independent enrollment broker, as proposed by the Department and approved by the federal government. The Lewin report points out a number of areas that need to be addressed as the pilots continue, including outreach, provider relations, care management, quality assurance, and cost.

We appreciate the cooperation and courtesy of the Department of Health and Family Services and the many county staff, citizen members of long-term care councils, and provider representatives

who have worked with the Lewin Group throughout the evaluation process. The second implementation report is available on our Web site at *www.legis.state.wi.us/lab,* or it can be obtained by contacting our office at (608) 266-2818.

Sincerely,



Janice Mueller
State Auditor

JM/KW/bm

Enclosure

FAMILY CARE PILOT PROGRAM

Family Care was created in 1999 Wisconsin Act 9 as a redesign of the State's long-term care system. The program, which is administered by the Department of Health and Family Services, is currently being piloted in nine counties. Its goals include eliminating problems related to long-term care, such as a perceived bias toward institutional care, and streamlining a fragmented and often confusing array of funding streams for services. The Family Care model creates two new community organizations: Resource Centers to provide "one-stop" shopping for information and assistance for the elderly and physically and developmentally disabled, and Care Management Organizations (CMOs) to help arrange and manage services for those determined eligible for program services. The program also uses managed care principles, including capitated payments, to help control costs.

The legislation authorizing Family Care required an independent evaluation of the program to be administered by the Legislative Audit Bureau. In 1999, the Lewin Group was awarded a contract for this evaluation, which is being performed in three stages. The Lewin Group has submitted its second report on program implementation, and we have summarized its findings in eight principal areas. A report on the program's impact and cost-effectiveness is expected in September 2002.

Infrastructure Development

The Lewin report outlines the roles and functions of the various agencies administering Family Care in the pilot counties. It indicates a total of 40.5 full-time equivalent employees have been hired in the four counties operating Resource Centers, and staffing ranges from 8.9 positions in Jackson County to 18.6 in Kenosha County. In the five counties operating both Resource Centers and CMOs, staffing totals 313.2 full-time equivalent positions, ranging from 19.3 in Richland County to 174.9 in Milwaukee County.

Increased demands on the economic support staff who determine whether applicants meet financial eligibility criteria has emerged as a key infrastructure development issue in Family Care. Economic support staff determine eligibility and track information for a number of programs in addition to Family Care, including Wisconsin Works (W-2) and the Food Stamp program. While Family Care participants remain a small portion of the caseload, the proportion of the caseload they represent more than doubled in Portage, La Crosse, and Fond du Lac counties since the start of Family Care in those counties.

The Lewin report indicates that counties have made progress in their efforts to use information technology effectively. It reports that spending on information technology related only to CMO operations totals $2,064,348, and information technology expenditures represent 32.1 percent of all Family Care start-up funds. The report also notes that each county has taken its own approach to information technology, and each has a different information technology system in place for the Resource Center and CMO functions. For example, although a software application provided by the Department ensures uniform statewide application of the level of care calculation that is a required part of eligibility determinations, Resource Centers have either added to information and referral software they had in place prior to Family Care or purchased software designed

specifically for the tracking of contacts, program and service information, referrals, and outcome activities. The Department has appropriately encouraged the sharing and transfer of systems technology among the counties.

Governance

In approving the federal waivers that allowed the Family Care pilots to be created, the federal government expressed concern about the potential for a conflict of interest if the one entity responsible for all aspects of eligibility determination and enrollment—the county—were to have an incentive to restrict care or limit eligibility. In response, the Department submitted a waiver proposal to the federal Center for Medicare and Medicaid Services (formerly the federal Health Care Financing Administration) that addressed the apparent conflict by introducing an independent enrollment broker function to ensure that participants receive unbiased information about available program services. The proposal was approved, and the enrollment broker function is to be implemented by January 2002.

The Lewin report notes, however, that the enrollment broker function creates concerns that include another administrative entity for consumers enrolling in Family Care, and a need for additional administrative funding. The Department will need to provide specific guidance to the counties on the role of the broker and to develop the contract with the broker. The report also notes that implementation of the enrollment broker function will increase the importance of electronic information exchange and good working relationships among the Resource Centers, CMOs, and economic support staff who make program eligibility determinations.

Outreach

The Lewin report indicates that Resource Center staff are meeting their goals for contact with the elderly and physically disabled, and all but two counties are meeting contract goals for individuals with developmental disabilities. For the period from February 2000 through March 2001, contacts in the nine counties ranged from 4,500 in April 2000 to 6,200 in February 2001. The report also indicates that the most common outcome of these contacts has been information dissemination (51 percent). Only 14 to 15 percent of all contacts resulted in referral to the Family Care functional screen, which is the first step in determining eligibility for the Family Care benefit.

Outreach is a costly and time-consuming activity, and the Lewin report notes that the counties unanimously reported inadequate Resource Center funding given the scope of their contract requirements. Three counties were observed to have suspended outreach activities because of the volume of the contacts. The Lewin Group suggests the Department continue to monitor Resource Center activities to ensure services are not limited.

Access to Benefits

The Lewin report notes that the success of the pilot program depends on the efficient management of services and costs. The pilot counties are addressing administrative issues, but the report states

that access to care has improved, particularly when measured by elimination of waiting lists for community-based care. Waiting lists have been eliminated in Fond du Lac, Portage, and La Crosse counties. Milwaukee County plans to eliminate waiting lists by December 2001, and Richland County's goal is July 2002.

The Lewin Group also examined the extent of new enrollment in Family Care, defined as being entered in the system and receiving CMO services. It reported that enrollment increased dramatically with the start-up of CMOs. The report notes, however, that some counties have implemented a "delayed enrollment" status, which means individuals will begin receiving services soon after being found eligible—but not immediately—because the CMO is not prepared to begin providing services. In essence, Fond du Lac, La Crosse, and Richland counties have slowed enrollment because of CMO capacity limits, such as the need for additional staff.

CMO employees hired as provider network developers are charged with developing a CMO's capacity to provide care management services within a county. The report notes that with the exception of La Crosse County, counties have complied with the requirement that CMOs devote a staff position to network development. Variations exist among the counties in terms of which providers are in short supply, but the report indicates a shortage of personal care providers is a problem statewide. In Fond du Lac County, the longest-running pilot project, shortages in community-based residential facilities and adult family homes for the elderly are also noted. Providers with whom the Lewin Group met generally reported a positive working relationship with the CMOs.

The Lewin report notes that it is too early in the implementation of Family Care to attribute reductions in nursing home use to the program because outcome data are not yet available. The report states, however, that the Department must develop a definition of diversions from nursing home placement because the federal waivers require Family Care cost-effectiveness calculations to include semi-annual tracking of diversions. Some nursing home closings are reported to have resulted in individuals being placed successfully in the community in Milwaukee, Portage, and Fond du Lac counties.

Providers reported a number of administrative issues of concern. For example, many providers would appreciate prior authorization instructions. Providers also indicated that the prior authorization process is burdensome for small items. Finally, although the providers reported that Family Care is administratively simpler than the State's long-term care system, they indicated it presents financial uncertainties because another referral is not guaranteed when a Family Care participant disenrolls or dies.

Care Management

The Lewin report notes that Family Care has created the conditions necessary for achieving choice in types of care, but it is too early to know whether both participant preferences and cost-effectiveness goals can be met through the Family Care care management system. The report describes, in some detail, the care management approach taken by the pilot counties, and it notes that varying methods and strategies have emerged. However, which approach might be most effective cannot be determined at this time. Caseloads per care manager are smaller than

caseloads had been before Family Care, but care managers' increased responsibilities in areas such as quality assurance and cost, as well as a greater emphasis on involving participants in care decisions, demand an intensive administrative time commitment.

The Lewin report also notes that care management in an acute, emerging situation is challenging and that more can be done to ensure continuity of care when a participant is discharged from a hospital. However, providers reported generally good working relationships in planning for ongoing care. For example, although providers are generally not involved in developing an individual service plan for each program participant, they may be closely involved in developing subsequent changes in care plans.

Family Care represents a change in practice for care managers in that there is now an increased emphasis on costs. A resource allocation decision method instrument developed by a work group of Department of Health and Family Services staff and care managers is designed to balance consumer preferences, outcomes, and costs. Training in the instrument has been provided in all pilot counties at least twice, and all counties report using it—although the Lewin report notes differences in how it is used. The report notes that the interdisciplinary team model inherent in Family Care is time-intensive, but it shares findings from other national studies that suggest long-term savings can eventually be generated by more intensive administrative planning time.

Consumer Direction and Advocacy

Consumer direction is described by the Lewin Group as providing a spectrum of financing and delivery models that allow program participants varying amounts of choice and control over decision-making regarding their long-term care. Experience in Wisconsin with self-directed care in programming for persons with developmental disabilities helped to provide the framework for the design of Family Care. All CMOs are required, by contract, to have self-directed options in place by January 2003. It is the self-directed support option that counties report as the focus of their activities relative to consumer direction.

The Lewin Group reports that the self-directed support option has been used in Milwaukee, Portage, and La Crosse counties, although on a limited basis. In these counties, a fiscal intermediary is available to provide the fiscal and administrative functions of an employer, while the program participant is involved in the selection of the provider and the scheduled provision of services. Providers indicated that they may direct future marketing efforts more toward consumers. Participant representatives reported to the Lewin Group that they believe a greater range of choices is provided to them under Family Care, but they continue to seek greater choice and options.

Quality Assurance and Improvement

The Family Care program represents a shift in quality assurance efforts for long-term care, and counties report that they are addressing newly raised quality issues by, for example, assessing participant satisfaction and monitoring the quality of the functional screens that are used in making eligibility determinations. CMOs also provide oversight of the quality of services offered

by providers. The Lewin Group found that the counties are generally at the early stages of communicating quality standards to providers, but some providers reported an increased emphasis on quality in their contracts with the CMOs.

The Department assessed 14 desired program outcomes through interviews with program participants and care managers. From November 2000 to January 2001, 355 participants in the counties of Fond du Lac, Portage, La Crosse, and Milwaukee were interviewed. The Department found that 43.1 percent of the participants it interviewed had chosen the services they were receiving, and 78.0 percent of participants were satisfied with the services they received. As expectations rise through an emphasis on consumer choice, Family Care managers will be watching to see whether reported satisfaction and the related outcomes change.

Capitation and Program Expenditures

Total expenditures for the Resource Center and CMO portion of Family Care totaled $32.2 million in calendar year 2000. Expenditures are expected to increase significantly in 2001, as CMO enrollment is expected to increase to approximately 5,100 by December 2001. It should be noted that these costs exclude the Department's administrative costs and the costs of certain services paid directly by Medical Assistance, including hospital services, physician services, pharmaceuticals, and certain other benefits.

The managed care component of Family Care requires the payment of fixed-capitated rates for participants. In calendar year 2000, the final capitation rates ranged from $1,467 in Milwaukee County to $2,436 in Portage County; in calendar year 2001, they range from $1,656 in Milwaukee County to $2,584 in Portage County. The Lewin Group notes that additional experience in the pilot counties will answer questions the counties raise about the adequacy of the capitation rates. Its impact and cost-effectiveness report will address the issues related to capitation rates more extensively. However, counties that spoke with the Lewin Group expressed concern that the capitated rates do not adequately address the intensive administrative and information technology costs associated with Family Care. The Lewin report includes a number of potential comparisons for determining the adequacy of the administrative component of the rate.

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Wisconsin Family Care Implementation Process Evaluation Report II

Final Report

Prepared for:

Wisconsin Legislative Audit Bureau

Prepared by:

The Lewin Group

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August 13, 2001

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APPENDICES

EXECUTIVE SUMMARY

Since the first implementation report in November 2000, the Department and the Family Care pilot counties have made considerable progress in implementing the program. Richland County has now joined Fond du Lac, Portage, La Crosse and Milwaukee counties in full implementation of the Family Care model with a Care Management Organization. At least three of the first four counties have moved from enrolling existing waiver cases to enrolling substantial numbers of new members. Interdisciplinary care management teams are also in place to facilitate service delivery in all of the CMO counties. However, the Family Care pilots are at different operational stages in terms of processes, capacity, and enrollment. The overall principal findings of implementation progress are as follows:

A. Infrastructure

The relationships among the Care Management Organization (CMO), Resource Center (RC) and the Economic Support (ES) Unit surfaced as a crucial component in the intake and enrollment process for Family Care. Integration with Economic Support Units in the pilot counties, the entity responsible for financial eligibility screening, was complicated by the unit's position within a separate state division from DHFS. DHFS was therefore limited in its ability to forecast the significant workload strain on the county Economic Support Units. Pilot counties have had to work to foster the coordination among the CMO, RC and ES. All counties now have ES workers specializing in Family Care related eligibility to increase productivity and improve communication. The optimal physical location for the unit remains unclear. IT system integration aids in information transfer between the three entities and has a potential impact on efficiency and effectiveness of the enrollment process as well.

B. Governance

The Centers for Medicare & Medicaid Services' (CMS)[1] guidance on the governance issue continues to dominate many aspects of the future of Family Care. CMS has approved DHFS' request for a 1915 b/c waiver combination with the inclusion of an independent enrollment broker to curb the potential of having the same entity, currently counties, ultimately responsible for all aspects of eligibility determination and enrollment. It remains to be seen what effect this solution to the conflict of interest will have on consumers who will be channeled through yet another person in the pathway to Family Care membership.

C. Resource Center Outreach

RCs continue to conduct effective outreach to individuals who would benefit from information about long-term care options. In CMO counties, they also provide outreach and intake related to the CMO benefit. Aggressive outreach efforts have been halted by some CMO county RCs due to the overwhelming staff resources needed to respond to functional screen requests. RC staff in CMO counties raised concerns about their ability to provide sufficient attention to RC functions other than CMO intake.

[1] Agency formerly known as the Health Care Financing Administration (HCFA).

D. Access to CMO Services

CMO counties clearly serve a greater number of individuals in the community than prior to Family Care. The promise of elimination of traditional waiting lists with Family Care has been realized in Fond du Lac, Portage and La Crosse. Richland and Milwaukee work to steadily decrease their waiting lists. However, Fond du Lac, La Crosse and Richland have had to slow new enrollments due to capacity constraints. Monthly new enrollments have yet to reach a steady state in most counties. All of the counties continue to develop their provider networks and the Department continues to monitor the capacity of the CMO provider networks.

E. Provider Relations

Provider and consumer representatives reported increased access for some consumers. Providers indicated the new administrative burden as minimal and expressed commitment to resolve issues with the county CMOs. The counties are still working through some administrative issues related to service provision, particularly prior authorization.

F. Care Management

Family Care's revised approach to care management has yet to demonstrate that it can meet both goals of consumer preferences and cost-effectiveness. The CMO counties have made great strides in implementing the interdisciplinary team with increasing participation of consumers and providers. Care management teams have also begun to employ the Resource Allocation Decision Method (RAD) to balance cost and consumer need. Care management under Family Care can be time-intensive and CMOs have responded to this by setting individual goals for caseloads size by population. Only Richland and Portage (elderly/PD) CMOs have met target goals for caseloads. The role of the RN within the care management team has moved beyond initial assessment.

G. Consumer Direction

Family Care has embraced a large part of the spectrum of consumer direction. The CMO contract, DHFS quality assessment tool, and the Self-Directed Support (SDS) option all contain supports for varying levels of consumer direction -- from selecting support workers and providers to assuming some employer functions. Most of the pilot county efforts have centered on the development of the SDS option from the general guidelines provided by DHFS. Portage, La Crosse, and Milwaukee all have consumers using the option. According to program stakeholders, marketing, consumer support, safety, accountability, and support from the community are all essential parts of building an effective SDS option.

H. Quality Assurance/ Improvement

The Department has committed substantial resources to the quality design of Family Care and devised a comprehensive strategy that is now being integrated with county approaches. A major tenet of the Department's philosophy of quality in Family Care directs responsibility and accountability as close to the consumer as possible. Therefore, the state has encouraged pilots to assume a high level of responsibility and has also provided avenues for consumers to assume responsibility through internal advocacy, governing boards, County Long Term Care Councils and grievance procedures. Many resources are being committed to an assessment of program quality through the Member Outcome Tool. The tool, in keeping with leading-edge research in long-term care quality, measures consumer outcomes from the consumer's perspective instead of program procedures traditionally measured in assessments of program quality.

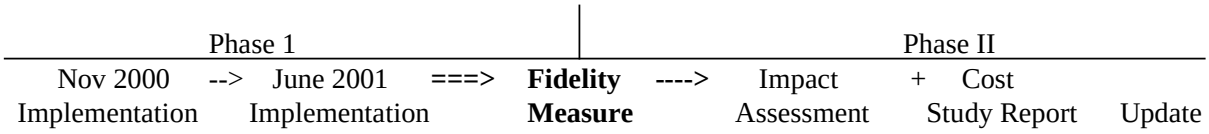
I. Program Expenditures

Due to retrospective rate calculations, all of the counties returned money to DHFS at the end of 2000. However, the majority of program expenditures, as expected, in the CMO counties supported per member per month payments for services coordinated through the CMO. The remaining expenditures supported start-up costs and RC activities equally. Information technology costs comprised nearly one-third of the start-up costs. DHFS has included seven percent in the capitated rate for CY 2001 for administration and another two percent for the devolution of state activities to the county. After gaining more operating experience, the CMOs will need to assess whether the amount allocated for administration adequately covers fixed and variable administrative expenses.

I. INTRODUCTION

A. Purpose of Report

The Lewin Group is in the process of conducting a two-phase evaluation of Family Care. This evaluation involves three distinct parts: 1) an **implementation process** evaluation, which focuses on documenting how the Family Care Program is being implemented in the five full model pilot counties; 2) an **impact** evaluation that will assess the system and individual level outcomes of Family Care; and 3) a **cost-benefit study** that will serve the interests of the State and provide an initial basis for the Center for Medicare and Medicaid Services' (CMS) independent review requirements.



This report serves as an update to The Lewin Group's November 2000 evaluation of the implementation of the Family Care program. It also marks a transition from Phase I to Phase II of the Lewin evaluation. Although we conclude that the Family Care pilots are at different operational stages in terms of processes, capacity, and enrollment, this report documents the progress they are making to this end. The goal of this report is to establish a baseline for assessing key aspects of the implementation process among the pilot counties. As Phase II of the evaluation begins, this report presents a measure of program progress/stability in the Family Care pilot counties. Data gathered and analyzed in Phase II will be examined with respect to this measure.

1. Phase I

The primary activity during Phase I of the evaluation was to monitor and assess the process of how the Family Care Program is being implemented in the five counties that are implementing both components of the Family Care model – Resource Centers (RC) and Care Management Organizations (CMO). The process evaluation of implementation examined program organization, service delivery, context, and other key data elements to assess the effectiveness of implementation and identify lessons that can assist in replicating the program in other parts of Wisconsin, as well as in other states. The process evaluation also will inform the impact and cost-effectiveness evaluations.

The Lewin Group began conducting the Phase I evaluation in February 2000. The first Implementation Process Report submitted to the Governor on November 1, 2000 involved the establishment of baseline information on the major structural features of the program, as well as a preliminary assessment of procedural and structural program information. The report can be found at http://www.legis.state.wi.us/lab/reports/00-0famcaretear.htm

This second Implementation Process Report marks the transition into Phase II of the evaluation, which will involve program impact and cost studies. After this report, The Lewin Group will continue monitoring the process of program implementation throughout Phase II; however, the

emphasis of the analyses will shift from process issues toward implications related to program outcomes.

An important evaluation objective of Phase I is to determine the degree of program stability prior to beginning the Phase II impact assessment. To this end, we have developed a measure of Family Care program fidelity that will enable us to ascertain the extent to which the counties have established programs that adhere to the legislative and programmatic requirements of the Family Care model and the range of innovation across counties. This measure, described in more detail in ***Section III. Methodology***, incorporates the key structural and programmatic components of the model. Programs will be considered stable if they have implemented the minimum features or levels of service required within each domain.

2. Phase II

The level of program stability as documented using the fidelity measure at the end of Phase I of this evaluation will inform the subsequent **impact evaluation phase**. We expect the measure to evolve as implementation matures and the pilot counties reach greater program stability. The impact phase will assess the extent to which the program is meeting overall goals of Family Care. These goals include:

- Preventing or delaying declines in functioning and the need for long-term care services;
- Promoting the efficient use of services to increase the number of individuals for whom long term care (LTC) services will be available; and
- Facilitating access to appropriate use of LTC services and supporting consumer choice; providing quality services to foster consumer independence, enhancing knowledge and dignity, and ensuring consumer safety.

In addition to the program impact assessment, Phase II will involve a **cost-benefit study** to assess the extent to which program benefits justify program costs. This cost-benefit assessment will include both quantitative and qualitative data and incorporate, to the extent possible, the viewpoints of all the major stakeholders involved in Family Care, including program participants, the State, the CMOs and RCs, as well as the general public not involved directly in Family Care. Analyses will include both present and future estimates of costs and benefits. Additionally, in accordance with the legislative requirements for the evaluation, the cost-benefit study will include a comparison between Family Care and nursing facilities. This assessment will yield aggregated comparisons at the program and facility levels, controlling for the case mix of consumers served. During the Phase II evaluation period, we anticipate submitting reports in June 2002 and September 2002. A brief update will also be provided in January 2003.

II. OVERVIEW

A. Progress of Pilot Counties

The Department of Health and Family Services (DHFS) was authorized to pilot the Family Care Program in five counties by 1999 Wisconsin Act 9. Currently, five counties are operating Care Management Organizations (CMOs) and nine counties are operating Resource Centers (RCs) (see ***Exhibit II-1***). Fond du Lac, Portage, La Crosse and Milwaukee Counties began CMOs, signifying full implementation of Family Care during CY 2000. These counties have all been operating as CMOs for at least a year and three have moved from enrolling existing waiver cases to enrolling substantial numbers of new members. Interdisciplinary care management teams are also in place to facilitate service delivery in all of the CMO counties. Richland started a CMO in January 2001. Kenosha and Marathon Counties both plan to begin CMOs contingent upon available funding. Jackson and Trempealeau are currently piloting the RCs, but are not planning to pilot the CMOs at this time. The start of a CMO and RC in Forest, Vilas, and Oneida Counties, known as the Human Service Center, also depends on future funding. The budget for the next biennium provides for an expansion of Family Care to Kenosha.

Exhibit II-1
Start Dates of Family Care RCs and CMOs in Pilot Counties

County	RC	CMO
Fond du Lac	1999	Feb. 2000
Jackson	1999	
Kenosha	1999	
La Crosse	1999	April 2000
Marathon	1999	
Milwaukee	1999	July 2000
Portage	1999	April 2000
Richland	2000	Jan. 2001
Trempealeau	1999	

B. 1915 (b)/(c) Waiver Combination

In order to operate a program using capitated payments for services and providing services in the home and community, the Department had to apply for a 1915(b)/(c) waiver combination from Medicaid (see ***Exhibit II-2***). The 1915(b) waiver mandates Medicaid enrollment into managed care, uses a "central broker", and limits the number of providers for additional services. The 1915(c) waiver allows the Department to provide long-term care services as an alternative to institutional placement with a more generous income criteria. Both waivers eliminate the requirement for state-wideness and comparability of services. The (b)/(c) waiver combination affords the Department the opportunity to offer home and community based services to an expanded population with the 1915(c) waiver through a managed care system with the 1915(b) waiver.

Exhibit II-2
Requirements Waived by the 1915 (b) and 1915 (c) Waivers

b/c Waiver Combination	
Freedom of choice 1915(b) Waiver	Home and Community Based 1915(c) Waiver
State-wideness	State-wideness
Comparability of services	Comparability of services
Freedom of choice	Community income and resource rules for the medically needy

CMS recently approved the Department's request for two 1915(b) waivers - one for Milwaukee County and one for Fond du Lac, Kenosha, La Crosse, Portage, and Richland counties. The waivers, effective for two years, will begin January 1, 2002. The 1915 (c) waiver was also approved June 1, 2001 for three years.

III. METHODOLOGY

This report is an update of the November 2000 report prepared by The Lewin Group and examines the implementation progress of Family Care from the November baseline through the end of May 2001, using information collected from:

- Site-visits;
- Telephone communication;
- Review of the documentation and data provided to us by DHFS and the Family Care pilot counties; and
- Provider telephone interviews.

A. Site-Visits

1. Timing and structure

The Lewin Group conducted site-visits during the week of May 14 through May 18, 2001. During this week, we visited the pilot counties currently operating both a CMO and a RC: Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. In each pilot county, we met separately with a group of staff representatives from the CMO and RC. The RC and CMO groups consisted of management staff and in some cases, direct service workers.

We also interviewed a group representing each county's Long Term Care Council, with the exception of Portage, for about an hour and a half. In Portage, the Long Term Care Council had only recently been appointed, so we met with consumer and provider representatives designated by the CMO staff.

In addition to county representatives, we met with State staff from the Center for Delivery Systems Development and representatives from the State Long Term Care Council. A list of interviewees appears in ***Appendix A.*** The remaining site-visit is scheduled to occur in the Spring of 2002.

2. Development of the Fidelity Measure

During the first year of monitoring the implementation of Family Care, the Lewin team identified and collected data pertaining to at least eight core domains that appear fundamental to the program and are required Family Care contract elements. These core domains are: 1) System Structure; 2) Governance; 3) Outreach; 4) Service Access; 5) Care Management; 6) Consumer Direction; 7) Quality; and 8) Capitation. The first Lewin report presented baseline information on each of these core domains. The information served as a basis for developing a "fidelity measure." The fidelity measure is an evolving measure of the extent to which counties and the state adhere to the central tenets of the Family Care model. The development of this measure will serve the following purposes:

1) Enable the measurement and assessment of program stability prior to the impact evaluation;

2) Ensure the systematic tracking of program progress and structure throughout the evaluation period (Phases I and II);

3) Enable cross-county comparisons on the core program domains and components;

4) Provide a foundation for systematically integrating and analyzing data from the various data sources involved in the evaluation;

5) Provide the Department with an empirically derived and tested measure that can be used in monitoring on-going and future efforts to implement and replicate the Family Care program; and

6) Create variables of program structure that can be used in the analyses of program outcomes.

In collecting data for this report, we sought information at the county site-visits about progress in relation to the core domains of the fidelity measure. The fidelity measure informed the creation of protocols for the interviews with the CMO staff, RC staff, and representatives from the county Long Term Care Councils. Prior to the site-visits, The Lewin Group forwarded a draft of the CMO protocol to LAB and DHFS for comment. Suggested changes were incorporated and also were used to revise the protocols for the RC staff and the county Long Term Care Councils (copies of the protocols appear in ***Appendix B.***). Prior to the site visits, copies of the protocols were sent electronically to each pilot county to facilitate meeting preparation.

It is important to note that the fidelity measure is a fluid model that will evolve and get more specific as the program progresses. The information we collected during the site-visits, coupled with suggestions from the Department, further informed the development of the fidelity measure. The revised fidelity measure appears in ***Appendix E.*** This measure will serve as a metric by which the progress of a Family Care pilot program can be charted, with the expectation that fully mature programs will fall within the definitions or range for each component. Models meeting the minimum requirements for Family Care and innovative pilot programs will establish the floor and ceiling endpoints for the range associated with each component. The completed fidelity measure will be a tool to assess each program on the eight domains and components. These assessments will then be integrated into analyses regarding the effectiveness and impact of Family Care implementation.

3. Follow-up Telephone Calls

Subsequent to the site visits, we conducted follow-up telephone calls with county staff to obtain additional information and clarification/confirmation regarding our understanding of information collected in order to report consistent and accurate data about implementation across counties.

B. Telephone Communication

The Lewin Group also monitored the development of the program through our biweekly calls with LAB and the Department beginning in April 2000, as well as through other calls on an as needed basis. We maintained regular communication with pilot county staff during this period in order to collect monthly data from the counties as outlined in our work plan. This process was modified once it was determined that most of this data could be available at the state level beginning in March 2001.

C. Documentation Review and DHFS data

We reviewed the following documentation and data supplied by the pilot counties and DHFS:

- DHFS Monthly Monitoring Reports;
- DHFS Pre-Admission Consultation (PAC) reports;
- Contracts;
- Quality assurance and improvement plans;
- Self-directed support option plans;
- Grievance procedure plans; and
- Quarterly reports submitted by the pilot county RCs and CMOs to the Department.

In reviewing these documents, we assessed county procedures and plans, as well as county compliance with state contract requirements. The information also informed our data collection around the site-visit and provided a context to monitor the Family Care program evolution. Since we did not interview the Resource Center-only counties, documentation and DHFS data served as the primary source of information for these counties found in this report.

D. Provider Telephone Interviews

Following the submission of the first implementation process evaluation report in November 2000, we administered a feedback survey to key program stakeholders (e.g., Family Care pilot county staff, State Long Term Care Council members, and DHFS staff) to elicit feedback about the accuracy, and the comprehensiveness of the report. One of the major recommendations that emerged from this feedback survey was that Lewin should incorporate the provider perspective of the program to a greater degree in capturing the whole experience of Family Care. Therefore, for this second implementation process report, we interviewed twenty providers over the telephone, in addition to meeting with provider representatives from the County Long-Term Councils during our May 2001 site-visit.

To select the providers for telephone interviews, we used provider lists and contact information provided by the pilot counties. We chose a provider and an alternate provider representing one of the following service areas for each CMO: durable medical equipment and supplies,

transportation, personal care, home health, homemaker services, employment, adult day care and day services. A total of twenty providers were selected for the four CMOs that began in 2000. All of the providers we contacted agreed to be interviewed.

Based on feedback from LAB and DHFS, we revised a telephone script for the interviews (***Appendix C***). Using this script, we conducted a total of 20 interviews (19 full interviews) with provider representatives. One provider interviewed only had experience serving one Family Care member, so this provider's responses were not included in the analyses of the other interviews. We interviewed four providers from both La Crosse and Fond du Lac counties, five providers from Portage, and six from Milwaukee for a total of 19 interviews. All of the providers interviewed in Milwaukee had been under contract with the county CMO for at least six months and at least a year for the others. The majority of providers had longstanding relationships with the counties. The interviews lasted approximately one half hour to 45 minutes and covered issues related to target populations, communication, consumer direction, prior authorization, billing, and quality assurance.

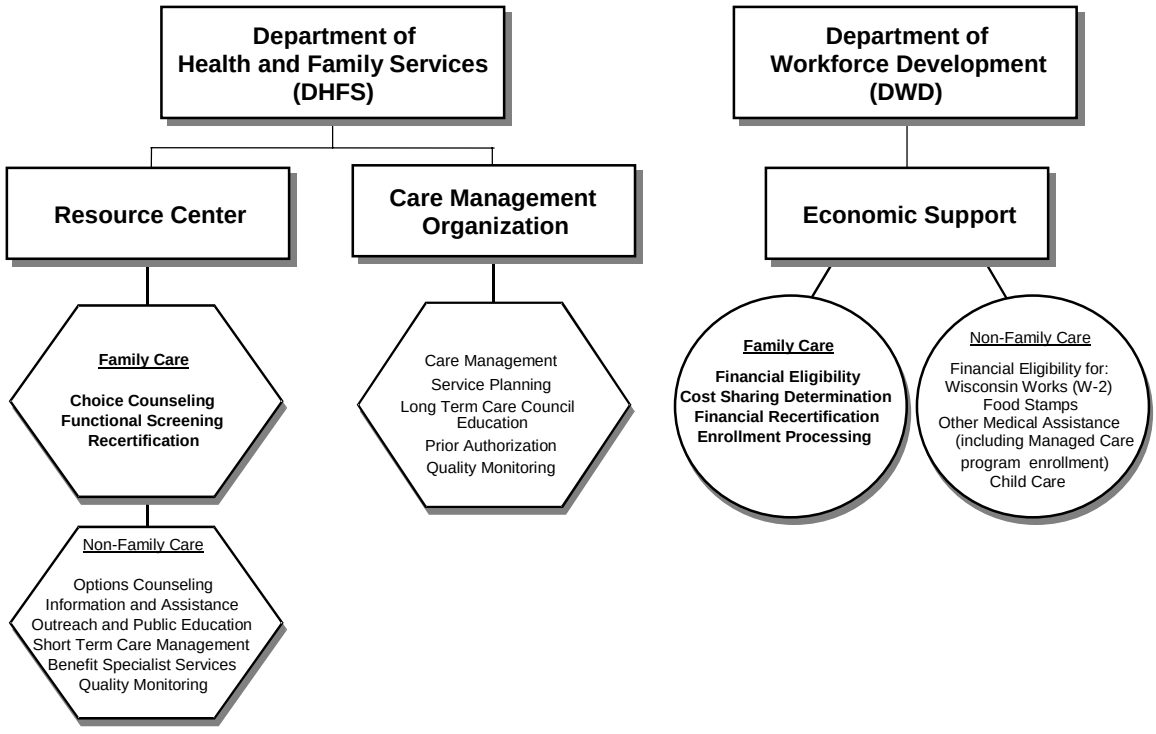
IV. INFRASTRUCTURE DEVELOPMENT

As the CMO counties continued to implement the Family Care model, two key areas related to infrastructure development emerged: 1) the relationships among entities that are involved in the CMO enrollment process, including increased demands on Economic Support staff; and 2) the role of IT systems in carrying out critical functions, including the ability of the IT systems of the entities involved in enrollment to exchange information and how it has a potential impact on efficiency and effectiveness.

A. Current Roles and Functions of Key Agencies

Three county-level agencies are integral to intake and enrollment for Family Care – Resource Centers (RC), Economic Support (ES) Units and the Care Management Organizations (CMO). In our previous report, we outlined the roles and contract requirements related to RCs and CMOs. As ***Exhibit IV-1*** highlights, another county agency, the economic support unit, also plays an essential role in access to the Family Care benefit.

Exhibit IV-1
Current Roles and Functions of Key Agencies



Note: Short-term care management is not a RC requirement. However, some RCs have funds to provide such services.

In order to access the Family Care benefit, an individual must be:

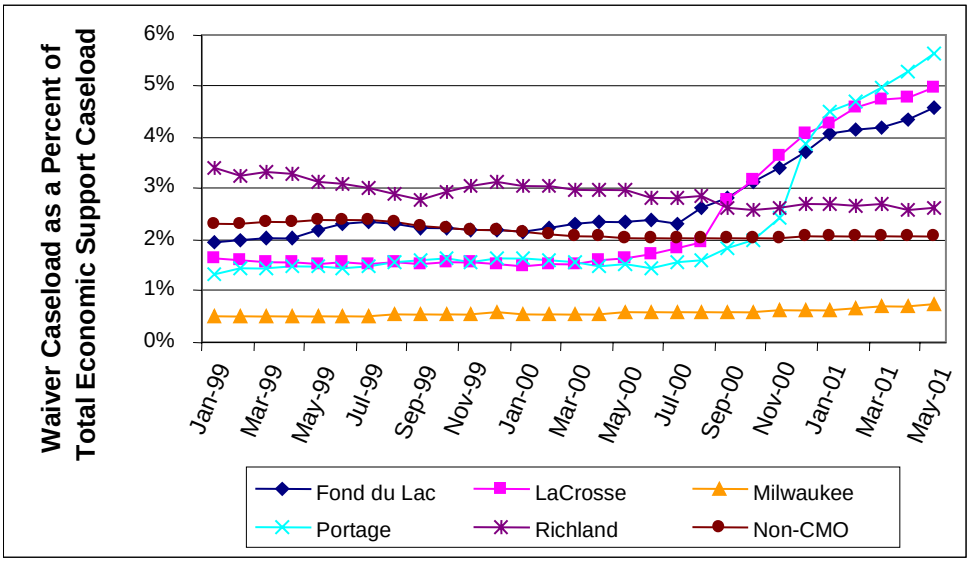
- found functionally eligible at the comprehensive or intermediate levels (determined by the RC);
- found financially eligible for Medical Assistance (MA) and be willing to enroll with a cost-share agreement (determined by ES);
- provided choices about enrollment (currently performed by the RC);
- entered into the state data system as enrolled (done by ES); and
- provided services (delivered by the CMO).

ES determines financial eligibility for MA and processes enrollment by: 1) inputting the final level of care (LOC) determination for Family Care supplied by the RC for CMO reimbursement purposes; and 2) determining cost-sharing and inputting that amount into the Client Assistance for Re-Employment and Economic Support (CARES) system.

Economic Support performs eligibility determination and ongoing tracking for a number of other programs targeted to the low income population (other non-Family Care Medical Assistance (MA), Wisconsin Works (W-2), which is Wisconsin's Temporary Assistance to Needy Families (TANF) program, the continuance of child only cases, child care assistance, and food stamps, among others). While waiver recipients as a proportion of measured ES functions generally constitute a small percentage of total ES caseloads, the proportion of the caseload accounted for by waiver enrollments nearly tripled in some of the counties since the start up of the CMOs (see ***Exhibit IV-2***).[2] However, the total measured ES caseload per 1,000 county residents in the CMO counties generally did not increase more than non-CMO counties (see ***Exhibits IV-3*** and ***IV-4***). This suggests that the new waiver applicants may be crowding out other ES activities because the lack of additional staff has limited the ability of ES staff to process additional applications.

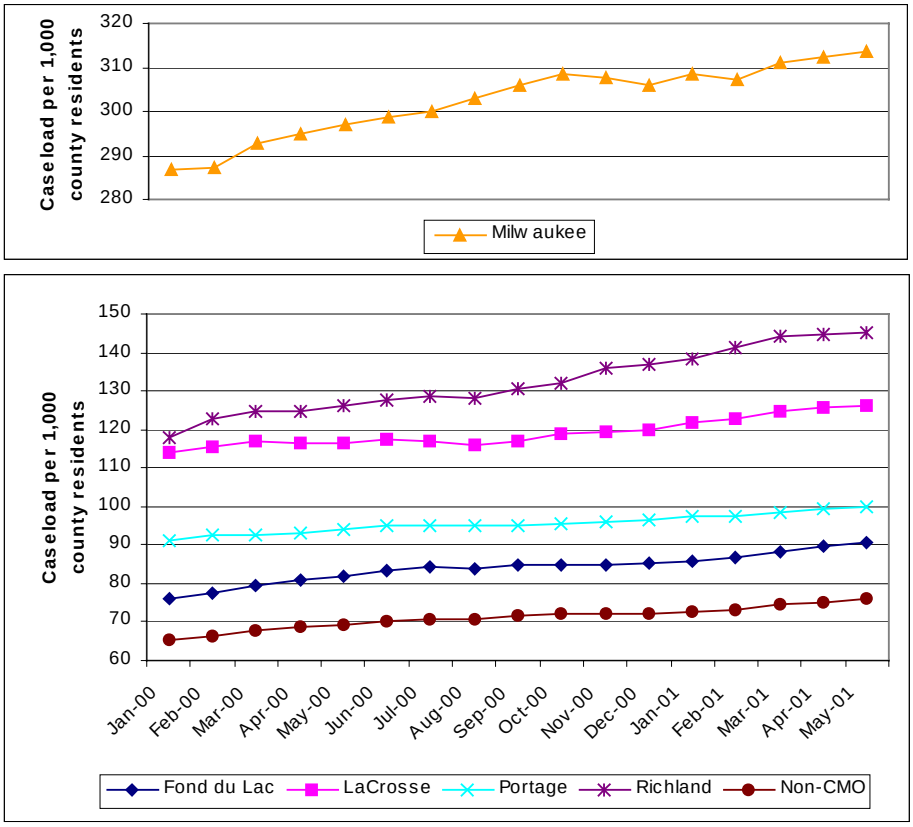
[2] Economic Support staff have responsibility for other programs, however data on the caseloads for these programs were not available. It is also important to note that not every case requires the same level of effort.

Exhibit IV-2
Waiver Caseload as a Percent of Measured Economic Support Caseload



Source: Data from the Division of Economic Support statistics for W-2, Food Stamps, Medical Assistance, and child care found at http://www.dwd.state.wi.us/des/research_statistics/default.htm accessed July 11, 2001.

Exhibit IV-3
Measured Economic Support Caseload per 1,000 County Population



Source: Data from the Division of Economic Support statistics for W-2, Food Stamps, Medical Assistance, and child care found at http://www.dwd.state.wi.us/des/research_statistics/default.htm accessed July 11, 2001.

In the CMO counties, the demands of Family Care have prompted requests to county boards to approve additional staff. The Department of Workforce Development (DWD) monitors economic support specialists throughout the state. The Department of Health and Family Services (DHFS) has no authority to monitor and set priorities for ES workers. In the planning of Family Care, DHFS did not fully anticipate the strain on the local economic support units as a result of the increase in waiver applications, and MA and cost share determinations related to Family Care.

Exhibit IV-4
Economic Support Measured Caseload Statistics for Selected Months

	Jan-99	Jul-99	Jan-00	Jul-00	Jan-01	May-01
Fond du Lac						
Waiver	125	154	159	191	340	406
Total	6,394	6,536	7,421	8,190	8,327	8,816
Percent	2.0%	2.4%	2.1%	2.3%	4.1%	4.6%
LaCrosse						
Waiver	181	173	183	230	556	672
Total	10,976	11,260	12,209	12,505	13,053	13,525
Percent	1.6%	1.5%	1.5%	1.8%	4.3%	5.0%
Milwaukee						
Waiver	1,253	1,337	1,527	1,614	1,858	2,224
Total	247,094	254,360	269,639	281,897	289,855	294,911
Percent	0.5%	0.5%	0.6%	0.6%	0.6%	0.8%
Portage						
Waiver	73	83	100	99	296	378
Total	5,475	5,521	6,116	6,385	6,552	6,716
Percent	1.3%	1.5%	1.6%	1.6%	4.5%	5.6%
Richland						
Waiver	57	53	65	65	67	68
Total	1,673	1,757	2,112	2,302	2,482	2,602
Percent	3.4%	3.0%	3.1%	2.8%	2.7%	2.6%
Non-CMO						
Waiver	5,327	5,577	5,839	5,930	6,252	6,578
Total	228,919	234,716	270,163	291,606	300,577	313,890
Percent	2.3%	2.4%	2.2%	2.0%	2.1%	2.1%
Wisconsin						
Waiver	7,016	7,377	7,873	8,129	9,369	10,326
Total	500,531	514,150	567,660	602,885	620,880	640,503
Percent	1.4%	1.4%	1.4%	1.3%	1.5%	1.6%

Source: Data from the Division of Economic Support statistics for W-2, Food Stamps, Medical Assistance, and child care found at http://www.dwd.state.wi.us/des/research_statistics/default.htm. Economic Support is also responsible for additional programs, however data for these programs were not available.

In the original Family Care budget request, DHFS staff set aside funds for additional ES workers, recognizing that ES would now handle non-MA cases for FC, in addition to their regular workload. The state also responded, as an addendum to the "Income Maintenance Program Administration" contract, by allocating a small amount of additional funds in the Family Care budget through the Department of Work Force Development.

During the site-visits, the counties consistently noted that ES staff were having difficulty processing the number of individuals referred by the Resource Centers. However, counties that

had more closely involved the ES staff (Richland, Portage and La Crosse) established better working relationships and had fewer administrative difficulties. Currently, in all CMO counties, only a few of the ES staff specialize in Family Care, allowing them to become sufficiently familiar with the Family Care program such that the ES application review becomes routine, instead of a novel activity. Being able to establish eligibility on a routine basis increases efficiency and productivity. Not all of the counties used this specialization initially. Those that did, tended to have ES workers who specialized in waiver and nursing home eligibility determinations prior to Family Care.

An issue yet to be resolved in the FC counties is the optimal location for Economic Support workers. Some counties have all three parties involved (RC, ES and the CMO) in ongoing communication and planning activities. For some counties (Milwaukee and La Crosse), proximity has aided ES staff involvement because the RC, CMO and ES were co-located in the same building. Most RC staff indicated a need for proximity to the ES staff in order to provide accurate and timely advice to potential eligibles seeking information. CMO staff also expressed a desire to have easy access to ES staff for ongoing questions and re-certification.

B. Staffing Requirements Among Key Agencies

Each of the key agencies involved in Family Care at the county level have specific staffing needs to meet their commitments to Family Care and to other ongoing activities. ***Exhibit IV-5*** outlines the major functions in terms of staffing requirements among the agencies involved in implementing Family Care at the county level. In some counties, each function/role is carried out by a different individual, while in other counties, roles and functions are combined (See ***Exhibits IV-6 and IV-7***). For example, some counties combined the Resource Center information and assistance intake function with the functional screen administrator. Some CMO counties distributed provider network responsibilities among multiple workers. Other CMOs have significantly more business staff. The staffing differences across the programs appear to reflect both the size of the county staff and the importance placed on different aspects of implementation. ***Exhibit IV-8*** summarizes the RC and CMO staff by county.

Exhibit IV-5
Staffing Functions Among Key Agencies

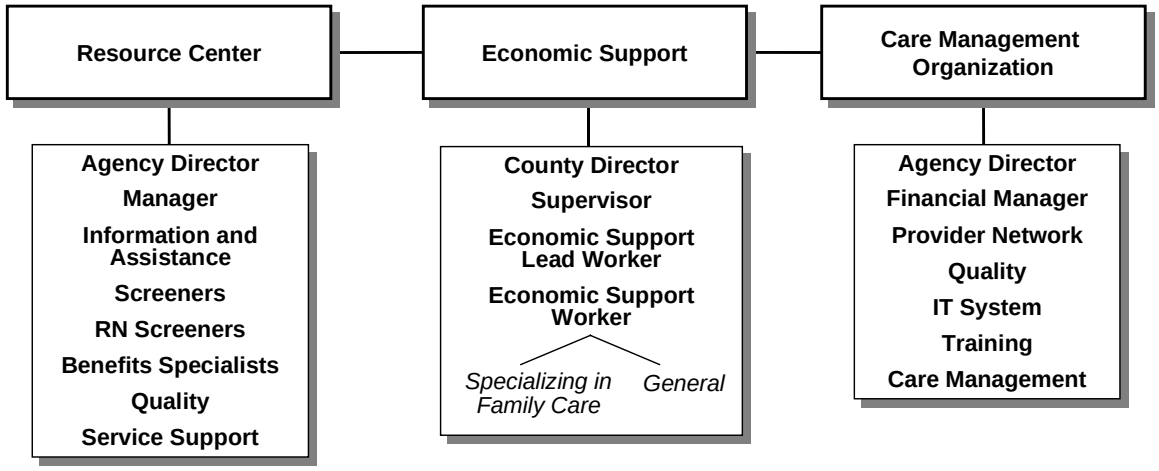


Exhibit IV-6
Resource Center Staffing of Full Time Employees (FTEs) as of March 31, 2001

RC Position	Fond du Lac	Jackson	Kenosha	La Crosse	Marathon	Milwaukee	Portage	Richland
Agency Director							0.25	
RC Manager	1.00	1.00	2.00	0.75	1.00	1.00	0.75	0.50
Supervisors						4.25		
I and A	2.25	6.50[a]	6.10	1.75	6.00	9.00	3.75[a]	1.50[a]
Screeners (non RN)	4.25		8.40	4.50	5.00	25.00		
Screeners (RN)			1.00	1.00	1.00	1.00		0.25
Nurses	0.30							0.25
Disability Benefit Specialist	0.25	0.90	1.00	0.50		[c]	0.25	
Support Staff		0.50					0.58	0.50
Quality Coordinator						1.00		
Brief Services						2.00		
Enrollment Specialist						1.00		
Outreach Specialist						1.00		
Social Service Specialist	3.75					10.00		
Case Managers			0.05[b]					
Total	**11.8**	**8.90**	**18.55**	**8.50**	**13.00**	**55.25**	**5.58**	**3.00**

[a] These individuals also perform screening.

[b] Kenosha uses case managers to complete screens on existing cases**.**

[c] Milwaukee is not required to have a disability specialist because the RC focuses on the elderly only, and there is already a well-established elderly benefit specialist program throughout the state.

Note: Trempealeau did not provide staffing information in their quality report.

Source: Resource Center 1st Quarter 2001 Reports provided to The Lewin Group by DHFS.

Exhibit IV-7
CMO Staffing of Full Time Employees (FTEs*)* as of March 31, 2001

CMO Position	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Administration					
LTS Manager			0.30		0.20
CMO Manager	1.00	0.80	1.00	1.00	0.88
Administrative Assistant					
Fiscal					
Asst. Director (financial)	0.75[a]	1.00	0.50	1.00	1.00
Analyst			0.50		
Accountant			0.50		1.00
Budget Analyst			0.30		
Business Support Staff	7.00[a]			4.50	1.00
Provider Network					
Coordinator	0.75		1.00	1.00	
Contracts Spec.	0.75	0.70	5.00		1.00
Quality					
QI Coordinator	1.00	0.30	1.00	1.00[d]	
IT System					
IT Workers	0.25[a]	[b]	1.50	0.30[d]	0.20
Training					
Training Coord.			1.00		
RN Trainer			1.00		
OT Trainer			1.00		
SW Trainer			1.00		
Care Management					
Member Relations					1.00
Team Supervisors			3.00		
Nurses	7.50	8.00		3.00	2.00
DD CMs	7.00	8.00	NA	5.50	8.00
Elderly/PD CMs	9.00	10.00	101.00[c]	8.00	
Service Aides	4.00				
Total	**39.00**	**28.80**	**119.60**	**25.30**	**16.28**

[a] In Fond du Lac, Fiscal Management, Accounting, and IT systems are supported by the department that also supports other county departments. It is difficult to portion out exact FTEs.

[b] La Crosse contracts out for this service within the county IT department.

[c] This number includes RNs.

[d] These duties are the responsibility of the FT CMO Financial Manager.

[e] These duties are the responsibility of the FT CMO Manager in Portage.

Source: Care Management Organization 1st Quarter 2001 Reports provided to The Lewin Group by DHFS.

Note: Milwaukee contracts with Keylink for billing and claims processing.

Exhibit IV-8
Summary of CMO and RC FTEs by County as of March 31, 2001

	Fond du Lac	Jackson	Kenosha	La Crosse	Marathon	Milwaukee	Portage	Richland
RC staff	11.8	8.9	18.6	8.5	13.0	55.3	5.6	3.0
CMO staff	39.0	NA	NA	28.8	NA	119.6	25.3	16.3
Total	50.8	8.9	18.6	37.3	13.0	174.9	30.9	19.3

Source: CMO and RC 1st Quarter 2001 Reports provided to The Lewin Group by DHFS.

C. Information Technology (IT)

During this period of the evaluation, the counties continued to make progress in their efforts to use IT effectively. Counties are required to have IT systems that can: 1) track Resource Center contacts, program and service information, referrals, and outcome activities; 2) support the functional screen automated system used for making level of care determinations; and 3) in CMO counties, manage care services and pay provider bills for the CMO. Other functions that are not required to be electronic, but could benefit from data stored electronically, include: 1) individual service plans (ISPs) and planned outcomes developed by care management teams and CMO members; 2) CMO assessments; 3) CMO care manager case notes; 4) prior authorizations for services; and 5) quality tracking initiatives. The systems listed are not required to be integrated, although there are some advantages to being able to tie them together for reporting, planning, and management functions.

Each of the pilots has taken its own approach to IT, some choosing to build their own systems, some contracting out major functions, and others purchasing existing software packages and adapting the applications as necessary (See ***Exhibit IV-9***). The Resource Centers have either added to information and referral software they had in place prior to Family Care or purchased software from vendors designed specifically for this activity. The state has provided the functional screen software application because it generates the level-of-care determination required for the MA waiver eligibility, which must be applied uniformly across the state. The functional screen application is being re-designed into a web-based version that will allow improved access. The web version will be released in the fall of 2001.

Exhibit IV-9
Development of County Information Technology Systems

	Resource Center		Care Management Organization					
	I&R and Outcomes	**Functional Screens**	**Assessment**	**Case Notes**	**ISPs & Outcomes**	**Prior-Authorization**	**Billing Internal**	**Provider Claims Processing**
Fond du Lac	Packaged software (CMHC)	State provided	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)
LaCrosse	County developed – customized software (DRI)	State provided	Manual process	Manual process	County developed – customized software (DRI)	County developed – customized software (DRI)	County developed – customized software (DRI)	County developed – customized software (DRI)
Milwaukee	County developed – customized software	State provided	County developed – customized software (Keane)	County developed – customized software (Keane)	Contracted system (Keylink)	Contracted system (Keylink)	County developed – customized software	Contracted system and services (Keylink)
Portage	Packaged software (IRIS)	State provided	County developed – customized software (Schenk)	County developed – customized software (Schenk)	County developed – customized software (Schenk)	County developed – customized software (Schenk)	County developed – customized software (Schenk)	County developed – customized software (Schenk)
Richland	Packaged software (IRIS)	State provided	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage

Source: DHFS provided information and site visit interviews.

The greatest diversity in IT systems occurs for the CMO functions of developing ISPs, tracking services, and processing claims. For these functions, most of the initial CMO counties contracted for customized software. The counties' diverse approaches to IT systems have presented challenges for both the counties and the state. The state provided funds within the counties' start-up grants for IT development. To build their respective systems, the counties allocated more than $1 million of these state start-up funds, plus some of their own funds. In addition, state IT staff serve as consultants to the counties. The counties' different approaches to developing their systems has resulted in a different customized system for each county, which reduces potential economies of scale that could be achieved with greater sharing of common systems. This also means that each CMO has different capabilities regarding the integration of its IT functions and, thus, management of the CMO's finances. DHFS responsibility for the functional screen also introduces coordination and compatibility issues because the software continues to evolve and will move to a web-based version in the fall of 2001. As a result, counties have not been able to integrate the functional screen software into their other IT efforts without substantial adaptations over time.

State funding to provide start-up grants and IT staff consultants will diminish and, therefore, future counties implementing Family Care will need to take greater advantage of leveraging software developed and lessons learned with the existing systems, rather than developing new ones. The State encourages the sharing and transfer of system technology between counties to promote efficiency. Richland's CMO capitalized on the experience of another CMO, Portage, and transferred the Portage IT system for a fraction of the actual cost of the systems.

IT system development is central to building an effective program in the Family Care model, particularly for the CMOs. Without basic, nearly real-time information about the members and their service use and costs, CMOs may find it difficult to manage the capitated payments and coordinate care. Integration of the core CMO functions permits the generation of management reports that can assist staff in understanding the consequences of decisions. To date, it appears that not all of the counties are taking full advantage of the data they have available to them, as evidenced by the difficulty they had generating data reports requested for the evaluation. The ability to generate a variety of data reports is important not only to the evaluation, but also for managing their programs. It is possible that as counties emerge from the start-up phase and have more experience with their data systems, they will have greater opportunity to continue to advance their data reporting and management capabilities.

The ability of counties to share information electronically among the RC, ES, and the CMO might also create efficiencies since electronic transmission of information generally reduces the need for re-keying of information. DHFS's movement to web-based functional screens will mean CMO staff will have increased access to these data for those individuals who become members, rather than the current situation where typically only RC staff have direct data access.

An ongoing issue for the counties is the maintenance and upkeep of their systems. IT systems require annual resource commitments to maintain both the hardware and software. For example, in the near future, all of the counties will need to plan and implement Health Insurance Purchase and Portability Act requirements related to patient-level data storage, including the use of CPT-4

coding.[3] The counties contend that these types of costs are not adequately accounted for in the capitated rates, even though DHFS included seven percent for administrative purposes in the capitated payment rates and another two percent for devolution of former state activities to the counties. We discuss funding for administrative functions more fully in ***Section XI. Capitation and Program Expenditures***.

[3] CPT-4 is a coding convention for physician and other provider procedures.

V. GOVERNANCE

In the November 2000 evaluation report, governance was reported as an issue and area of uncertainty for the pilot counties, as well as DHFS. Issues around governance and the Centers for Medicare & Medicaid Services' (CMS)[4] guidance on the matter continue to dominate many aspects of the future of Family Care. CMS remains concerned about having the same entity, currently counties, ultimately responsible for all aspects of eligibility determination and enrollment under a fiscal model that has incentives to restrict care or possibly limit eligibility. The potential for conflict of interest exists. In addition, as the Family Care model evolves, CMS anticipates that multiple CMOs would compete so that the choice for beneficiaries is not just the county CMO or fee-for-service Medical Assistance covered long-term care services.

In our last report, we noted that the lack of a resolution to the governance issue had delayed plans to separate the RC from the CMO in three of the four initial CMO counties as they awaited clarification. Since November, all five CMO counties have established separate governing boards with no overlap in membership. These boards all report to the county. Some counties appointed membership for only one year until they receive a final ruling from the State regarding the rules for separation.

The pilot counties appeared more certain of the role of the governing boards required by contract compared to the role of the County Long-term Care Councils required by s. 46.282 (3), Wis. Stats. At the time of the last report, the counties struggled with defining separate roles for these bodies. By contract, the CMO and RC boards must reflect the diversity of the CMO and RC service areas. CMO boards are responsible for maintaining a plan for the CMO's separation from the eligibility determination and enrollment counseling functions. The RC boards must oversee the development of a mission statement for the Resource Center and determine relevant structures, policies, and procedures of the Resource Center operation in keeping with state requirements and guidelines. The RC governing board also must identify unmet needs and plans to address them. The County LTC Councils act only as advisory committees, not governing committees, and are required to provide general planning and oversight to the CMO.

Interviews with members of the county Long Term Care Councils revealed a correlation between length of program implementation and appointees' understanding of and involvement with the Family Care Program. In the pilot counties that have been implementing the program for the longest period of time, Council members reported that CMO and RC staff consulted them regarding major policy decisions and kept them informed of ongoing operational issues. This level of understanding and involvement was much more advanced than in the Spring of 2000. In contrast, but similar to the early experiences of the more established counties, the Long Term Care Council members in the more recently implemented program in Richland had a limited knowledge of both Family Care and their role in this program.

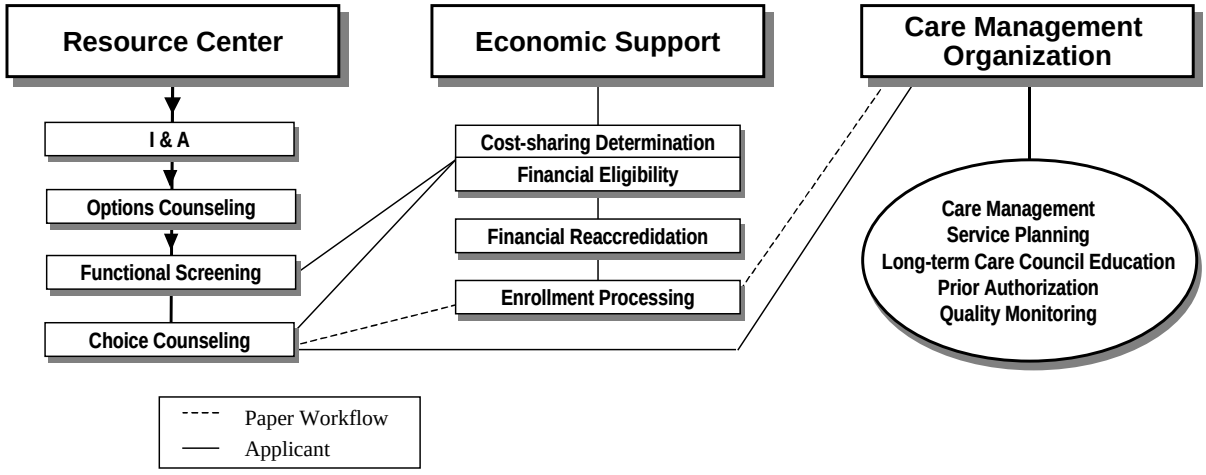
Since our last evaluation report, DHFS, in their CMS waiver proposal, narrowed the possible models for separation to one which involves an enrollment broker. Under this model, DHFS would contract with one or more private entities to provide enrollment counseling outside the

[4] Agency formerly known as the Health Care Financing Administration (HCFA).

Resource Center contract, which would provide unbiased advice regarding options, thereby protecting the interests of the individual. CMS approved Wisconsin's 1915(b) and (c) waiver applications June 1, 2001 with the inclusion of the enrollment broker model. Counties are expected to begin implementing the enrollment broker by January 1, 2002.

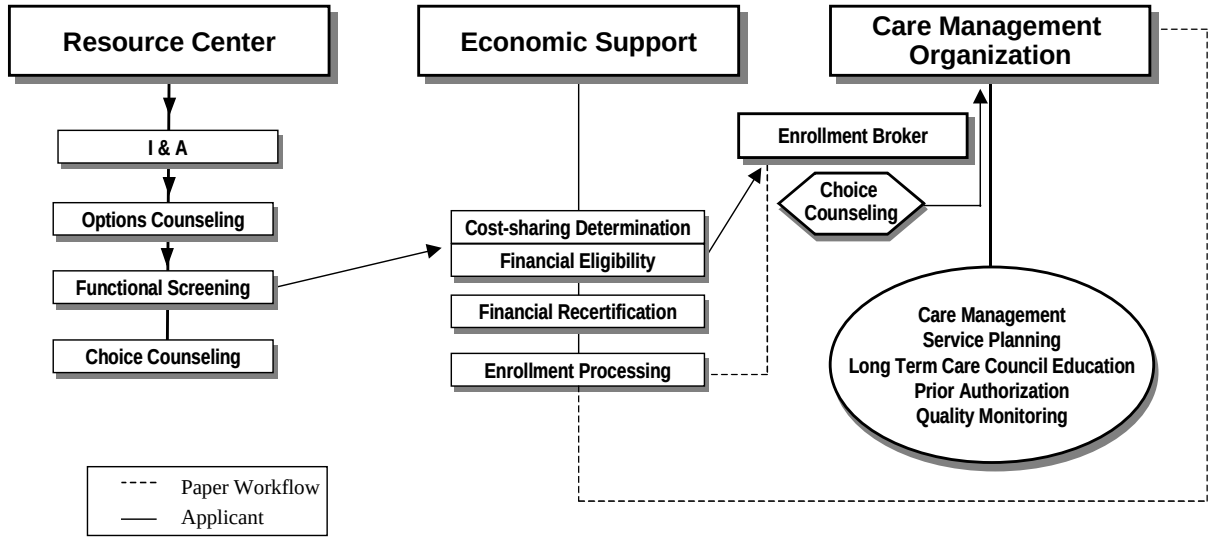
Exhibit V-1 provides a simplified version of the current enrollment process and ***Exhibit V-2*** depicts the new process that includes an enrollment broker. In the new enrollment process, an individual enters at the Resource Center and receives information and assistance (I&A). The individual then receives options counseling and then can elect to be screened for functional eligibility. After functional eligibility is determined, the individual must go to ES for financial eligibility and cost share determination. If eligible, the person must receive choice counseling from the RC (***Exhibit V-1***) or the enrollment broker (***Exhibit V-2***). During the site visits, the pilot counties expressed concern about the enrollment broker model because it introduces another person with whom consumers must interact and may further complicate the already cumbersome enrollment process (see ***Exhibit VI-12 Pathways to CMO Services***). Separation might require additional funding and this type of arrangement could raise concerns from county employees and unions objecting to the "privatization" of these service functions. The next step for DHFS is to provide specific guidance to the pilot counties regarding the relative roles of the enrollment broker and the RC and to start the contracting process for the enrollment brokers.

Exhibit V-1
Current Enrollment Model



Note: Family Care enrollment functions listed. For full agency functions see ***Exhibit VI-12***.

Exhibit V-2
Adding An Enrollment Broker



VI. OUTREACH

Under Family Care, Aging and Disability Resource Centers (RCs) conduct outreach to individuals who would benefit from information about long-term care options. In CMO counties, they also provide outreach and intake related to the CMO benefit. In addition to the five counties that have CMOs, four other counties operate RCs. The RCs appear to continue to be successful in their outreach efforts. However, RC staff in CMO counties raised concerns about their ability to provide sufficient attention to RC functions other than CMO intake.

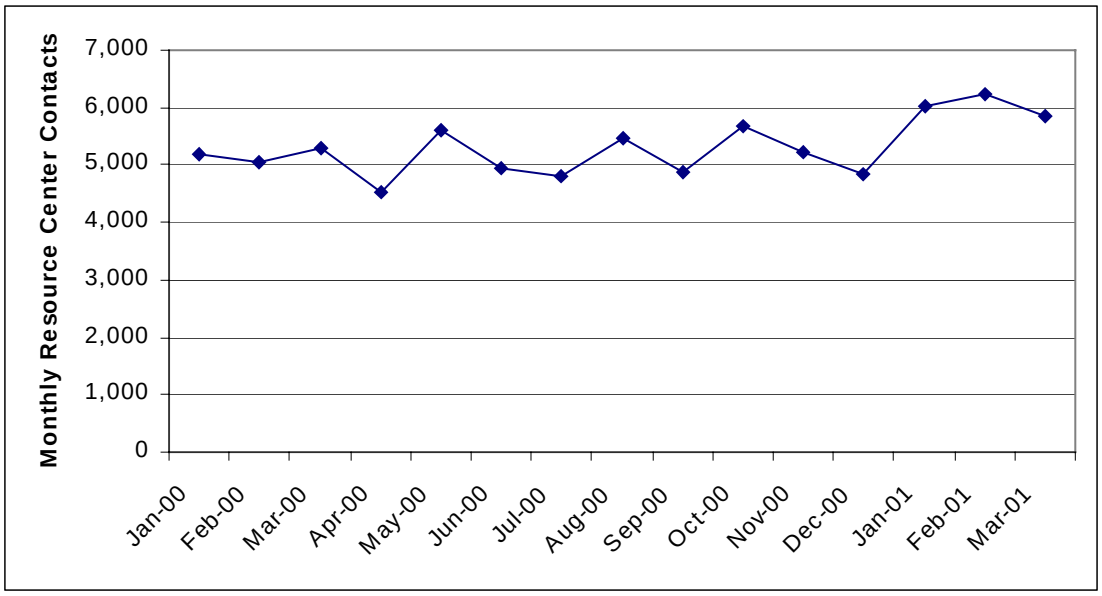
A. Resource Center Contacts

RCs provide information, assessment, and counseling regarding long-term care services and, for some consumers, serve as an access point for the home and community-based service system. RCs fill a gap in long-term care information between consumers and providers that was largely unmet prior to Family Care. Of the nine counties with RCs, only Milwaukee, Portage, and Marathon operated centers that supplied long-term care information and assistance (I&A) prior to the Family Care grants.

The number of RC contacts per month in the nine counties combined ranged between 4,500 to 6,200 over the period January 2000 to March 2001. The number of contacts appears to have accelerated since January 2001, possibly as a result of an increase in Pre-admission Consultation (PAC) referrals. Certain providers (nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR), Community-based Residential Facilities (CBRF), Residential Care Apartment Complexes (RCAC), and adult family homes (AFH)) must notify RCs when an individual with an expected long term care need of 90 days or more seeks admission to the facility. DHFS suspended the reporting requirement for hospitals because of the volume of inappropriate referrals[5].

[5] The pilot RCs that implemented mandatory PAC referrals from hospitals reported being overwhelmed by the number of referrals to which they had to respond. The RCs reported that the majority of these referrals were inappropriate, in that the individuals being referred did not have a long-term care need of 90 days or more. DHFS' response was to suspend the requirement for mandatory referrals from hospitals. DHFS is in the process of adopting changes to Family Care requirements that will allow referrals from hospitals to be voluntary at this time. In addition, DHFS is working with the pilots to develop appropriate referral guidelines for hospitals.

Exhibit VI-1
Monthly Resource Center Contacts



Source: DHFS Family Care Monthly Monitoring Reports

Since January 2001, Fond du Lac, La Crosse, Marathon and Richland all had significant increases in PAC referrals. In most counties, provider compliance with the PAC referral has been less than 100 percent, with some counties reporting approximately 50 percent compliance. The state has provided training to RCs and providers, and has urged counties to pursue higher referral rates. The increases since the start of the year may be a result of active efforts on the part of the RCs to remind providers of their obligation.[6]

Counties reported that providers approached PAC as all or nothing -- either they referred all contacts or did not refer any contacts. According to RC staff, providers did not appear to make a determination regarding whether an individual would have a long term care need for 90 days or more. Most RCs do not discourage this practice because, although these contacts may not result in an immediate request for assistance, the RC will have made its services known to an individual who may call in the future.

Within three days of a PAC referral, RCs are required to contact referred individuals and offer them an in-home visit to discuss their situation and the options available to them. Most counties have been able to make contact for the majority of referrals within the time limit; however, only Jackson, La Crosse, Marathon, Portage, and Trempealeau meet the time criteria for 70 percent or more of contacts during the October 2000 to March 2001 period (see ***Exhibit VI-2***). The Department did not express concern over these percentages because they assume that the RCs are making a reasonable effort to respond to referrals as quickly as possible and staff are considering

[6] The Bureau of Quality Assurance (BQA) can levy fines of $500 against providers that do not comply. They are expected to begin levying fines in October 2001.

dropping the three day time requirement for future RC contacts. Not unexpectedly, the vast majority of PAC referrals (93 percent) are for individuals age 65 and over.

Exhibit VI-2
Percent of PAC Referrals Contacted Within Three Days
October 2000 to March 2001

	Number	Percent
Fond du Lac	58	63%
Jackson	8	73%
Kenosha Aging & PD	197	60%
Kenosha DD	0	NA
La Crosse	489	94%
Marathon	101	97%
Milwaukee	162	43%
Portage	61	95%
Richland	12	57%
Trempealeau	29	94%
All Resource Centers	1,117	72%

Note: Milwaukee has not reported data for 2001 and the information for Jackson is based on only eight referrals.

Source: DHFS PAC reports.

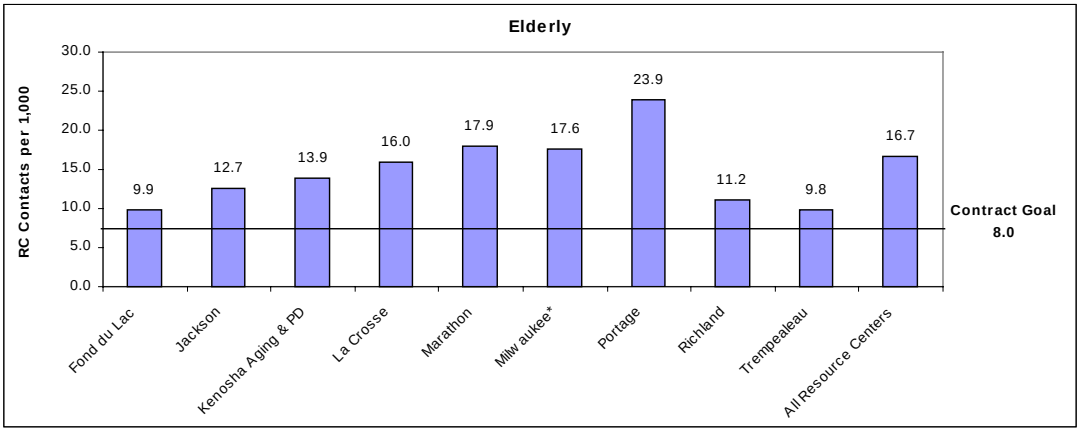
B. Resource Center Contract Goals

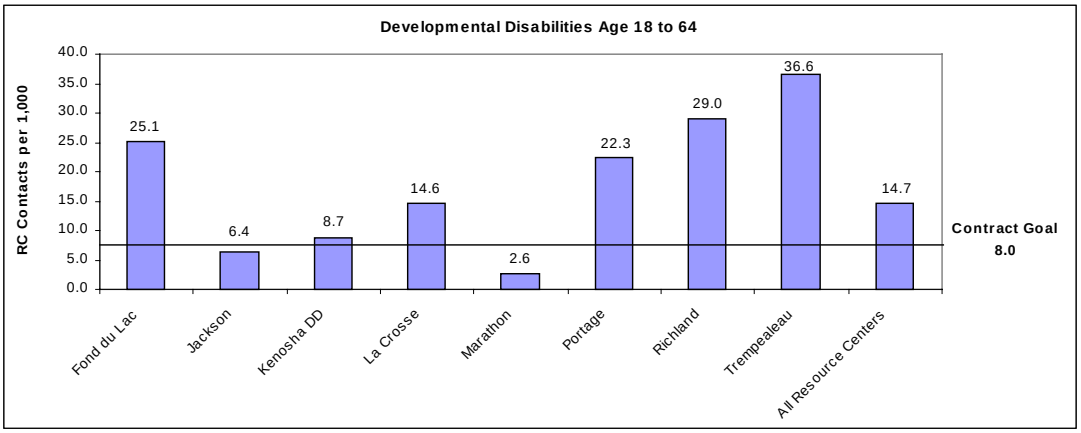
The 2000 RC contracts included contact goals of four per 1,000 target population for the first six months of operation and 20 per 1,000 by the end of CY 2003. Under the current contracts, the state has provided a year 2001 specific goal of eight per 1,000. Among the counties with RCs, all but Marathon for the DD population, exceeded the four contacts per 1,000 target population. In fact, based on 2000 data, only Marathon and Jackson would not have met the 2001 goal of eight per 1,000 and this was for the population with developmental disabilities only (see ***Exhibit VI-3***). Four of the RCs have contacts greater than 15 per 1,000 among the elderly population and, for those with physical disabilities, the contacts per 1,000 ranges from 19.8 to 127 with most between 80 and 90 contacts per 1,000.[7] Therefore, it appears that most counties will likely have little trouble meeting the contact goals for 2001. All but Portage county will have to increase elderly contacts between 12 and over 200 percent to meet the 2003 goal of an average of 20 contacts per month. All the counties, with the exception of Jackson, have already exceeded the 2003 goal for physically disabled contacts and five of the counties will need to increase contacts from the individuals with developmental disabilities to reach the 20 contacts per month.

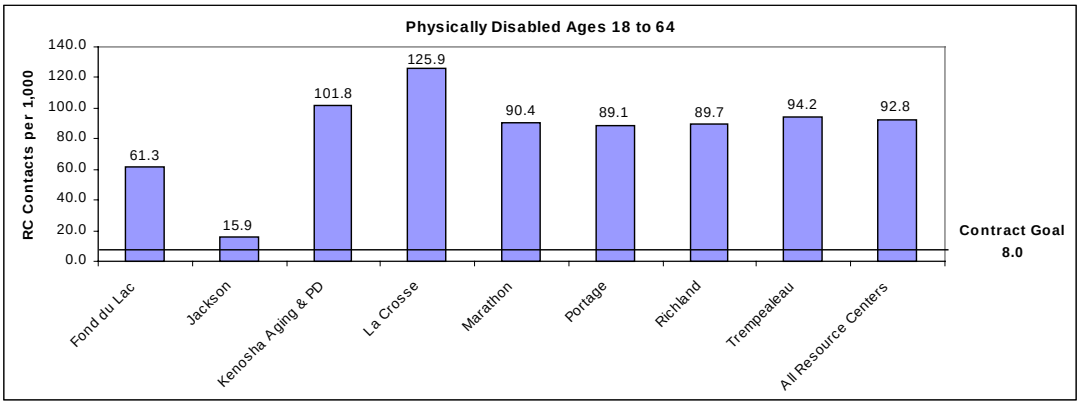
[7] The number of individuals with developmental disabilities and physical disabilities by county were estimated by DHFS based on national prevalence estimates for the 18 to 64 age group. The reliability of such estimates is difficult to assess because no county-based survey efforts of sufficient sample are available. It is possible some of the wide variation in the contacts per 1,000 for these populations may be a function of the estimated denominator.

In the aggregate, the elderly generate the most RC contacts (see ***Exhibit VI-4***). However, a significant proportion of contacts were not classified by target population. The Department encouraged Resource Centers to avoid having the reporting requirements guide the conversation with the callers. Therefore, unknown contacts may represent calls in which the target group of the individual was not critical in assisting the caller. Including the unknown contacts and using total county population for the per 1,000 measure provides an indication of the general effectiveness of overall outreach. With the exception of Portage, using this broader measure demonstrates somewhat less variation (between 2.0 and 4.0 contacts per 1,000 county population) than the population specific estimates (see ***Exhibit VI-5***). Portage reports over nine contacts per 1,000 county population. Portage continued to receive voluntary PAC referrals from the county hospital after the requirement was lifted. Also, the Portage RC operates within a senior center and meal-site, therefore they experience many more drop-in contacts than other counties. Portage also reported the highest percentage of unknown contacts which could also be a result of brief requests for information made by individuals passing through the senior center for whom the RC did not collect target population information. The only other RC with such a highly visible locale is Marathon, however, Marathon did not report an unusually high volume of contacts or unknown contacts.

Exhibit VI-3
Average Monthly Resource Center Contacts per 1,000 Population, January - March 2001

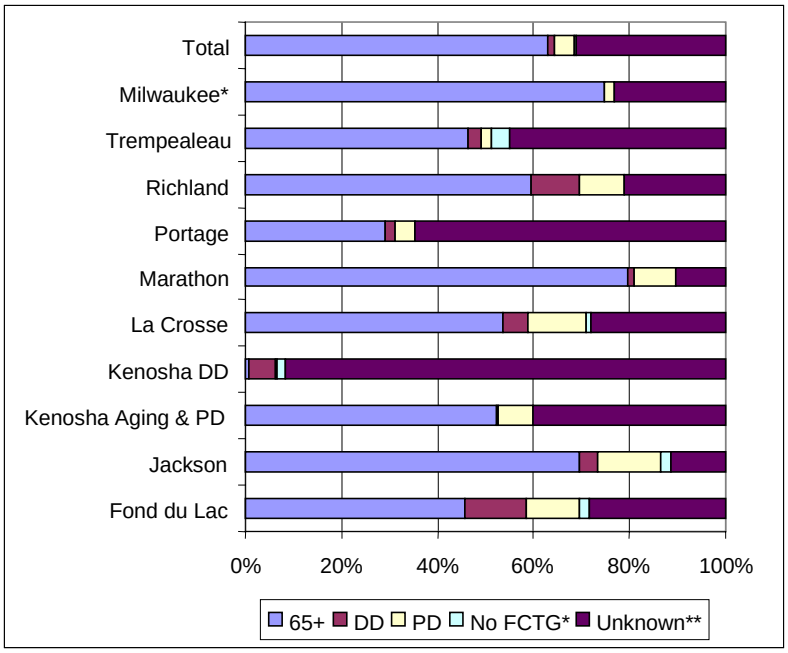






Source: The Lewin Group analysis of DHFS provided data.

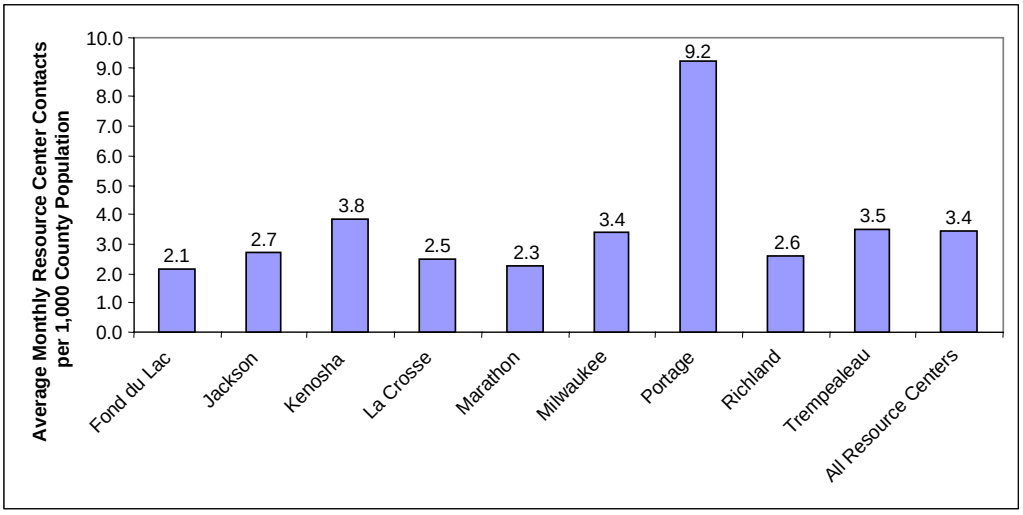
Exhibit VI-4
Resource Center Contacts by Target Population
March 2000 to February 2001



Note: No Family Care Target Group (FCTG) indicates that the person was known to have a disability or medical condition, but that this did not fit into a Family Care target group.

Source: The Lewin Group analysis of DHFS provided data.

Exhibit VI-5
Average Monthly Resource Center Contacts per 1,000 County Population



Source: The Lewin Group analysis of DHFS provided data.

The RCs use a variety of outreach strategies to meet their goals. ***Exhibit VI-6*** summarizes the outreach activities outlined in the RC's quarterly reports. All of the counties distribute literature and speak to community groups as part of their outreach strategies. Many of the RCs maintain websites with information. For example, Marathon, Portage, Kenosha, Milwaukee, and Fond du Lac list on their respective websites hours of operation and the types of services provided by the RC. Some of the counties are employing broader media strategies. For example, at the end of last year, La Crosse partnered with Jackson and Trempealeau to produce a polished television advertisement that RC staff described as very effective. La Crosse reported that during the months that the TV ad aired (November 2000, December 2000 and January 2001) they experienced 370 contacts, the highest number of contacts in the RC's history. RCs are also pursuing targeted outreach as appropriate with several counties pursuing providers. In the CMO counties, three of the five counties (La Crosse, Portage, and Richland) have put further outreach activities on hold because staff are overwhelmed by the volume of contacts based on previous outreach activities, word-of-mouth, and PAC referrals.

Exhibit VI-6
Resource Center Outreach Activities

Outreach Strategy	Fond du Lac	Jackson	Kenosha	La Crosse	Marathon	Milwaukee	Portage	Richland	Trempea-leau
General Public									
RC Literature (brochures, posters, magnets)	X	X	X	X	X	X	X	X	X
Directory of Services Developed and Distributed		X	X		X				
Public Speaking to Community Groups	X	X	X	X	X	X	X	X	X
Presence at Health Fairs	X				X				
Website	X		X		X	X	X		X
Community Info. Sessions		X							
Media									
Radio		X						X	
TV Ad/ Interview Show		X		X					X
Newspaper Ads		X		X					
Newspaper Articles	X		X						
Targeted Outreach									
Hmong Elders Focus Group				X					
Presentations to School System	X			X					
Provider Presentations/ Meetings (Group)		X						X	X
Provider Meetings (Individual)	X			X					
Staff and Budget									
Full time outreach staff						X			?[a]
2000 Funds Spent for Outreach[b]		$20,242		$6,596		$1,455		$3,429	$16,679

[a] Trempealeau did not provide staffing information in their quarterly report.

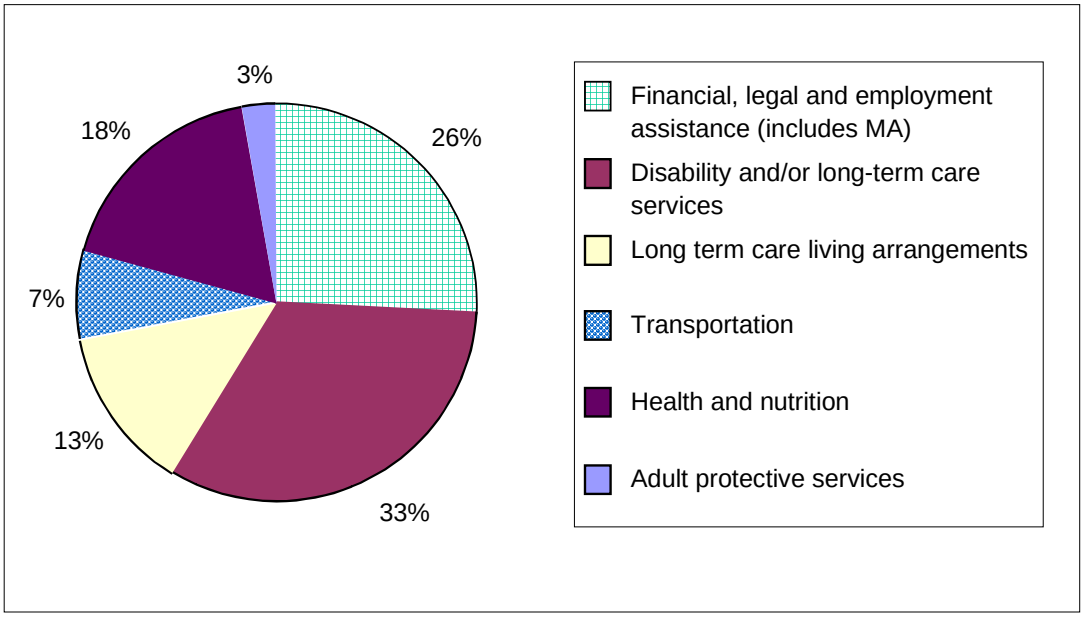
[b] Information provided only for those RCs that submitted a budget to DHFS.

Source: Quarterly reports submitted by Resource Centers and RC budgets submitted to DHFS by the pilots.

C. Resource Center Services

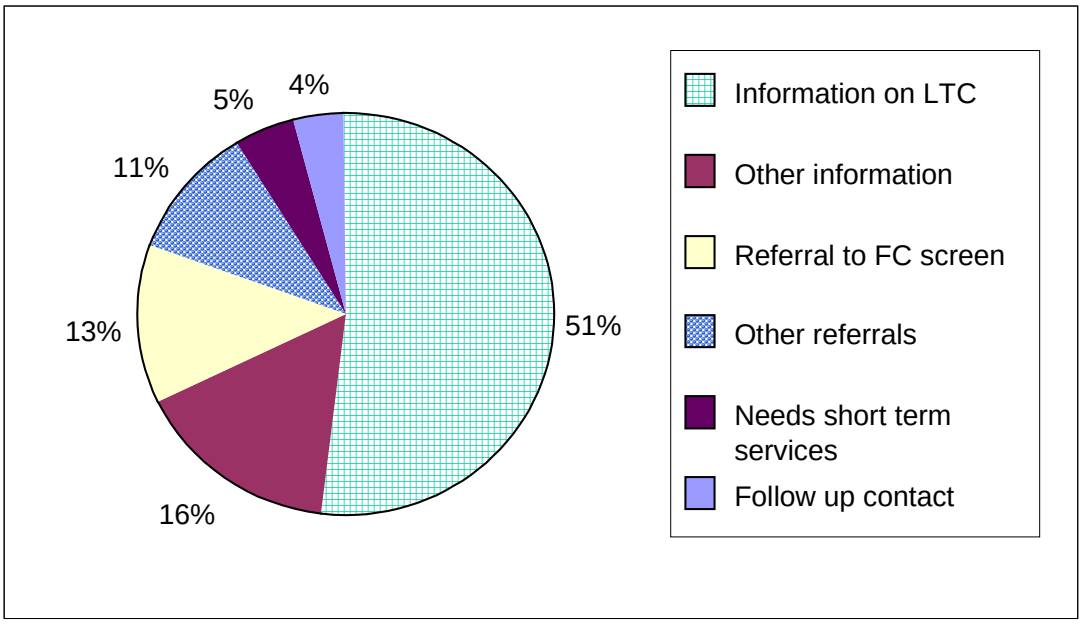
Exhibit VI-7 and VI-8 display county reported data regarding information sought from and outcomes of RC contacts. Over half of contacts pertained to disability and long term care services, and appropriately half of the outcomes provided long term care information. In addition to the more standard information and referral activities, four of the RCs are undertaking research-based prevention activities to demonstrate effective prevention practices using funds from competitively awarded state grants.

Exhibit VI-7
Types of Resource Center Information Sought
February 2000 to March 2001



Source: The Lewin Group analysis of DHFS provided data.

Exhibit VI-8
Resource Center Outcomes
February 2000 to March 2001



Source: The Lewin Group analysis of DHFS data.

Exhibit VI-8 highlights information dissemination as the most common service provided by the RCs. A major part of this activity is providing individuals information about available services. In the CMO counties, all of the RCs are actively working to create up-to-date provider lists. ***Exhibit VI-9*** displays the range of services identified and tracked by each of the RCs. In general, the RCs are providing a similar range of core services. In addition to the services listed, Milwaukee, La Crosse, Portage, and Fond du Lac maintain information about services such as volunteer service, emergency resources, financial assistance, advocacy, legal and tax assistance and companionship activities. Some counties provide information about leisure and recreational activities and companionship opportunities.

Providers interviewed were aware of the services of the Resource Center. Overall, most providers acknowledged that the information provided by the Resource Centers was accurate and comprehensive. Many have used the RCs as a referral source for consumers in need of long-term care information and Family Care eligibility determination. Providers commented during interviews that they have noticed a change in the functioning of populations served. Providers noted that individuals are no longer entering the system at the point of crisis, which may indicate that the Family Care model reaches individuals sooner than the previous system.

Exhibit VI-9
Type of Providers Known by Resource Center
by Type of Service

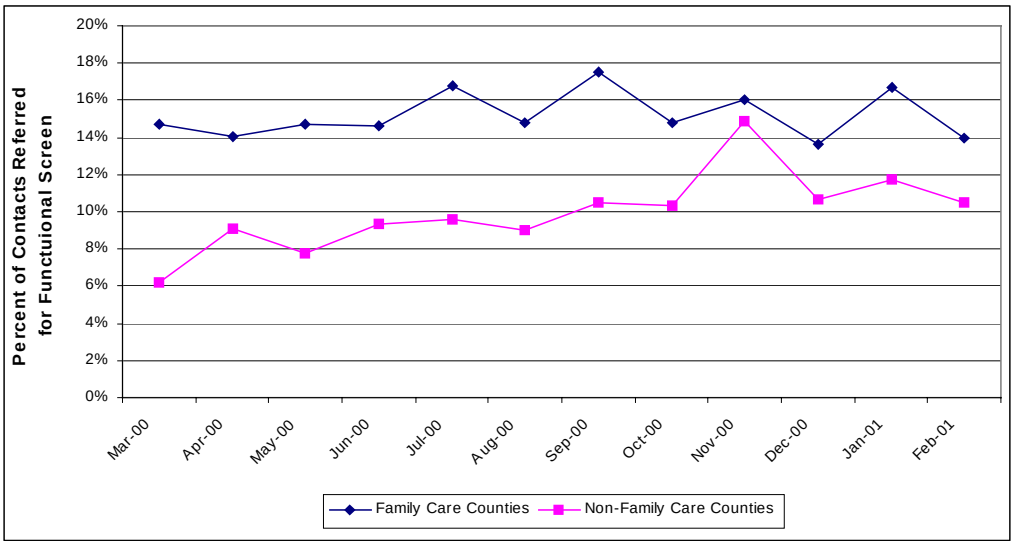
	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Adaptive Aids	X	X	X	X	X
Adult Day Care	X	X	X	X	X
Adult Family Home	X	X	X	X	X
Assisted Living Facility	X	X	X	X	X
Case Management	X	X	X	X	X
CBRF	X	X	X	X	X
Congregate Meals	X	X	X	X	X
Daily Living Skills	X	X	X	X	X
Day Services/ Treatment	X	X	X	X	X
Employment-related	X	X	X	X	X
Guardianship/Money Management	X	X	X	X	X
Home Care (medical & supportive)	X	X	X	X	X
Home Modification	X	X	X		X
Interpreter Services	X	X	X	X	X
Meal Delivery	X	X	X	X	X
Medical Equipment	X	X	X	X	X
Mental Health	X	X	X	X	X
Nursing Facility	X	X	X	X	X
Rehabilitation/Therapy	X	X	X	X	X
Respite Care	X	X	X	X	X
Speech & Language Path.	X	X	X	X	X
Substance Abuse	X	X	X	X	X
Transportation	X	X	X	X	X

In an effort to improve RC service delivery, all of the counties are making progress toward building an IT infrastructure. Milwaukee RC staff maintain a searchable database of provider information, while Fond du Lac, Portage, and La Crosse use outside groups to maintain the databases. These searchable databases enable an RC to keep rosters and information regarding providers updated and accurate. Only two RCs make provider information available via the Web for those consumers who choose not to or are unable to get to the RC office. Kenosha posted directories for both aging and disability services on their web-site. In Fond du Lac, the database of available providers is on the web allowing consumers, as well as RC staff, to search for information.

D. Resource Centers' Role in CMO Access

In counties with a CMO, RCs serve as the centralized access point for CMO enrollment. Between 13 and 18 percent of RC contacts in CMO counties result in a referral for a functional screen for potential CMO benefits (see ***Exhibit VI-10***). This percentage is consistently higher than in counties without a CMO probably because, unlike the non-CMO counties that have lengthy wait lists, services will be available if an individual is determined eligible.

Exhibit VI-10
Proportion of Resource Center Contacts Referred for a Functional Screen



Note: The increase among non-CMO care counties in November 2000 is largely due to Marathon county reporting twice as many referrals as most other months.

Source: The Lewin Group analysis of DHFS data.

A rough estimate of the proportion of Resource Center FTE hours spent conducting functional screens shows that the CMO counties spend a much larger proportion of available Resource Center staff time hours on functional screens (18.9 percent versus 5.4 percent) (see ***Exhibit VI-11***). Among the CMO counties, the percentage ranged from 13.4 percent in Richland to 36.4 percent in La Crosse. The higher percentage of time spent conducting functional screens may be related to the lower staffing levels (i.e., with the exception of Milwaukee, CMO counties with lower FTEs per 100,000 county population had higher percentages of staff time spent conducting functional screens).

The RCs must commit significant amounts of time to contacts on the path to CMO enrollment. ***Exhibit VI-12*** depicts the role of RCs in the CMO enrollment process. Some staff of the RCs in CMO counties worried that if the level of demand for CMO intake and re-certification continues at the current rate and funding does not increase, the broader outreach and information and referral activities will suffer because the CMO-related activities tend to monopolize their efforts. The Department notes that only 14-15 percent of all contacts are referred for a screen, which indicates that Resource Centers serve a clientele that is not limited to those eligible for the Family Care benefit.

Exhibit VI-11
Percent of Resource Center Staffing Time Devoted to Functional Screens

County	FTEs per 100,000 county population	Percent of staff time for screens
Fond du Lac	12	24.5%
Jackson	47	2.9%
Kenosha	12	6.2%
La Crosse	8	36.4%
Marathon	10	6.0%
Milwaukee	6	14.3%
Portage	8	29.3%
Richland	17	13.4%
Trempealeau	NA	NA
CMO counties (average)	7	18.9%
Non-CMO counties (average)	14	5.4%

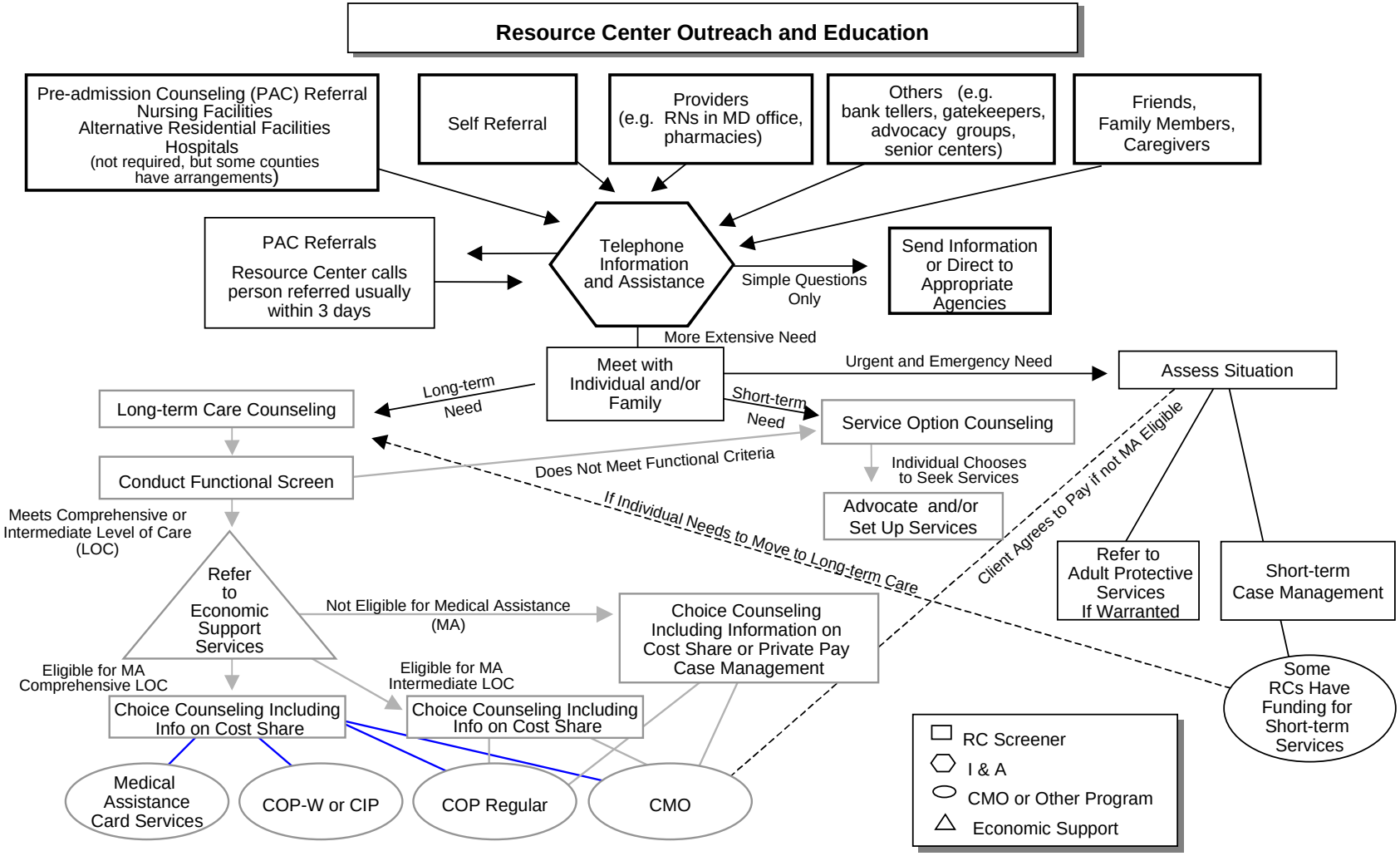
Note: Calculation based on average total time spent conducting screens in January to March 2001 (average functional screen times of 3.5 hours based on state interviews times the number of functional screen referrals) divided by total staff hours available (Resource Center FTEs times 160 hours)).

Source: The Lewin Group analysis of DHFS data.

E. Resource Center Funding

The RCs unanimously indicated that the funding levels were inadequate given the scope of requirements in their contracts. A DHFS workgroup examined and developed workload estimates for each RC activity. These workload estimates were the basis for the legislature's RC funding levels. The majority of Resource Center funds come from state general purpose revenue (GPR). However, RCs could collect federal funds for the information and assistance (I&A) function during CY 2000 based on a county specific formula estimating the percentage of MA eligibles per population for whom they provided I & A. The RCs in CMO counties had an additional source of funds available in CY 2001 in the form of Medicaid reimbursement for administering the functional screen. They can collect funds for each screen performed, not just for MA eligibles, since it is considered an eligibility function.

Exhibit VI-12
Pathways to Family Care CMO Services



Note: In the enrollment broker model, choice counseling will be performed by an independent agency.

VII. ACCESS TO CMO BENEFIT

This section addresses the elimination of waiting lists for waiver services, CMO enrollment, provider network development, and administrative issues related to service provision. Three of the five counties (Fond du Lac, Portage and La Crosse) have eliminated their waiting lists and are enrolling substantial numbers of new members. Three of the counties (Fond du Lac, La Crosse and Richland) have had to slow new enrollments due to capacity limits. All of the counties continue to develop their provider networks. The counties are still working through some administrative issues related to service provision, particularly prior authorization.

A. Wait Lists for Services

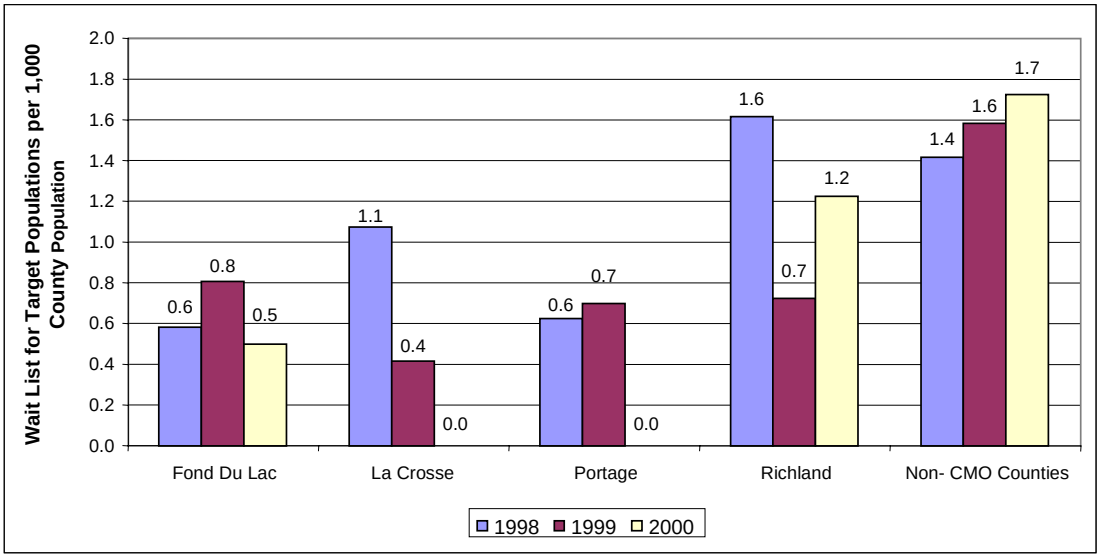
To ensure access to services by individuals entitled to the Family Care benefit[8] within two years of starting operation, pilot counties are required to eliminate waiting lists for services offered through the CMO. ***Exhibit VII-1*** displays the status of the waiting lists for the Family Care target populations per 1,000 county population from December 1998 to December 2000. By spring 2001, waiting lists had been eliminated in all of the CMO counties, with the exception of Richland and Milwaukee. Milwaukee anticipates eliminating waiting lists by December 2001 and Richland by July 2002.

Exhibit VII-1 also shows that even though some CMO counties experienced increases in waiting lists in the years prior to implementing the CMO, these counties began reducing waiting lists upon implementing the CMO. The waiting lists for non-CMO counties continue to increase. Milwaukee faces a particular challenge in eliminating their waiting list. On a per 1,000 basis, Milwaukee's wait list among those age 60 and over was more than three times the average for non-CMO counties.

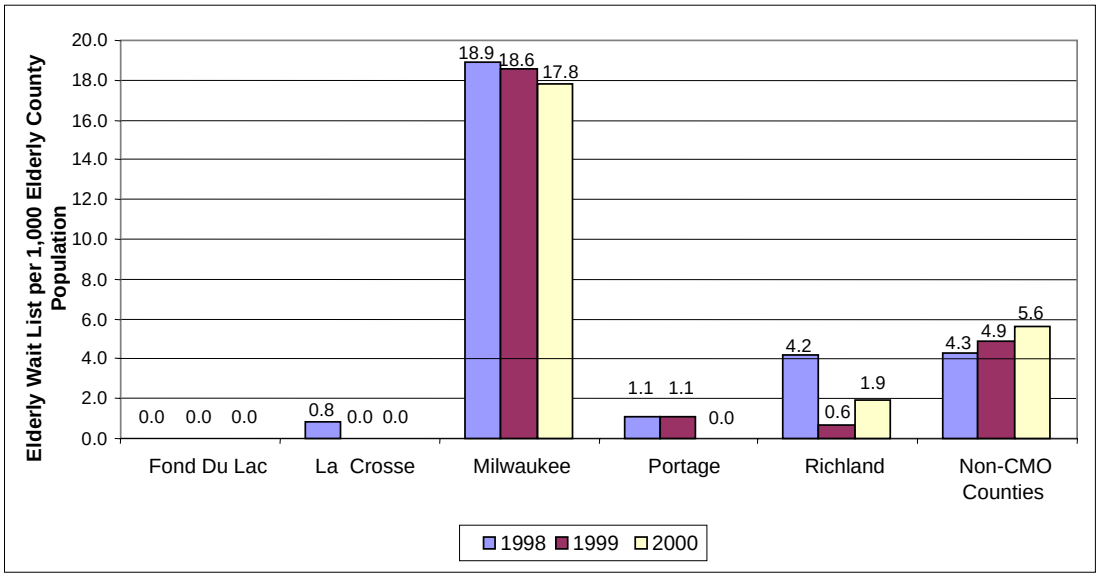
[8] Individuals entitled to the Family Care benefit must qualify at the comprehensive functional level or qualify at the intermediate level and be eligible for MA, be grandfathered from an existing program, or be in need of adult protective services.

Exhibit VII-1
Number of Individuals Per 1,000 County Population in Family Care Target Populations Waiting for Services in the CMO Counties and the Remainder of the State, 1998, 1999, and 2000

All Target Populations



Elderly Population

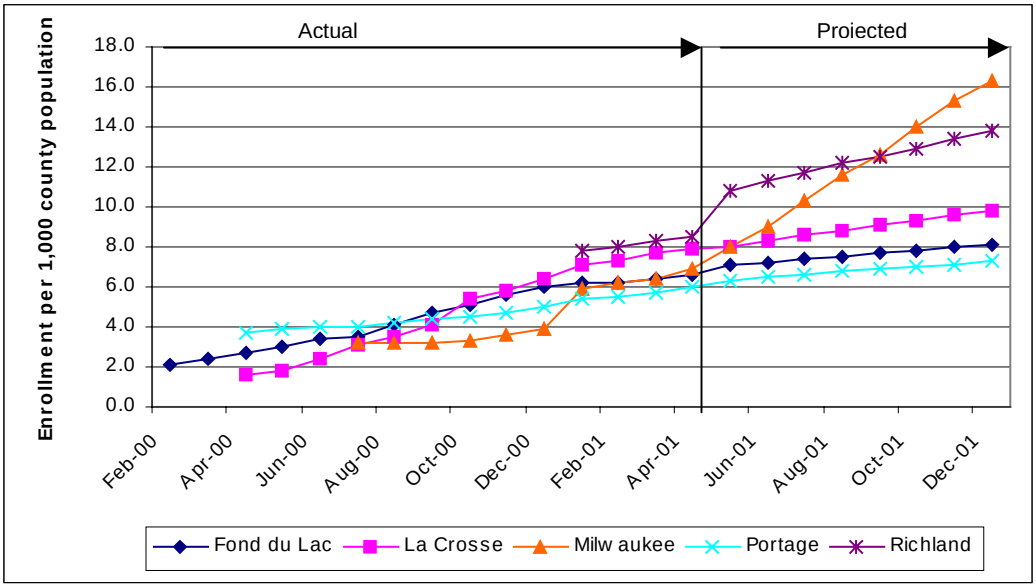


Source: The Lewin Group analysis based on wait list estimates provided by DHFS.

B. CMO Enrollment

CMO enrollment continues to grow and is expected to increase through at least the end of this year (see ***Exhibit VII-2***). To date, CMO enrollment does not appear to have reached a stable point in all of the counties. The jump in enrollment between April 2001 and May 2001 is the result of inconsistencies between reported and budgeted enrollment. In Milwaukee, issues related to Economic Support have caused significant delays in eliminating their waiting list. In January, enrollment increased from approximately 600 to 900 as a large number of pending re-certifications were enrolled in the program. Milwaukee projects substantial increases through the end of the year as they eliminate their wait list.

Exhibit VII-2
CMO Enrollment per 1,000 County Population

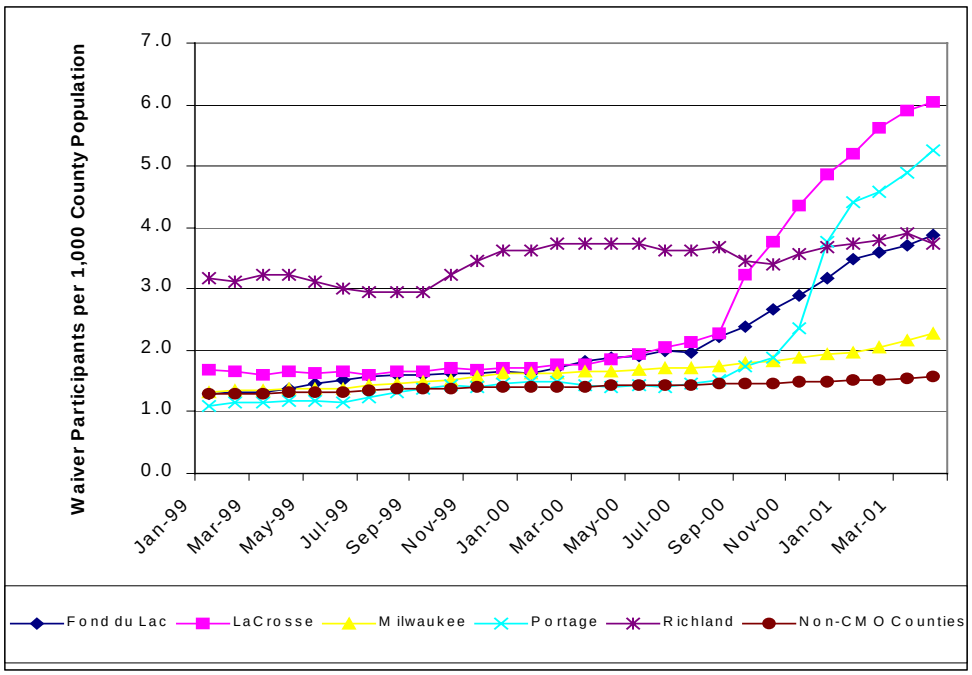


Note: Milwaukee is based on the county population age 60 and older.

Source: The Lewin Group analysis of data provided by DHFS.

In order to assess whether enrollment might be approaching a steady state and the extent to which the CMOs have increased access to new enrollees, we examined 1915(c) waiver enrollment prior to and during CMO operations. ***Exhibit VII-3*** shows waiver recipients per 1,000 persons in the county based on the CARES system data, which ES maintains. This measure of enrollment indicates the extent of new enrollment because individuals already in the waivers that converted to the CMO would not be reflected as increased enrollment. The graphic indicates that eliminating the wait list prior to CMO start up in Fond du Lac, Portage, and La Crosse had little impact on the trend line compared to the new enrollment. Starting in September 2000, several months after the start up of the CMOs, the number of waiver recipients per 1,000 county population began to increase dramatically; doubling in Fond du Lac and tripling in La Crosse and Portage. Richland, with its recent CMO implementation, had only small increases, although the number of waiver recipients per 1,000 was much higher than the other counties prior to the CMO startup.

Exhibit VII-3
Waiver Participants per 1,000 County Population



Source: Data from the Department of Health and Family Services Medicaid statistics found at http://www.dhfs.state.wi.us/Medicaid1/caseload/intro.htm accessed July 11, 2001.

Milwaukee's waiver enrollment based on CARES system data appear depressed relative to the other counties for three reasons: 1) Milwaukee continues to enroll its existing elderly waiver population into the CMO; 2) the Economic Support staff in Milwaukee have had difficulty processing the large volume of cases which has resulted in significant lag time between the RC's functional screen and financial eligibility determination; and 3) the per 1,000 county measure in Milwaukee does not isolate to the elderly population, therefore, unlike the other counties, the measure is diluted by the inclusion of populations not included in Family Care.

1. Delayed Enrollment

Some counties currently operate using a "delayed enrollment" approach in which there are individuals who have met the eligibility requirements and chosen to become a CMO member, but the CMO is not prepared to begin providing services. Enrollment indicates that an individual has been entered into the state system as enrolled and is receiving services from the CMO. Delayed enrollment is an administrative status that indicates that individuals will begin receiving services soon after they are found to be eligible, but not immediately. Unlike wait lists, delayed enrollment connotes an expectation that services will begin in the relatively near future. Delayed enrollment numbers are not reflected in the waiting list numbers reported in ***Exhibit VII-1***. The circumstances under which the counties instituted delayed enrollment differ:

- In Fond du Lac, the number of individuals who had been found eligible but not yet receiving services from the CMO built up to 20 individuals during the months of November 2000 to February 2001 because, due to a lack of space, the CMO could not hire additional care management staff. In January, the CMO moved to their new larger offices and by March had hired the budgeted additional staff. At that point they could begin taking new enrollments that were not urgent or emergency care. Now that the CMO is fully staffed, 15 new enrollees, and 15 individuals from the delayed enrollment list and personal care program conversions are being assessed and plans of care are being developed each month.

- In La Crosse, the higher than expected monthly enrollment, even after eliminating their wait list, has put a strain on the CMO's ability to serve new members. La Crosse anticipated 15 new enrollees per month and, as of May 2001, still averaged approximately 30 per month. La Crosse instituted a delayed enrollment plan that applied only to individuals not on Medical Assistance. However, county staff indicated that the number of new members per month continues to be high and they may need to adopt a different strategy.

- In Richland, the CMO began operation in January. As part of their start-up planning, Richland purposefully decided to limit enrollment to three to four individuals per month (DD rollovers from Community Aids, and one to two from the elderly/PD waiting list). Richland developed a delayed enrollment list in November of 2000 when the RC opened because the CMO did not begin operating until January 2001. Beginning in May 2001, they began taking four to five individuals per month from the delayed enrollment list.

C. Provider Network Development

In order to provide adequate access to services, the CMO provider network developers must build and sustain a network that supports the service needs of the CMO members. ***Exhibit VII-4*** displays the number of providers who have signed a contract with the CMO in various service areas as of April of 2001 compared to July of last year. Milwaukee and Richland both noted that the list of providers they contract with does not yet accurately reflect the options available to Family Care members because they are still in the process of developing contracts with providers selected by CMO members. Information for Milwaukee was unavailable. The provider network developer did not feel that the CMO provider network reflected capacity because the CMO will contract with any provider that a consumer selects.

The provider network developer is responsible for ensuring that adequate capacity exists and contracts are signed between the CMO and the provider, as well as the annual renewal of contracts and the recruitment of new providers. Prior to Family Care, the long-term care manager or comparable person carried out this function. DHFS realized the enormity of this task and required that the CMOs devote a staff position exclusively to network development. All of the CMOs have at least 1.00 full-time provider network developers with the exception of La Crosse (see ***Exhibit IV-7***). Providers interviewed indicated frequent communication with the network developers in the pilot counties and also noted provider network developers as extremely responsive to provider concerns.

1. Consumer Choice of Providers

Some CMOs identified areas in which they could use additional providers to expand consumer choice. La Crosse identified the need for increased consumer choice in the areas of adult day care, transportation in the rural areas, supported employment, and sheltered workshop. Fond du Lac noted that they are experiencing shortages of qualified providers of residential care, particularly CBRF's and adult family homes for the elderly, handicapped accessible homes for the DD, and in-home personal/attendant care for all target populations. Portage noted adding a number of providers and services to their provider network within the last year. Richland indicated that there are not many providers in the community to contract with for DD services because the majority of DD services were provided by the county under the previous system. It is important to note that shortages in personal care are not specific to Family Care. Results from a study reported in May 2001 by Stephanie Robert of the University of Wisconsin School of Social Work revealed that Family Care managers and care managers state-wide reported that personal care/supportive home care services are the most difficult services to access or provide.

Exhibit VII-4
Number of Providers Contracting with the CMO, by Type of Service, May 2001

Type of Service	Fond du Lac	La Crosse	Portage	Richland
Adaptive Aids	1	3	6	27
Vehicle				3
Adult Day Care	1	8	2	9
Adult Family Home	17	128	29	30
Assisted Living Facility	3	4	NT	5
Case Management	1	1	2	8
CBRF	23	19	17	17
Chore Services	4			
Congregate Meals	1	2 (many sites)	1	1 (6 sites)
Daily Living Skills	8	5	5	1
Day Services/ Treatment	5	4	2	2
Employment-related[9]	9	3	6	9
Guardianship/Money Management		4	1	2
Home Care (medical & supportive)	31	8	7	29
Home Modification		various	1	12
Interpreter Services		2	2	1
Meal Delivery	5	3	2	4
Medical Equipment/Supplies	28	17	6	13
Mental Health	4	5	6	4
Nursing Facility	11	11	6	12

[9] Includes supported employment and sheltered workshop.

Exhibit VII-4, continued
Number of Providers Contracting with the CMO,
by Type of Service, May 2001

Type of Service	Fond du Lac	La Crosse	Portage	Richland
Recreation/Alternative Activities	6			
Rehabilitation/Therapy	6	9	6	39
Respite Care	10	4	14	34
Speech & Language Path.	5	7	4	11
Substance Abuse	1	3	2	6
Transportation	10	8	6	22
Total	195	258	132	301

Note: "NT" indicates that the CMO does have a contract with this type of provider. The total number may not represent the total number of contract that the CMO has because some providers may be counted twice if they provide more than one service type.

Source: Data provided by counties.

D. CMO and Provider Response to Community Unmet Need

Since commencing the Family Care pilot, county CMOs have invested much effort in educating providers on the Family Care model. The providers interviewed for the evaluation were knowledgeable about the goals of the FC program such as increased consumer choice, increased access to services, and reduction of institutionalization. Most also felt the training and education provided by the CMO was adequate. A few DME/DMS and transportation providers noted that the group training meetings hosted by the CMOs were not geared toward them. Many of the providers we interviewed commented on having a long-standing relationship with the county. The counties successfully built upon this history by involving the providers in the planning committees for the CMO and keeping them well informed as the model developed. The ties were particularly strong in the smaller counties. These providers indicated a more certain procedure for who to contact at the CMO when administrative or clinical problems arose.

Service planners at the CMOs track the services for which consumers have unmet needs. The network developer at the CMO then uses that information to add to the network. In Fond du Lac, a cab company expanded services as a result of discussions with the CMO over the need for night and weekend transportation. The Fond du Lac Long-term Care Council intends to talk with providers to identify additional CMO member needs and work with the providers to address these needs. In contrast, La Crosse noted an increased strain on providers since beginning Family Care and they intend for the Self Directed Support Option[10] to relieve some of the stress on the provider system. The La Crosse LTC Council also indicated a commitment to advocate for more providers. To expand residential options, the Portage CMO partnered with CAP[11] services to design a duplex for 4 CMO members. The building is owned and maintained by CAP, CMO members pay rent, and the CMO contracts for residential support workers to serve the members.

[10] This option will be described in greater detail in the *Consumer Direction* section of this report.

[11] Community Action Programs, an area non-profit organization.

Some standardized evidence exists to demonstrate the efforts of the CMOs to make services available to CMO members. Results from a study reported in May 2001 by Stephanie Robert of the University of Wisconsin School of Social Work revealed that Family Care care managers in comparison to care managers state-wide cited the availability of types of service providers as a less frequent barrier to formal services.

Despite expanding services to greater numbers of individuals, none of the providers interviewed reported having to increase their capacity, with the exception of one daily living skills provider who hired more staff initially. Similarly, providers did not note an increase in referrals since the beginning of Family Care. One of the Milwaukee LTC Council members noted that adult day care centers may be getting fewer referrals from the CMO than they previously received from the county, possibly because consumers are not selecting this service option.

E. Increased Community-Based Care through Nursing Home Relocations and Institutional Diversions

Nursing facility relocations are occurring in the pilot counties and, in some counties, the CMOs are actively conducting outreach in nursing facilities. In recent years, Milwaukee has experienced a number of recent nursing home closings and, in 2000, 310 residents were displaced due to these closings. Approximately 10 percent (32) of those individuals were relocated to the community.[12] Portage had five relocations in the first quarter of 2001. They also reported that in the same period three elderly members living in CBRFs were prevented from entering nursing homes when they depleted assets. Fond du Lac had two nursing facility relocations in the first quarter of 2001, while La Crosse did not report any relocations during this same period. DHFS plans on reviewing functional screen data to reveal if the living situation of individuals screened in nursing facilities resulted in relocation after one year. Additionally with the approval of the waiver, CMS requires DHFS to track, on a semi-annual basis, individuals being diverted from institutions as a result of Family Care. CMS will use the information to make adjustments to the cost effectiveness calculations. The Department does not currently collect this information and will have to develop a standardized definition of an institutional diversion. As a result, some counties consider every CMO member served in the community a diversion, while others count only those individuals whose functional level might warrant institutional placement if other services were not available.

F. Administrative Issues

Serving an increased volume of people requires an organized, streamlined process to identify and fulfill the service needs of consumers. During the start-up period, the administrative burden on the CMOs has been substantial. Developing operational procedures and engaging providers has been labor intensive. The CMOs are still developing effective ways of creating a functioning service delivery system under Family Care, and have faced several challenges along the way.

[12] Data provided by Joyce Allen, DHFS.

1. Prior Authorization

Prior authorization procedures for services delivered by providers under the Family Care benefit are time intensive for both the CMO care managers, who authorize services, and the providers, who deliver the services. CMOs have struggled to develop a consistent and timely process to ensure that providers receive authorization before delivering services (i.e., prior authorization procedures). However, Portage noted that in the first quarter of 2001, they were still receiving claims for services that had not been authorized. Providers noted that they did not receive standardized information from care managers about the prior authorization process. All CMOs, except Richland, now have a verbal process in place. Providers interviewed reported that written authorization usually follows the verbal. Nevertheless, many of the providers indicated that they would appreciate additional training from the CMO on the authorization process.

Another administrative burden for the CMO related to prior authorization concerns for DME/DMS services. The CMOs indicated that the administrative costs in matching service codes with providers and tracking authorizations for small items far exceeds the monetary costs for these items. A couple of county staff representatives recommended that these services be excluded from the benefit. Providers also indicated that small items, such as cottonballs and gauze pads, termed MA allowables under the previous system, did not require prior authorization. Under Family Care, the CMOs are requiring that each individual item be authorized. Providers find this extra step burdensome for small items and they also mentioned the potential for such a process to limit consumer choice and independence. The Department suggests, and some CMOs practice, controlling this problem by not requiring pre-authorization for small items, but having providers bill for them and review usage later. In an attempt to streamline the process, Portage uses the service plan to pre-authorize these types of items and the interdisciplinary team reviews the authorization every six months.

2. Administrative Burden on Providers

Overall, providers interviewed noted that the program was administratively simpler than the previous system. For example, using the CMO as the primary contact for questions about care delivery and billing has simplified the system. Some DME providers also reported that the CMO reduced the amount of paperwork from the previous system in which they had to send documents to the state Medicaid office to receive authorization to provide certain items.

Compared to the old system, providers have not experienced any changes in reimbursement with the advent of the CMO. Generally providers are still paid at the MA rate. However providers no longer have a budget with the county and are instead reimbursed for each individual consumer served. This represents a major change for providers, such as adult day services, because they can no longer count on a consistent number of consumers from the county. When a consumer dies, the provider is not guaranteed another referral from the county, which makes program planning and budgeting difficult. Most providers are reimbursed anywhere between two weeks and one month after submitting a claim. Some providers interviewed indicated experiencing problems related to changes in billing procedures, while other providers did not note significant changes in the billing system. The new Family Care system has the potential to hold providers more accountable for the services they provide.

3. CMO Access Issues

Although service delivery remains largely unchanged under the new system, access has been increased through the opportunity for services to be delivered more equally, creatively, and rapidly than the previous system. Representatives from the county LTC Councils overwhelmingly cited expanded access to services when commenting on Family Care in relation to the previous long-term care system. Family Care appears to be increasing the responsiveness of the LTC system to consumer's needs. The following three examples provide evidence of increased consumer access:

- ***Equality in service delivery*** -- La Crosse noted that they are now able to expand service access to the entire disability population. Eliminating waiting lists has allowed them to expand services to younger people with disabilities transitioning from the school system as they turn 18. Previously these individuals could not apply for services until they turned 18 leaving them at the bottom of waiting lists with effectively no access to needed services.

- ***Creativity in service packages*** -- In Fond du Lac, a CMO member requested a special type of water therapy that was not available through providers in the county. With guidance from a physical therapist, the CMO member was able to perform some of the exercises on her own in a community swimming pool. The CMO coordinated with the pool and the Wisconsin Coalition for Advocacy to obtain a free annual pass for the CMO member's attendant to accompany her to the pool.

- ***More rapid service delivery*** -- Under the previous system, obtaining a large item such as a wheelchair required the provider to submit a prior authorization form to the State Medicaid office. The office then had 21 days to approve, deny or request more information regarding the claim. Under Family Care, the authority to make decisions such as this is devolved from the state to the county, meaning that care managers authorize these items, as needed, on a more timely basis.

G. CMO Disenrollment

Exhibit VII-5 shows that approximately 7.2 percent of members have disenrolled since the start up of CMOs. Across the counties, three out of five disenrollments resulted from deaths. Milwaukee has had a higher "disenrollment" rate because of slow processing of waiver rollovers that were pending re-certification. However, this resulted in no interruption of service to the consumers. The computer system automatically disenrolls individuals after a year if they have not been re-certified. The primary reason for lost eligibility was changes in financial circumstances. Disenrollment to date has been lower than Medicare+Choice disenrollments, which averaged 13 percent in 1996.[13] A similar 1915(b) and 1915(c) combination program,

[13] Families USA, (1997). ***Comparing Medicare HMOs: Do They Keep Their Members?*** Washington D.C.

Texas Star+Plus, had less than one percent of enrollees switching plans in any given month during 1998-99.[14]

Exhibit VII-5
Reasons for Disenrollment; Percent and Absolute Number

	Cumulative Percent Disenrolled*	Deceased	Pending* or Lost Eligibility	Voluntary Disenroll
Fond du Lac	9.1% (62)	58.1% (36)	17.7% (11)	24.2% (15)
Portage	5.2% (44)	59.1% (26)	18.2% (8)	22.7% (10)
La Crosse	10.0% (43)	79.1% (34)	14.0% (6)	7.0% (3)
Milwaukee	7.3%(72)	47.2% (34)	36.1% (26)	16.7% (12)
Richland	2.0%(3)	66.7% (2)	33.3% (1)	0.0% (0)
State Total	7.2%(224)	58.9% (132)	23.2% (52)	17.9% (40)

*Based on March Members plus disenrollees.

Note: Richland is based on three individuals. Milwaukee has a high percentage pending re-certification which make them appear to have disenrolled.

Source: The Lewin Group analysis of data provided by DHFS.

[14] Borders et al. (1999). *STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness*. Submitted to The Texas Department of Human Services by the Public Policy Research Institute of Texas A&M University.

VIII. CARE MANAGEMENT

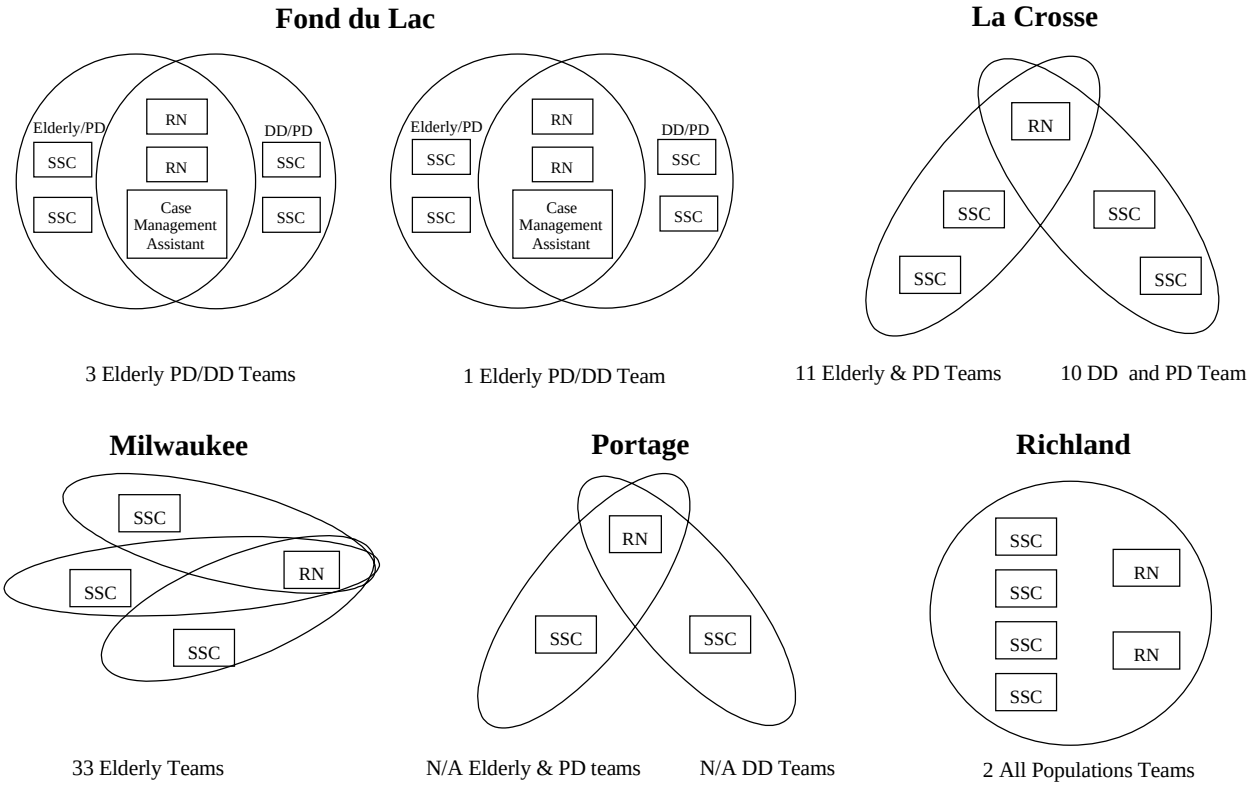
Care managers assume a critical role in the ability of the Family Care model to meet its goals. Care managers serve as a link connecting consumers with the services and supports that meet their needs. The success of the Family Care model depends on the efficient management of services and costs to accommodate both the consumer's service needs and the financial viability of the CMO. In this section, we address how Family Care has changed pilot counties' approach to care management, but conclude that it is too early to know whether both consumer preferences and cost-effectiveness goals can be met.

A. The Care Management Approach

The use of interdisciplinary care management teams departs from practices prior to Family Care where a single care manager, usually a social worker, was solely responsible for functional eligibility determination and care management. Prior to Family Care, care managers functioned primarily as service brokers. With the introduction of RNs, a team approach, a greater emphasis on involving consumers, and responsibility for quality assurance as well as costs, care management becomes a much more complex and time intensive endeavor.

Under Family Care, the pilot counties have the ability to tailor their approach to the formation and composition of the interdisciplinary team. The only contract requirements for the CMO interdisciplinary teams are: 1) all teams must have one RN and one social service coordinator; 2) one individual must be identified as the member's primary care manager; and 3) the CMO must have the capacity to offer an enrollee the choice between at least two care management teams. Given this latitude, a variety of care patterns have emerged (see ***Exhibit VIII-1***). In Milwaukee, one RN works with three social service coordinators and cases are distributed based on anticipated need. In Fond du Lac, the team is comprised of social service coordinators, two RNs, and one case management assistant (where the RNs and the assistant are shared with another team). The case management assistants' responsibilities include direct service provision such as transportation to doctor's appointments, shopping and social activities as well as some administrative work. Richland CMO staff recently formed two large teams that work with all populations. Care managers on the teams are specialized to the populations, while the four nurses are split evenly between the two teams. The management of the Richland CMO allowed the social service coordinators and the RNs to decide the formation of the teams and indicated they are open to adjustments as needed. Portage has yet to finalize team composition. They are considering forming pods of social service coordinators and RNs. At this point they have social service coordinators specific to target populations, but RNs are handling all target populations. Currently one RN and one social service coordinator make up a team for a CMO member. In most cases, the social service coordinators are taking the lead on managing the member's care unless the consumer has more intense medical needs, in which case, the RN leads the team for that consumer. It is too early to determine what approach to care management might be most effective.

Exhibit VIII-1
CMO Care Management Team Configurations



Note: Portage has not yet formalized its team arrangements. Nurses are not population, nor Social Service coordinator specific.

Aware of the intensive care management model of the interdisciplinary team, CMOs reported an effort to control caseload sizes. The CMOs have all set caseload goals for social service coordinators and RNs. ***Exhibit VIII-2*** compares current caseload sizes to target caseload sizes for social service coordinators. Fond du Lac, La Crosse, Milwaukee, and Portage (DD only) have not yet met their target goals for caseload size.

Exhibit VIII-2
CMO Target and Current Care Manager Caseload Size

CMO	Current	Target
Fond du Lac		
Elderly/PD	50	40
DD	50	40
La Crosse		
Elderly/PD	45	40
DD	45	40
Milwaukee		
Elderly	40	35
Portage		
Elderly/PD	37	45
DD	50-55	45
Richland		
Elderly/PD	35	35
DD	35	35

The average caseload size of about 40 is smaller than caseloads prior to Family Care. In the COP program in Milwaukee, caseloads were as high as 60 individuals per care manager. The pilot counties noted a significant reduction in the caseload size for social service coordinators caring for the DD population as compared to pre-Family Care arrangements. Portage reported that caseloads for the DD population averaged between 70-80 prior to Family Care and are now 50-55.

When the CMOs began, RNs only participated in the assessment process. The role of the RN continues to evolve to include responsibilities broader than assessment. DHFS advocated for the expansion of the role of the RN as a means of achieving greater prevention of acute care episodes and more coordinated primary care. DHFS has asked the pilot CMOs to develop practice guidelines for RNs incorporating a prevention and wellness role. ***Exhibit VIII-3*** indicates that the CMOs have progressed in their efforts to determine the number of RNs per member needed to accomplish the functions outlined for them.

Exhibit VIII.3
CMO Target and Current RN Caseload Size

CMO	Current	Target
October 2000		
Fond du Lac		
Elderly/PD	100	100
DD	125/150	125/150
La Crosse	120	80
Milwaukee	100	Still developing
Portage	100	Still developing
Richland	N/A	N/A
May 2001		
Fond du Lac	100	80
La Crosse	100	80
Milwaukee	100	80
Portage	125	80
Richland	50	Still developing

As the role of the RN expanded under Family Care, the county goal for the number of nurses per members decreased. In Fond du Lac, for example, RNs are now evaluating consumers' need for therapy and DME, accompanying consumers to the doctor, and performing more of a teaching role than previously. As a result, their caseload goal has been amended to one RN per 80 members, down from 100 to 150. Portage also noted that RNs are playing more of a prevention and wellness role. In Richland, RNs have just been hired and a goal has not been set. The teaming arrangements permit RNs to have a higher number of consumers in their caseloads. Most of the pilots agreed that 80 is a manageable caseload for RNs. However, none of the CMOs have reached that goal. The CMOs also reported that the DD population does not require as much nursing care. Consequently, RNs have a higher number of DD consumers in their caseloads.

Care management under Family Care strives to consider acute and primary care needs to a greater degree than in the past through the inclusion of RNs and active efforts to monitor all aspects of a member's health care. However, the hospital discharge process currently presents a challenge to most of the CMOs. When CMO members are admitted to the hospital, it is important that the CMO is aware of the member's change of status so that they can be involved in the discharge planning process. The CMO can act as an advocate for the consumer and family members by ensuring that the hospital discharge planner works closely with the interdisciplinary team to assess the consumer's preference for home health agencies when creating a plan to maintain continuity of care. CMOs reported that hospital discharge planners are not checking a patient's Family Care eligibility status. As a result, the consumer or family members and personal care providers are the most reliable sources of notification to the CMO. Home health agency providers noted that many times their clients are discharged from the hospital to another home health agency, often times one connected with the hospital franchise. This problem of care coordination between the acute and long-term care sectors is common nationally and is not unique to Wisconsin's long-term care system or the Family Care model. Family care represents a promising opportunity to bridge the gap between these sectors and eliminate the problems in care coordination.

Some of the pilot counties have taken action to improve this process. Richland has made great strides to coordinate with the hospital in the county and has organized an acute and primary care workgroup. Subsequently, Richland CMO care managers are able to access the hospital database and review medical charts for their members. Portage CMO staff indicated that they have a hospital discharge planner on the County LTC Council which they hope will result in improved coordination.

B. Consumer and Provider Involvement in Care Management

The pilot counties have made progress in incorporating CMO members into the care planning process. The first Lewin report documented that staffing shortages and caseload conversions prevented CMOs from fully realizing the potential for consumer participation in the care planning process since care managers only had time to maintain current service plans. DHFS' six month quality review results indicated that only two (Milwaukee and La Crosse) of the four CMOs had an interdisciplinary team assigned to each CMO member with, at minimum, a nurse and a social service coordinator who knew the member. Now, as noted above, interdisciplinary teams are administratively in place in all of the CMOs.

CMOs develop individual service plans (ISP) with each member and have that member sign the plan. The ISP lists out the services and the associated costs, giving the consumer a greater knowledge about the services that they receive. Many providers noted that consumers under Family Care seemed to be more knowledgeable about the services that they were receiving. Some also indicated that since the start of Family Care, care managers are more attentive to consumer requests.

There is room for increased provider participation in the service planning process since they have the most regular contact with consumers. Service providers can serve as advocates for consumers. Some providers we interviewed identified consumer advocacy as a role they wish to play as the Family Care model continues to evolve. In most cases, however, providers simply received authorization for specific services from the CMO and did not receive a copy of the individualized service plan (ISP) for a consumer. Many were not aware that an ISP was created by the CMO. Some providers indicated that they would like to receive a copy of the ISP as a tool in their own assessment and planning for the consumer. In some instances, providers were involved in care planning with the consumer and the CMO. However, the providers generally reported that they did not see a change in care planning since the beginning of Family Care. It is important to note that care planning appears to be more integrated among providers for the DD population. When asked about this finding, providers indicated that this approach is not new to them. Rather, it has been the traditional model for service planning with the DD population.

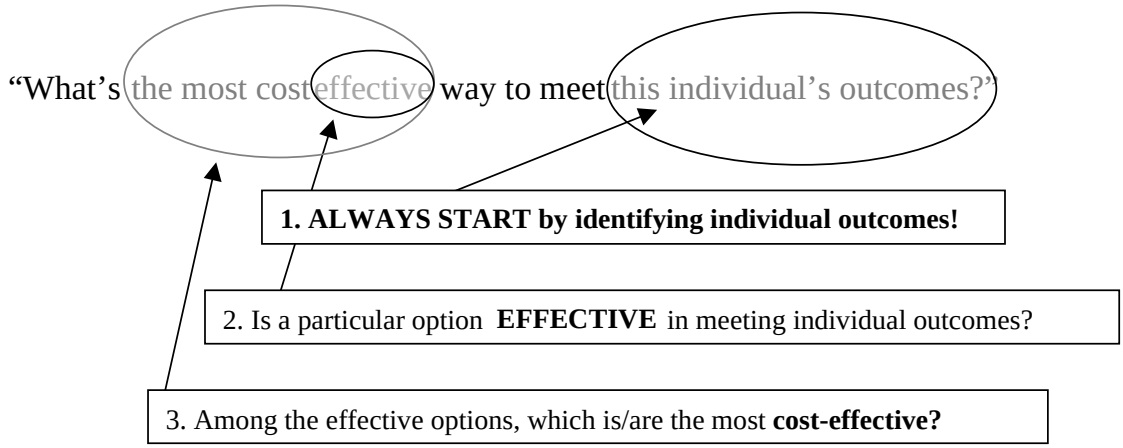
Providers that indicated that they were not involved in the initial care planning noted that they were more involved, however, in the on-going care planning process. For example, transportation providers reported that they coordinate with the CMO if the consumer needs more rides authorized than were originally planned. Prior to Family Care, some providers of MA card services, such as DME/DMS, dealt only with the State Medicaid office for authorization. The Medicaid office had no face-to-face interaction with the consumer. Now, with Family Care, each consumer has a care manager with whom the providers can interact on a regular basis. Providers

noted that they had good lines of communication with the care managers and reported the relationship with the CMO as positive.

C. Balancing Consumer Preferences and Costs

The Department has made a considerable effort to encourage the use of the Resource Allocation Decision Method (RAD) as a means of balancing consumer outcomes and cost. A workgroup of DHFS staff and care managers developed the RAD method in order to clarify that consumer preference should not be the only factor in Family Care service delivery decisions. The WI Partnership Program (WPP) sites also provided input in the development of the method. ***Exhibit VIII-4*** displays the logic of the RAD method as described by DHFS. During the DHFS quality site reviews with the pilot counties, the RAD method was identified as a training need. The Department offered training to the pilot counties upon request. All pilots have participated in RAD training offered by DHFS at least twice.

Exhibit VIII-4
The DHFS Resource Allocation Decision (RAD) Method



Source: DHFS.

The CMOs all indicated that they use the RAD method in the care planning process. The CMOs reported practice of the use of the RAD method through case reviews in staff meetings and internal trainings on the RAD method. CMO staff commented that the most useful method of training around the RAD was case application in this type of group setting. There is some cross-county variability in the application of the RAD. Most of the CMOs reported that they were using the RAD for difficult situations in which disagreements arose among the interdisciplinary team members about the most appropriate service plan. Some of the CMOs require use and documentation of the RAD for each member, while others use it more selectively and provide narrative in the member's chart. Milwaukee implemented a checklist for documenting the RAD method that the team inserts into each consumer's chart.

The new emphasis on cost represents a shift in care management practice from the previous system. The CMOs struggle to achieve a balance of how much cost information should be made available to the care managers so they can create an appropriate care plan in collaboration with the member and the team. In La Crosse, initially the care managers had full responsibility for

incorporating the cost of services into the ISPs. They are now redirecting some of that responsibility to the business staff. In contrast, care managers in Portage have requested more information about cost because the care managers currently develop the ISP without concrete cost information and the business staff provide the cost information later. Once the IT systems in Portage progress to a higher capability, the care managers in Portage will be able to use real-time cost information in their ISP development.

The interdisciplinary team model of case management may result in more costly administration than the previous long-term care system, but could result in cost savings for acute and primary care. The increased responsibility for care managers demands an intensive administrative time commitment. The CMOs reported that the interdisciplinary teams meet about once a week formally and sometimes more frequently informally. A preliminary study of care managers who experienced the change to Family Care revealed that service arrangement in Family Care is often more difficult than the previous system.[15] This experience has been documented in other interdisciplinary models of care. For example, Challis et al (1991)[16] noted that an interdisciplinary team approach for a program designed to provide alternative care in the community to the elderly involved extra costs to the social services department administering the program, but lower costs for health services. Also, the PACE model, characterized by intensive care management by an interdisciplinary team, has successfully fulfilled its promise of reducing hospital and nursing facility use and nursing facility length of stay.[17] Outcome data on nursing facility and hospital use is not yet available for Family Care. The State Long-Term Care Council reported that the number of Medicaid patient institutional days in Family Care counties is slightly less than the statewide average. The Department acknowledges that it is too early to attribute this difference to Family Care, but they will continue to track the information on a quarterly basis.

[15] Robert, S. A. (2001, May) "Early Evidence from Wisconsin's Family Care Long-term Care Pilot Program: Continuity and Change in the Provision of Formal Services." *Report Series: Long-term Support in Wisconsin – The Perspective of Care Managers. Report #1*. University of Wisconsin School of Social Work

[16] Challis, D., Darton, R., Johnson, L., Stone, M., and Traske, K. (1991). "An Evaluation of an Alternative to Long-stay Hospital Care for Frail Elderly Patients: II. Costs and effectiveness." *Age and Ageing*. 20: 245-254.

[17] Doyle, A. and Masland, J. (1997). "Managed Care for the Elderly in the United State: Outcomes to-date and potential for future growth." *Health Policy*. 41 (Suppl.): 145-162.

IX. CONSUMER DIRECTION AND ADVOCACY

Consumer direction is a major tenet of the Family Care model. It is a concept that emerged from the disability community and has received increased national attention in recent years by policymakers, practitioners, advocates and researchers in its applicability to the entire long-term care population. Consumer direction is not a single approach. It is a spectrum of financing and delivery models designed to empower consumers, provide choice, and allow individual control over decision-making. At one end of the spectrum is professional management of prescribed services and at the other end is a self-directed cash model. In between these extremes is a range of options that vary by level of individual control, autonomy, and self-determination. Family Care has embraced a large part of the spectrum.

A. Consumer Direction Design in Family Care

In 1997, several counties in Wisconsin, including La Crosse, received Robert Wood Johnson Foundation grants to pilot Self-Determination for Persons with Developmental Disabilities projects. This concept provided a framework for the design of Family Care. Under the Family Care demonstration, aspects of consumer direction have been incorporated into the Family Care CMO contracts, the Member Outcomes Tool[18], and the design of self-directed support (SDS) options, which is a requirement of the CMO contracts (see ***Exhibit IX-1***).

Exhibit IX-1
Consumer Direction under Family Care

CMO Contract
The CMO is to inform members of the full range of services in the long-term care benefit package
The CMO is to provide the support necessary to allow optimum member participation in the Individual Service Plan development and updating and around decision-making
The ISP is to include expected outcomes and members' goals and preferences
Discussion is to occur with the member concerning any ISP updates, denials or changes in service
Members are to have a choice of providers, at a minimum, for personal care, home health, private duty nursing, supportive home care and chore service
The CMO is to consider a member's request for a non-CMO provider
The CMO is to recognize each member as an individual and emphasize each member's capabilities
Members are allowed to change care management teams up to two times per calendar year
The CMO is to seek formal member input around communication, access, choice, and status changes
Members are to be given an opportunity to continually participate in CMO quality improvement and give input and feedback on the quality of the CMO services
The CMO is provide materials to members that are understandable in language and format
The CMO is to actively promote the exercise of member rights
Members may participate in a self-directed support option
Contract language around provisions for private room choice are currently underway
Members can file a grievance directly to the fair hearing process

[18] A more detailed description of the Member Outcomes Tool is provided in ***X. Quality Assurance and Improvement.***

Exhibit IX-1 (continued)
Consumer Direction under Family Care

Member Outcomes Tool [a]
People are treated fairly
People have privacy [b]
People have personal dignity and respect
People choose their services [b]
People choose their daily routine
People achieve their employment objectives [b]
People are satisfied with services
People choose where and with whom to live [b]
People participate in the life of the community
People remain connected to informal support networks
People are free from abuse and neglect
People have the best possible health
People are safe
People experience continuity and security
Self-Directed Support Option
An annual budget for each individual is determined unique to that individual's needs
Mechanisms exist to enable participants to change providers and service arrangements
Use of informal supports is encouraged thereby shifting away from reliance on formal providers
Individuals are given an option to use a fiscal intermediary to handle direct employment of providers
Individuals are given an option to use a co-employment agency, under which an employment agency acts as the employer of record for an employee of a service provider chosen and supervised by the individual and his or her support team

[a] The outcomes are incorporated into the ISPs and are intended to drive the care planning process. The Department plans to use the CMO-generated reports around these outcomes to establish standards and benchmarks for the program.

[b] The specific member outcomes related to consumer direction that the Department is closely monitoring during the 2001 contract period.

B. Pilot Experience

DFHS set guidelines in the CMO contract for SDS program design, planning, budgeting, and risk sharing. Every pilot county submitted their SDS option plans to DHFS outlining their strategy to phase-in the option for all members. The CMOs are required to phase-in the self-directed support option for all members by January 1, 2003. Several of the CMO representatives reported that the planning and design processes required extensive time and effort. In general, CMO representatives reported that consumer direction activities have been tied predominantly to the planning and implementation of the self-directed support (SDS) option.

The pilots have SDS options that are at various stages of development and some have members participating in different models. Portage currently has 10 percent of their CMO members using the option. The majority are DD and PD. Milwaukee views the option as a continuum and has about 1,200 people in the waiver and Family Care programs who are selecting their own homemaker. They are not sure how many of those individuals are Family Care members and do

not have any members using other forms of the option, which include self-advocacy classes. As of July 2001, La Crosse had 46 members using the SDS option, or about five percent. Although they have consumers interested, Fond du Lac does not have any CMO members using the option because they have not been able to start the program due to other staff resource strains.

Three main SDS models exist under Family Care. The first model is an agency-employed model. In this model the agency acts as the employer and performs the necessary fiscal and administrative functions. The second is the consumer-employed model. In this arrangement, the consumer assumes all employer functions and acts as the care worker's employer of record. CMO representatives felt that very few members possess the skills necessary to manage all employer functions. Currently, none of the CMOs offer this option to members. The third is a combination model of the former arrangements in which the consumer and the agency share the employer responsibility. An example given by the CMO staff was that the consumer recruits the care worker and the agency screens the worker and handles the payroll functions. In the combination model, the agency may also serve as an advocate in training and assisting the consumer to assume increasing responsibility for their care brokering. For example, the agency may help the consumer write a job description for a care worker. Portage, Milwaukee, and La Crosse CMOs have arranged for a fiscal intermediary to be available to manage some of the fiscal responsibilities of the employer functions. Fond du Lac is in the process of recruiting firms to handle the fiscal functions. Portage, Milwaukee, and La Crosse work with additional organizations that are available to provide functions both under the agency-employed and the combination models. Representatives from these counties also reported that they offer classes in self advocacy which provide assistance to members in communicating needs and expectations to employees. The Portage SDS workgroup developed a "service agreement" to guide members in this same effort.

The MEDSTAT group studied various state consumer-directed personal assistance programs and recommended that states consider implementing consumer-directed options in a spectrum model similar to the combination model noted above[19]. They recommend a single organization act as fiscal intermediary and consumer trainer in order to maintain control over the development and philosophy of the intermediary services provided.[20] This model reduces the cost in dealing with multiple agencies and promotes a more seamless system. However, one drawback of creating a state-wide model could be the absence of county-level support fostered in a collaborative development effort among CMO staff, consumers, and providers in designing the option specific to the county.

Discussions with CMO staff, consumers and providers revealed that there are at least five critical elements to the success of the Family Care SDS option:

1. **Consumers must be aware of the option.** DHFS required each county to have a formal outreach plan for the SDS option. All of the pilots opted to have the RCs introduce the

[19] Flanagan, S.A. and Green, P.S. (1997). *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations.* Prepared for: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Division of Aging and Long-Term Care Policy.

[20] Ibid.

option to consumers. Milwaukee actively recruited members to participate in the option as a way of piloting the plan. Fond du Lac noted that informational sessions with small groups of family members appeared to be an effective means of educating consumers and families around the option. Fond du Lac plans to include language in the Individual Service Plans (ISPs) that will prompt staff and consumers to discuss the option. Portage and La Crosse incorporated discussion of the option into the assessment and care planning stages at the CMO.

2. **Consumers must be supported to take on the employer role to the degree that they desire.** The CMO representatives reported that Family Care target populations have demonstrated varying levels of ability and interest in the SDS option. They noted that functions required to self-direct can be extensive and require new skills. For example, provider recruitment involves assessing competency and screening for past criminal activity. Providers then might have to be trained in order to perform the required tasks. Other employer functions, such as payroll and taxes, also need to be managed. The model the member chooses will dictate the degree of consumer responsibility for administrative and operational functions. Therefore, any program with a self-directed option should have a flexible design in order to accommodate the variation in CMO members' willingness and ability to manage the functions.

3. **Consumers must be protected and kept safe.** Central to self-directed care is increased autonomy and consumer responsibility. With this path to greater independence and dignity comes exposure to greater vulnerability. Balancing individual choice and potential risks is a challenge inherent in these models. Each CMO has outlined strategies for ensuring safety while maintaining consumer dignity. Milwaukee uses a model risk agreement with consumers, which was developed by the Assisted Living Federation of America. Milwaukee CMO members use the agreement to negotiate around risk while self-directing their care. Fond du Lac plans to address safety issues in the SDS advisory committee meetings. Portage and La Crosse both adopted use of the decision tree, "Utilizing Risk Taking by CMO Members: A guide for case managers," developed by the State case management workgroup. The Portage SDS workgroup also developed standards for independent providers to assure safety of both the member and the care worker. They have developed a document entitled, "Roles and Responsibilities in SDS," which provides a guide for CMO staff to assess the appropriateness of certain employer functions for the participant.

4. **Consumers must be held accountable through quality monitoring.** CMO representatives expressed that if consumers, proxies, or intermediaries are responsible for a fixed budget for services, they must be held accountable for the management of the budget to prevent misuse of funds. As mentioned earlier, none of the CMOs allows consumers to function in the consumer-employed model where the consumer is responsible for all employer functions. The Portage SDS option manual provides a guide on how to manage the budget. Milwaukee provides monthly statements of service costs to participants and the case manager is expected to discuss this with the member if requested. In all counties, consumers are given access to their records.

5. **Support for the program must be gained from community stakeholders.** Each pilot county formed a SDS committee comprised of providers, consumers, and county staff during the planning and development of the option. The County Long-Term Care Council representatives we spoke with were very knowledgeable of the option in their respective county. However, the majority of network providers we interviewed were not aware of the SDS option with the exception of those providers that were involved in the planning process. The providers who were aware of the option expressed great concern about the quality of services delivered under this option and the potential for consumer harm, particularly with respect to the use of independent providers. Some providers felt that they were not on a level playing field with the independent providers because the independent providers do not have to provide benefits or liability insurance. As a result, a few reported that they intended to increase their private pay business.

DHFS reported that by emphasizing self-directed supports with the counties, they aimed to plant the seed for counties to think about consumer choice and enable them to begin to develop this notion further. It appears that the pilot counties have made great progress in developing and implementing the SDS option. However, the pilots all reported that this option requires substantial demands on their time. Some county representatives felt that the development of the SDS option was an added burden since the concept was inherent in the overall Family Care model. In addition, representatives expressed that their preoccupation with the SDS option diminished other efforts to enhance consumer direction. Staff from the Milwaukee CMO felt that the SDS option was not necessarily applicable to the elderly population in terms of member willingness and ability to participate. Milwaukee chose to enhance consumer direction by developing a social marketing campaign for consumers about how to communicate with their physicians and families concerning their care.

Consumer representatives that we interviewed believe that Family Care members now have greater choice in selecting providers. One consumer noted that it is easier now to choose a provider upon discharge from a hospital instead of accepting a provider chosen by the discharge planner. An increase in consumer-directed supports was reported by 68% of care managers interviewed in a study conducted by Stephanie Robert of the University of Wisconsin School of Social Work.

However, the results of the Member Outcomes Assessment[21] conducted by DHFS revealed that the response "People chose their services" received just over a 40 percent rating, the lowest rating of all of the Family Care consumer outcomes. The Council on Quality and Leadership in Supports for People with Disabilities, the organization that assisted in the development of the tool, indicated that emphasizing consumer choice, particularly to a population not familiar with the concept as it relates to human services, may result in raised expectations contributing to a low score in the area of choice. DHFS reported that they would pay close attention in the future to this result and to the emphasis that the program places on attentiveness to consumer needs and desires.

[21] This assessment will serve as a baseline. The report can be found at http://www.dhfs.state.wi.us/LTCare/pdf/MemberOutcomesReport.pdf

Network providers also reported minimal changes with respect to consumer direction. Providers do not appear to be altering the way in which they deliver services. They felt that consumers are not requesting certain hours of service any more or less than under the previous system. Transportation providers indicated that consumers still call to set up rides. However, the increased role consumers play in decision-making under Family Care may be highlighted by the finding that some providers reported that they intend to place a higher focus on marketing services to the consumer with the increased choice that consumers now have in selecting a provider.

X. QUALITY ASSURANCE AND IMPROVEMENT

The pilot counties had just begun to develop their quality plans at the time of The Lewin Group's November 2000 implementation report. At this time, the pilot counties' preoccupation with start-up issues, such as staffing and transitioning waiver cases into the Family Care program, hindered their ability to focus on the quality assurance aspects of the program. The pilot counties are now moving forward in addressing their plans for quality as outlined by DHFS. The Department has committed substantial resources to the quality design of Family Care and devised a comprehensive strategy that is now being integrated with county approaches. The Department's quality assurance strategy focuses on ensuring that Family Care achieves the following original goals:

- Increased consumer choice;
- Improved access to and information about services;
- Improved decision making about long-term care;
- Creation of a comprehensive and flexible long-term care system;
- Improved quality through a focus on health and social outcomes; and
- Creation of a cost-effective long-term care system for the future.

A. State Multi-level Approach to Ensuring Quality

Over the past year, the Department has developed a comprehensive plan to assess quality in Family Care that constitutes a large component of their overall evaluation of the program. The plan addresses components of quality at the county level and at the individual member level across target populations. This multi-level strategy is intended to promote quality monitoring at both the program and consumer levels. In doing so, the Department, CMOs, RCs, and the Family Care members all play vital roles in promoting quality assurance. ***Exhibit X-1*** summarizes the components and the progress of the Department's plan to monitor quality at the county and individual levels. A more detailed description of the components of the multi-level approach can be found in ***Appendix D***.

Exhibit X-1
Progress of DHFS' Multi-Level Quality Plan

LEVEL	CMO	CMO Status	RC	RC Status
Family Care County System Level	**CMO CERTIFICATION**	Includes written quality plan; Ongoing	**RC CERTIFICATION**	Includes written quality plan; Ongoing
	ANNUAL SITE REVIEWS[22]	La Crosse – 7/01 Portage – 10/01 Milwaukee – 9/01 Fond du Lac – 8/01	**ANNUAL SITE REVIEWS**	La Crosse – 8/01 Portage – 6/01 Milwaukee – 6/01 Fond du Lac – 2/01
	TECHNICAL ASSISTANCE	Plan developed with CMO at time of site-visit	**TECHNICAL ASSISTANCE**	Plan developed with RC at time of site-visit
	CMO PERFORMANCE REPORTING	– Complaints, Grievances, and Resolution – Quarterly Narrative Reports – Outcome Focused Performance Improvement Projects – Quality Indicators	**RC PERFORMANCE REPORTING**	– Monthly I and A – Monthly PAC reporting – Annual QA/QI Project – Monthly FS reporting / Quarterly FS Reviews – Quarterly Narrative Reports
Individual Member/ Target Population Level	**DHFS FAMILY CARE OUTCOMES MONITORING**	Conduct additional analysis from the CMO Member Outcomes: The Baseline Assessment[23] CMO Member-Centered Service Plan Review	**RC CONSUMER SATISFACTION**	RC consumer satisfaction surveys

B. Pilot County Responsibility

Pilot counties must provide quality services and monitor the quality of care at the RCs and the CMOs. The Department continues to encourage the pilots to oversee quality of the Family Care program locally. Each RC and CMO must submit a quality plan to the Department for approval. The counties update the Department regularly through quarterly narrative reports, complaint and grievance reports, and through data reporting. They also participate in workgroups sponsored by the Department that allow exchange of information and ideas around incorporating components of quality in provider contracts, care management, self-directed supports, and information technology.

Individual RCs hold sole responsibility for assessing consumer satisfaction. The pilot counties must develop, administer, and analyze random satisfaction surveys. The RC must also monitor

[22] Six month reviews were also completed.

[23] Can be viewed at http://www.dhfs.state.wi.us/LTCare/pdf/MemberOutcomesReport.pdf

the quality of the functional screens that they administer and conduct local quality assurance checks before the screens are submitted to the state data warehouse. The Department plans to release a web-based version of the screen in September 2001 that will incorporate quality assurance checks automatically on-line. RCs must also have an annual focused Quality Assurance/Improvement plan.

The CMO must hold providers accountable for the services they provide to Family Care members. Responsibility for monitoring provider quality marks a shift from the pre-Family Care long-term care system. The Department has instructed the CMOs to incorporate quality assurance requirements in their contracts with providers. The pilot counties are currently at the early stages of developing strategies to communicate quality standards to providers, which is done primarily through the provider contracts. The providers we interviewed were largely unaware of any changes or quality enhancements required in their contracts, although some providers that had prior experience with the counties pre-Family Care did note an increased emphasis on quality in the contract language.

Milwaukee and Portage are coordinating quality assessment activities with the state licensing and quality monitoring agencies. This appears to be a helpful approach for those counties since it encourages an exchange of information regarding any concerns or issues the counties might have with providers. The Family Care contracts also require that the CMO have an internal complaint and grievance procedure. This allows the CMO an additional avenue to monitor provider services and address concerns directly. Lastly, the counties are expected to apply the results from the member outcome tool to evaluate services provided by the CMO. The Department provided technical assistance to the counties on how to analyze the results and use the tool in a formative process to make necessary adjustments.

The pilot county staff expressed mixed reactions to their new quality assurance responsibility. While they agree that the requirements helped to ensure improved care and service delivery to consumers, they were also overwhelmed by the time-intensive nature of the requirements. For example, some counties felt that the requirement to initiate a new quality project on an annual basis did not allow adequate time to fully develop and implement the first project without pursuing the subsequent one.

C. Individual CMO Member Responsibility

The Family Care model empowers the consumer to hold the county accountable for service delivery. Advocacy support for consumers is provided internally by the CMO and offered externally by the independent advocate. Consumers are also empowered to participate in the development of the Family Care program through the county Long Term Care Councils and CMO governing boards.

1. Advocacy

The CMO contract requires that the county provide a member advocate within the agency to educate consumers about advocacy services and member rights and to respond to any issues or concerns raised by the member. Each Family Care member is educated about his or her right to file a grievance directly to DHFS or to the fair hearing process before, during, or after the

internal CMO process. Staff from Portage County noted that Family Care has offered a new opportunity for consumers to voice concerns about their care because of the multiple information and access points surrounding the grievance process.

Independent advocacy has been offered through a state contract with the Wisconsin Coalition for Advocacy to provide an impartial entity to assist consumers with grievances, appeals, and fair hearings. The role of the independent advocate in the Family Care model included providing information and assistance, training, and technical support to individuals about how to obtain services and supports. Evidence indicates that consumers have used the independent advocacy services. During FY Year 2000, eighteen Family Care members were provided advocacy services and 180 received information and assistance, training, and technical support.[24] However, the independent advocate was recently eliminated in the Governor's proposed budget. Although the Senate has included the advocate in their version of the bill, the passage of the final act will determine the future of the independent advocate.

Pilot counties had mixed reactions regarding the utility of the independent advocate, although they generally reported minimal staff interactions with the advocate. Some counties indicated that the advocate was a beneficial aspect of assuring quality and essential to the program. Other counties reported that the advocate did not prove to be useful, questioned the professional capability of the advocate, and in one instance, asserted that the advocate had conflict of interest issues.

Additionally, the representatives from the State Long-Term Care Council interviewed remained in favor of maintaining the independent advocate as an important means for consumer advocacy. It is interesting to note that a small majority of providers we interviewed were generally aware of the independent advocate as a channel for consumer advocacy, but did not have experience with them.

2. Member Participation

The CMO contract ensures for consumer and member involvement in the operations of the CMO through the requirement to establish a CMO governing board that is reflective of the ethnic and economic diversity of the CMO service area. The governing board must be comprised of at least one-fourth older persons or persons with physical or developmental disabilities or representatives of these groups such as family members or guardians.

The County LTC Councils by contract are required to provide general planning and oversight to the CMO. According to s. 46.282 (2)(b)(1), Wis. Stats. the Council must be comprised of 17 members 9 of whom represent consumers in the three Family Care target populations proportional with the number of people in those target populations receiving long-term care in the state as determined by the Department. As the program evolves, the county Council will make recommendations to the Department regarding the need for additional CMOs. The County LTC Council must be educated about the goals and progress of Family Care in order to make such recommendations to the county and the state.

[24] Taken from the State Long-Term Care Council Annual Report 2001.

The Councils appear to be having more of a role in Family Care than this time last year. As noted previously, the representatives from the Councils perceived their role as information conduits for consumers and advisors to the county. The representatives from the County LTC Councils for Milwaukee, Fond du Lac, Portage[25], and La Crosse exhibited a considerable amount of knowledge about how the program operates. Richland LTC Council representatives did not have substantive experience with the program although they did have a sense of the overall goals of Family Care. The Richland representatives appeared to be at a knowledge level commensurate with the other CMOs in the beginning stages of implementation. The La Crosse Council noted their influence in the county board's decision to continue with Family Care as an example of an accomplishment. The Fond du Lac Council plans to talk to providers to address the unmet needs of members. County LTC Councils have also been established in Kenosha, Marathon, Jackson, and Trempealeau counties which will likely create the opportunity for the Councils to be involved in the development of a potential CMO in these counties.

D. Measuring Consumer Outcomes

The Family Care model shifts the perspective of quality assessment from the professional to the consumer. This shift recognizes that consumers' definitions of quality are different from those of professionals. By allowing the consumers to determine quality standards, it is expected that overall consumer satisfaction will be higher and better outcomes will be achieved. The notion of the "consumer perspective" is a departure from the previous system that relied more heavily on organizational process and outcome measures. The Family Care model is consistent with more recent leading-edge research around quality assurance in long-term care that calls for the consumer perspective to drive quality.

The Department continues to devote a considerable amount of effort to the Member Outcome Tool. The tool is designed to measure both consumer expectations (outcomes) and services provided (supports). The Council on Quality and Leadership in Supports for People with Disabilities initiated the tool through the development of an interview process designed to assess quality of life for people with disabilities in the context of service delivery systems. This interview measurement approach offers a way to assess if the 14 Family Care consumer outcomes are being met and if the CMO is offering the supports needed to achieve those outcomes. Questions on the tool are arranged in clusters pertaining to the 14 outcomes and the interviewer determines if the outcome and supports are present for the individual through conversations guided by the questions. The interviewer holds at minimum one conversation with the member and another with the member's care manager. Significant individuals in the member's life may also be interviewed as appropriate. Through a lengthy development process, the Department adapted the tool to the Family Care target populations with consultation from the Council, the Bureau of Aging and Long-term Care Resources (BALTCR), and the Bureau on Developmental Disabilities Services (BDDS).

From November 2000 to January 2001 the Department completed the first administration of the assessment tool on a total of 355 consumers in Milwaukee, Fond du Lac, Portage, and La Crosse

[25] The Portage county board chair delayed appointing a LTC Council because he was occupied with deliberating about making the CMO a separate county agency because the CMO budget exceeded the total Health and Human Services budget. We met with consumer and provider representatives in Portage in place of the Council.

counties. The Department issued a March 2001 report documenting the results of the first round of interviews. The tool was administered to Partnership sites during March, April and May 2001. Round two of interviews with CMO members began in May 2001. The Department anticipates completing the interviews at least by November 2001. The first report served as a baseline. The Department plans to use the results over time in the following ways:

- To offer context for DHFS review of the individual CMO operations;
- To assist each CMO in evaluating its' own performance;
- To compare Family Care to other county, state, and national programs; and
- To maintain a focus on consumer outcomes in service delivery and quality monitoring.

An important issue regarding consumer perceptions of quality was raised by the Council, namely that measuring consumer outcomes presents a challenge because consumer expectations may change as members become increasingly more aware of their rights as consumers. Therefore, as noted previously, positive results of the consumer outcomes could potentially diminish over time as consumer expectations are raised. If the CMO is successful in empowering consumers to advocate for their rights, consumer expectations could increase as the program evolves. The Department will need to monitor patterns that indicate this phenomenon is occurring as the program evolves.

XI. CAPITATION AND PROGRAM EXPENDITURES

This section presents an overview of the program expenditures for Family Care for both the Resource Centers and the Care Management Organizations. As expected, of the $32.2 million spent directly for RC and CMO activities, per member per month payments in the CMO counties for CMO enrollees account for the majority of the program's expenditures during calendar year 2000 (71%) with the remainder nearly equally divided between CMO start-up and ongoing RC functions. Within start-up expenditures, information technology dominated with nearly one-third of the total. This section also discusses the final capitated payments made to the CMOs.

A. Program Expenditures

During calendar year 2000, Family Care expenditures for direct resource center and care management organization activities totaled nearly $32.2 million (see ***Exhibit XI-1***).[26] The four initial CMO counties spent relatively similar amounts for CMO activities, between $6.0 and $7.2 million in each county during CY2000. In part due to its slower start-up relative to the other counties, a higher share of Milwaukee's CMO funding to date has been for start-up and wait list elimination activities (see ***Exhibit XI-2***). Start-up funds include several one-time allocations for putting in place the necessary infrastructure for implementation. The CMO counties allocated approximately 32 percent of these start-up funds to information technology development for the CMOs, although this percentage varied by county (see ***Exhibit XI-3***).

Exhibit XI-1
Family Care Spending for Resource Center and Care Management Organizations by County, CY2000

County	RC	CMO	Total
Fond du Lac	$432,097	$7,227,779	$7,659,876
Jackson	$205,396		$205,396
Kenosha	$626,205	$264,356	$890,561
La Crosse	$464,906	$6,010,603	$6,475,509
Marathon	$889,975	$7,841	$897,816
Milwaukee	$1,462,322	$6,996,127	$8,458,449
Portage	$280,532	$6,436,455	$6,716,987
Richland	$101,452	$600,365	$701,817
Trempealeau	$173,985		$173,985
	$4,636,870	$27,543,526	$32,180,396

Source: DHFS provided information.

[26] This amount does not include state administrative spending for oversight and support of the program.

Exhibit XI-2
Family Care CMO Spending Through CY2000

	Wait list elimination funds	Start-up		Capitated payments, CY 2000	Total
		CY1998-99	CY2000		
Fond du Lac	$172,271	$363,985	$522,124	$6,705,655	$7,764,035
Kenosha			$264,356		$264,356
La Crosse	$660,980	$247,521	$320,728	$5,689,875	$6,919,104
Marathon			$7,841		$7,841
Milwaukee	$1,235,138	$385,779	$2,544,104	$4,452,023	$8,617,044
Portage	$149,971	$412,641	$381,880	$6,054,575	$6,999,067
Richland	$279,995	$366,489	$600,365		$1,246,849
	$2,498,355	$1,776,415	$4,641,398	$22,902,128	$31,818,296

Source: DHFS provided information.

Exhibit XI-3
Family Care CMO IT Spending

	1999	2000	Total	% of Start-up Funds
Fond du Lac	$89,500	$312,552	$402,052	45.4%
Kenosha		$130,211	$130,211	49.3%
La Crosse	$45,500	$25,331	$70,831	12.5%
Marathon		$0	$0	0.0%
Milwaukee	$70,000	$851,160	$921,160	31.4%
Portage	$75,000	$185, 227	$260, 227	32.8%
Richland	$75,000	$204,867	$279,867	28.9%
Total CMO Counties	$355,000	$1,709,348	$2,064,348	32.1%

Note: Marathon has been provided a limited amount of start-up funds ($7,841), and none have been devoted to IT.

Source: DHFS provided information.

A small proportion of the Family Care budget is funded by new general purpose revenue (GPR) – approximately 24 percent of the total for FY 1999-2000 and 11 percent for the revised FY 2000-01 budget projection (see ***Exhibit XI-4***). Most state GPR funding used in Family Care is funding reallocated from existing programs including the Medicaid fee-for-service, Community Options, and the adult protective services portion of the Community Aids Programs. Counties also are providing gap funding and in-kind support for some administrative functions. ***Exhibit XI-4*** displays the preliminary and revised budget projections developed by DHFS for FY 2000-2001. The revised budget was less aggressive than the original projections, acknowledging the slower start-up period.

Exhibit XI-4
Projected Sources of Funding for Family Care

Funding Source	FY 1999-2000	Preliminary FY 2000-2001	Revised FY 2000-2001
Total expected cost	$26,676,200	$120,468,300	$70,618,253
Federal funding	$14,002,700	$65,279,500	$35,970,861
Total state funding (GPR)	$12,383,200	$49,807,900	$34,647,391
GPR reallocated from current programs	$5,920,400	$42,121,600	$26,961,091
New GPR	$6,462,800	$7,686,300	$7,686,300
Client cost-share revenue	$0	$5,057,600	NA
County community aids match (Adult Protective Services)[1]	$290,200	$323,300	$176,228

[1] County Community Aids Match Funds are used for Adult Protective Services (APS). For budgeting purposes APS and Family Care are budgeted in the same budget proposal. However, APS is a separate program.

Source: DHFS budget for Family Care found at www.dhfs.state.wi.us/LTCare/FCBUDGET9900.htm.

The Department recently concluded reconciliation of FY01 funding for Family Care. With the exception of capitated payments (which comprise the vast majority of Family Care spending), DHFS was not yet able to provide actual spending for FY 2000-01. While projecting expenditures in caseload-driven programs, especially new programs, is difficult, actual Family Care CMO member payment expenditures in FY01 were very similar to DHFS' revised projected level. ***Exhibit XI-5*** compares the projected and actual CMO payments. Future budget projections should prove easier given the first year experience.

Exhibit XI-5
FY01 Family Care CMO Payments

	Projected	Actual	Difference	% Difference
Non-MA CMO Payments				
GPR	$3,497,130	$2,028,896	-$1,468,234	-72.3%
MA CMO Payments				
GPR	$23,323,233	$22,381,898	-$941,335	-4.21%
FED	$33,217,938	$32,470,885	-$747,053	-2.25%
All Funds	$56,541,171	$54,852,783	-$1,688,388	-2.99%
Total CMO Payments				
GPR	$26,820,363	$24,410,794	-$2,409,569	-8.98%
FED	$33,217,938	$32,470,885	-$747,053	-2.25%
All Funds	$60,038,301	$56,881,679	-$3,156,622	-5.25%

Source: DHFS provided information.

B. Capitated Amounts

All of the ultimate average capitated payment amounts to the counties for 2000 were lower than the prospective composite rates paid during the course of the year (see ***Exhibit XI-6***). As a result, all of the counties returned some funding from 2000 to DHFS. The capitation methodology for 2001 did not change from that used for 2000. For 2001, all of the prospective composite rates are less than the prospective rates for 2000, which may reduce the amount of end of year reconciliation necessary.

In the development of the 2001 rates, there was some degree of negotiation between the counties and DHFS. After raising concerns about its historically low waiver expenditures for its elderly population, Richland's elderly component of the rate was based on other counties.

In our impact and cost-effectiveness analyses, we will undertake a more extensive analysis of the capitated payments.

Exhibit XI-6
Final Prospective CY 2001 Capitation Rates Compared to 2000

CMO County	CY 2000 Prospective Capitation Rate	CY 2000 Final Capitation Rate	% Change Prospective to Final	Final CY 2001 Prospective Capitation Rate	% Change Final 2000 to Prospective 2001
Fond du Lac	$1,839.27	$1,651.32	-10.2%	$1,818.36	10.1%
La Crosse	$1,885.05	$1,583.86	-16.0%	$1,749.68	10.5%
Milwaukee	$1,789.78	$1,466.64	-18.1%	$1,656.30	12.9%
Portage	$2,657.17	$2,435.57	-8.3%	$2,584.43	6.1%
Richland	NA	NA	NA	$2,020.26	NA

C. Budgetary Issues

Several budgetary issues have emerged. The Governor's budget did not fund CMO implementation in Kenosha or independent advocacy. However, the legislature approved funding for both of these items. The 01-03 biennial budget includes an increase in funding for the Resource Centers, based on workload projections developed by a Workgroup of Resource Center and Department staff and Resource Center utilization projections developed by the Department.

Finally, the counties continue to express concerns that the capitated rate does not adequately account for the intensive administration required by the CMO or major unanticipated expenditures, such as making their IT systems HIPPA compliant. DHFS included seven percent in the capitated rate to account for administrative functions of the CMO plus an additional two percent for the devolution of state responsibilities to the counties (e.g., claims processing).[27] It is

[27] Ultimately, the administrative percentage ends up to be closer to seven percent because of the two percent managed care discount built into the rates.

difficult to assess whether nine percent is an adequate amount. Expressing administrative costs as a percent of total payments is heavily influenced by the size of an organization's enrollment and the degree to which the administrative costs are fixed versus variable. For example, Kaiser of California has administrative costs of around three percent of revenue, but this is based on an enrollment that exceeds two million. Most TANF-oriented Medicaid HMOs have administrative costs between 10 and 20 percent. Administrative expenses for 23 HMOs in Wisconsin ranged from a low of 6.1 percent to a high of 17.3 percent, averaging 9.8 percent of expenses overall.[28] However, these organizations are responsible for several functions that the CMOs are not, including recruitment, enrollment and disenrollment requirements. In addition, the capitated payment rate paid for TANF and acute care HMO enrollees is much lower than that paid CMOs, both of which would tend to increase the percentage devoted to administration.

On the other hand, administrative expenses are comprised of both fixed (e.g., rent, IT, management salaries and benefits) and variable expenses (e.g., care management staff and to some extent billing). The enrollment levels in TANF or acute care HMOs are generally much larger than those of the CMOs. Therefore, fixed expenses are spread across a larger base. The smallest acute care HMO in Wisconsin was over 3,000 enrollees and the typical smaller HMO had at least 20,000 enrollees. The Wisconsin HMO with 3,000 enrollees had administrative expenses of $887,700 with most of those with around 20,000 enrollees having between $3 and $5 million in expenses. The expected CMO enrollment for the end of CY2001 ranges from 250 in Richland to 2,500 in Milwaukee, with about 500 in Portage, 800 in Fond du Lac, and 1,050 in La Crosse. An approximation of the amount allocated for administration resulted in approximately $550,000 in Richland to $4.5 million in Milwaukee (see ***Exhibit XI-7***).

Another factor to consider is that a large portion of the CMO's administration is in the form of care management, which for the most part is a variable cost. A recent report estimated that treatment planning for highly complex acute care HMO cases was between $150 and $285 per member per month.[29] If the same is true for CMO care management, using the $150 per member per month the care management component exceeds eight percent of the monthly capitated payment in the CMO counties.[30] However, it may be the case that not all CMO enrollees need this intense level of care management. After gaining more operating experience, the CMOs will need to assess whether the amount allocated for administration adequately covers fixed and variable administrative expenses.

Despite concerns about the capitated payment, two of the five CMOs (Portage and Fond du Lac) have sufficient confidence to opt out of risk sharing with the Department for 2001. They elected to opt out two years ahead of the projected three year time period of risk sharing.

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[28] State of Wisconsin, Office of the Commissioner of Insurance, *HMO Quarterly Statement Summary, Fourth Quarter 2000 – Unaudited* found at http://basger.state.wi.us/agencies/oci/hmo_info/quarstat/quar4_00.htm.

[29] Beronja, Nancy, Chimento, Lisa, and Forbes, Moira, (2000), *Impact of the Proposed Medicaid BBS Regulation on Medicaid Managed Care*, prepared by The Lewin Group for the Center for Health Care Strategies.

[30] Some level of care management is included in the non-administrative portion of the capitated payments, but not the full cost of the team orientation and lower caseloads of the current CMO approach.

Exhibit XI-7
CY 2001 Administrative Allocation

CMO County	Estimated Administrative Allocation (in millions)
Fond du Lac	$1.60
La Crosse	$2.00
Milwaukee	$4.50
Portage	$1.40
Richland	$0.55

Source: The Lewin Group calculations based on December 2001 expected enrollment and nine percent of 2001 prospective payment rates.

XII. CONCLUSIONS AND RECOMMENDATIONS

The following section summarizes the conclusions we can draw at this point in the evaluation. The discussion is organized using the major topic areas addressed in the report.

A. Governance

The Centers for Medicare & Medicaid Services (CMS formerly HCFA) stipulated in its approval of the 1915b/c combination waiver that, in addition to the separate governing boards for the Resource Centers and the Care Management Organizations, the Family Care enrollment process must include an independent broker to ensure that potential members receive unbiased information regarding their service options, and so that there is no conflict of interest regarding Family Care CMO enrollment. DHFS must comply with this and other requirements to plan for future competition for the CMO function.

Although conflict of interest is a legitimate concern, the CMS requirements:

- inhibit a one-stop intake process;
- introduce another individual into an already convoluted CMO enrollment process;
- create numerous hand-offs for enrollment;
- currently duplicate effort regarding information collection;
- increase the importance of developing electronic information exchanges; and
- increase the importance of developing a good working relationship between ES, RC and the CMO.

The roles of the County LTC Councils and the CMO and RC governing boards continue to evolve. Members of all three bodies appear to understand the program and have begun to contribute to decision making.

B. Outreach

Resource centers continue to increase the number of contacts per month. All nine of the counties with RCs have met contract goals for the elderly and physically disabled; seven of nine met contract goals for those with developmental disabilities. Meeting these goals has occurred despite the fact that the majority of CMO counties have suspended active outreach efforts due to the volume of functional screens related to CMO intake. The RCs need to continue to assess how well they are reaching the target populations and DHFS needs to continue to monitor CMO county RCs to ensure that CMO intake does not crowd out other RC activities.

C. Access to CMO benefits

DHFS and the counties continue to work through process issues related to CMO enrollment. All the CMO counties have the enrollment infrastructure components in place and have moved to

specialized Economic Support staff. However, soon the process will need to accommodate an enrollment broker. Counties that will implement a CMO in the future should consult with DWD regarding increased workloads for financial eligibility related to CMO enrollment to smooth the increased workload as a result of the initial ramp-up enrollment period.

Three of the counties (Fond du Lac, La Crosse and Portage) have moved beyond rolling over existing waiver participants to eliminating their wait lists and enrolling other new applicants; however, three of the counties (Fond du Lac, La Crosse and Richland) have slowed new enrollments due to CMO capacity. The continuing increases in enrollment suggest that enrollment has not yet reached a steady state.

CMOs must continue to sustain the positive relationship with providers that they have fostered thus far. This will be a struggle as consumers are provided more choice and the CMO is no longer able to guarantee business to providers. Overall, providers reported success of the program over the previous system by recognizing the value of the care manager to answer questions and concerns and to assure appropriate service use. However, under Family Care, providers no longer have a budget with the county and are instead reimbursed for each individual consumer. They can no longer count on a consistent number of consumers from the county. Some providers reported receiving a lower number of referrals than expected with Family Care. Provider accountability will continue to be increasingly important, as providers must ensure services are attractive to consumers. The CMOs are formalizing this accountability through incorporating quality provisions into their contracts with providers.

The success of the Family Care model depends on the efficient management of services and costs to accommodate both the consumer's service needs and the financial viability of the CMO. The counties are still working through some administrative issues related to care management and service provision. The care management team concept has taken root, but continues to evolve and has yet to demonstrate whether it can effectively manage to the capitated rates. Prior authorization, particularly for supplies, has become more cumbersome than previously (e.g., counties used to have up to $100 available for purchasing own supplies). The CMOs will need to determine the cost trade-off between the time spent by care managers generating prior authorizations and the potential for overuse if cash were provided.

D. Consumer Direction

Family Care has embraced a large part of the spectrum of consumer direction allowing for a range of options that vary by level of individual control, autonomy, and self-determination. CMOs appear to have created the conditions necessary for achieving choice and facilitating consumer direction:

- CMOs are making progress on provider networks, but not all contracts are in place;
- Network developers have fulfilled their role as liaison to the provider community; and
- Some providers reported increase competition and a need to market their services to individuals.

However, based on the first member outcome survey, members still seek greater choice and options.

E. Quality

DHFS and the counties have made significant progress related to quality assurance and improvement efforts. DHFS is using a multi-level approach that includes monitoring and oversight by their staff, responsibilities vested at the county level for monitoring providers and involving members, and member responsibility for accessing advocacy assistance and being involved in the care planning and implementation process. The focus of the program is on outcomes and members' views of whether their needs have been met.

F. Program Expenditures and Capitation

During calendar year 2000, Family Care spent $32.2 million directly for RC and CMO activities. Most of the spending (71 percent) went to the CMOs in the form of per member per month payments, with the remainder nearly equally divided between CMO start-up and ongoing RC functions. Within start-up expenditures, information technology dominated, accounting for nearly one third of the total. Most of the funds for Family Care are redirected federal Medicaid match and existing state spending for COP-W and CIP Medicaid 1915(c) waivers.

G. Fidelity Measure

Our assessment of the CMO counties based on the fidelity measure suggests that the counties involved in the Family Care pilot are making good progress toward full implementation and stabilization. The Fidelity measure matrix, presented in ***Appendix E***, presents the baseline assessment of Family Care implementation by county for each of the core domains and program components. It is important to note that for this initial assessment, we have used primarily yes/no responses to reflect the presence/existence of an element in the implementation of the model. For example, "CMO caseload goals met for all target populations" is an indicator related to the domain "Staffing Level." For each county, there is a "yes" or "no" indicating whether or not the county has met its caseload goals at this time. Ultimately, using data over time, this Fidelity Measurement Matrix will contain data depicted (where appropriate) as ranges within categories. However, since this is the first measurement point, it is not possible to calibrate each county to this type of range.

As noted above, the Fidelity Measure shows that there are several areas that remain in flux, such as enrollment, governance, and IT systems development. However, our overall assessment is that the programs have reached sufficient stability to begin Phase II of the evaluation, which will focus on program impact.

Appendix A

Site Visit Interview Participants

I. COUNTIES FULLY IMPLEMENTING FAMILY CARE

Fond du Lac

a. County Staff

Maggie McCullough	CMO Project Manager
Full Care Management Staff (RNs and Social Service Coordinators)	
Sandy Tryon	Resource Center, Supervisor
Marty Kloehn	DCP specialist/FFES/recert/WATTS/court
Bob Krebsbach	Social Worker– FFES
Mary Neuman	(SSS - phone at ADRC/support tasks for unit)
Mary Koplitz	Social Worker - I & A/choice counseling/DSS
Pat Tulledge	Social Service Specialist -SSS - phone at ADRC/support tasks for unit
Linda Berg	Social Worker - recerts/ ongoing cases

b. LTC Council

5 consumer representatives

3 provider representatives

La Crosse

a. County Staff

Peggy Herbeck	Resource Center, I & A
Sigrid Dooley	RN
Ruth Olson	Social Worker
Mary Faherty	CMO Contact
Nancy Schmidt	Network Developer
Dave Janney	Social Worker

b. LTC Council

3 consumer representatives

Milwaukee

a. County Staff

Chris Hess	CMO Contact/RC
Chester Kuzminski	Resource Center Manager
Meg Gleeson	CMO Project Manager
Cathy Eschete	Family Care CMO Training Coordinator
Keith Parkansky	Network Application Specialist (former)
Mark Lucoff	Contract Administrator

b. LTC Council

1 provider representative

1 consumer representative

Portage

a. County Staff

Jim Canales	CMO Contact
Janet Zander	Resource Center
Evelyn Heikenen	Resource Center, I & A
Rick Foss	CMO Section Supervisor
Randy Bestul	Network Development Manager
Jessica Schmidt	CMO Project Manager
Lucy Runnells	CMO Financial Manager

b. Consumer and Provider Representatives

3 Consumer representatives

6 Provider representatives

Richland

a. County Staff

Kim Enders	Resource Center Contact
Terri Buros	LTS Manager
Sharyn Knudson	Social Worker
Becky Cupp	Long Term Support Supervisor
Betsy Broadbent	Provider Network Developer
Linda Overbeek	Administrative Assistant LTS Unit

b. LTC Council

1 Consumer representative

1 Provider representative

II. FAMILY CARE STATE STAFF

Chuck Wilhelm	Director, Office of Strategic Finance
Judith Frye	Director, Center for Delivery Systems Development
Monica Deignan	Family Care Project Manager (former)
Fredi Bove	Current and future Family Care funding
Joyce Allen	State LTC council
Tom Lawless	Rate setting, risk management, cost effectiveness/ cost neutrality for b/c waivers
Dana Parpart	County IT systems development manager, coordination of technical assistance systems development and automated data reporting, BIS staff supervision
Greg Robbins	Family Care systems development oversight

Marci McCoy	Quality monitoring, program effectiveness research and evaluation
Julie Horner	CMO quality and Family Care monitoring and oversight

III. STATE LTC COUNCIL

Carol Eschner	Vice Chair, Interfaith, provider representative
David Slautterback	AARP

APPENDIX B

SITE VISIT PROTOCOLS

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APPENDIX B

Site Visit Protocol for Evaluation of Wisconsin Family Care Program
Care Management Organization Staff

County:

Date:

Lewin Research Team Interviewers:

Respondents:

Name	**Title**
1.	
2.	
3.	

I. SYSTEM DESCRIPTION

Overview

1. Please note the major turning points in the development of the Family Care model in your county (i.e. rate changes, contract changes).

Administrative Structure *(Please have county organizational chart available)*

2. Please discuss any changes in the administrative structure of the CMO since November 2000.

3. Please describe your relationship with the county board. What has been helpful in obtaining their support? What strategies have not been successful?

Relationship with the RC

4. What information is provided from the RC for each consumer? Has this changed since the beginning of FC? Please comment on the quality of the information.

5. How do you receive information from the RC? Probe: paper, electronic?

6. Please describe how the re-certification process has proceeded. How could the process be improved? Probe: How could the burden on economic support be eased?

Information Technology (IT) System Development *(Lewin will ask county specific questions here based on information known about each county)*

7. Please describe significant revisions you made to your IT plans.

8. How well do you think the system supports various agency functions (i.e., fiscal, care management, payment, quality, provider network)? Probe: What internal reports do you produce? How are they used?

Relationship with the State and Federal Government

9. Does current federal law restrict your programs' operations?

10. Are there any Family Care contract requirements that you find restrictive? What have been the most useful requirements? How receptive is the State to suggestions for modifications to the contract?

11. How would you characterize your county's relationship with the state with regard to the on-site review process? Have the reviews been helpful? How could the process be improved?

Staffing *(Lewin will ask county specific questions here based on information known about each county)*

12. What have been the significant changes in the staffing structure since the beginning of Family Care? Are your staffing levels sufficient?

13. In what areas could you use additional staff?

14. Please describe staff training efforts. Probe: types, cost, frequency, perceived usefulness, and future plans

II. FUNDING

1. What start-up funding did the CMO receive? Probe: source, dates received, adequacy

2. Does the system's sources of funding (e.g., Medicaid) present any barriers to operating the program? What are they and how could they be eliminated?

III. GOVERNANCE (Lewin Will Ask County Specific Questions Here Based On Information Known)

1. When did your county establish separate governing boards for the RC and the CMO? Probe: Any unresolved issues?

2. What has been the role of the governing boards? Probe: major accomplishments

3. When did (will) your county achieve the separation of the level of care and enrollment functions? Probe: Any unresolved issues?

4. What role has the county LTC Council played in the development of Family Care? Do you feel that your county LTC Council has been effective? In what ways could the function of the council be improved?

IV. ENROLLMENT

1. Please comment on the timeliness and accuracy of eligibility determination performed by the RC. Probe: What do you feel are the strengths and weaknesses of the LTC functional screen?

2. Does the CMO get a copy of the functional screen? How is it used in the assessment process?

3. How frequently do you enroll consumers while financial eligibility is still pending? Are there any issues surrounding this process? What happens to an individual if they are not eligible for FC? How often do consumers use the cost share option?

4. Have enrollments been delayed for any other reasons?

5. How do you define enrollment? When is an individual considered a CMO member? Probe: who decides the first date of service, eligibility

6. Please comment on any adjustments that you made to your projected (budgeted) enrollment numbers. What was the methodology behind the adjustment? Have you met your projections for all target populations? Why or why not?

7. Given the lag time in the state data reporting system, have you noted any problems in reimbursement?

8. Please note any significant patterns with regard to disenrollment. What is the most frequent reason for disenrollment?

V. ACCESS TO SERVICES *(Please fill in the chart about the cmo provider network at the end of this protocol)*

1. Describe ways in which members have gained increased access to services?

2. In what areas do members have unmet needs?

3. Which services do members use the most?

4. Are there services you think should be covered under Family Care but are not?

5. Which services, if any, require prior authorization.

1. Are providers able to staff the care patterns requested by the CMO? (i.e. amount of personal care, adult day care, etc)

2. When are new providers brought into the network? Probe: rolling, annually, as needed

3. Describe any notable changes in the provider relationships with the county since the beginning of Family Care.

4. What methods are the most effective in strengthening the provider network? Probe: level of communication with the RC

5. What methodologies do you use to assess provider capacity? (i.e. capacity in terms of member needs, provider needs, provider ability to provide services)

6. Are providers required to inform the CMO when a consumer is hospitalized? How has the hospital discharge process proceeded in providing continuity of service providers to consumers?

7. What is your strategy for assessing member choice of support workers within agencies?

VI. CARE MANAGEMENT AND CARE PLANNING

1. What is the composition of the interdisciplinary team? (ratio of SWs to RNs)

2. Does one individual function as the lead case manager? Is this person always a SW or a RN?

3. Please fill-in your staff to member ratios below.

	Elderly/PD			DD		
	Current	**Goal**	**Date goal set[31]**	**Current**	**Goal**	**Date goal set**
RN	:	:		:	:	
SW	:	:		:	:	

4. Do the populations differ in the intensity of care management needed?

5. How frequently does the interdisciplinary team meet?

6. What are the responsibilities of the RN on the team? Probe: prevention, assessment, consultation

7. Have you encountered any difficulty hiring RNs?

[31] This date should be in months from the CMO start date.

8. Please fill in the following chart relative to your caseload averages. Are your caseloads mixed or population specific?

Population	Prior to FC	Target	Current
Elderly			
PD			
DD			

9. How are the caseloads distributed among care managers? How do you assess when a care manager has an unmanageable caseload?
10. Is the RAD method used by all care managers?
11. Has the RAD tool lead to more appropriate service use?
12. Do care managers document when they use the method?
13. Please describe the training that has been provided to care managers on the RAD method.
14. What provider information is made available to the care managers for care planning? Probe: format of information, spreadsheet, etc.
15. In what ways are members and their families involved in the care planning and monitoring processes? Do you have a method to document such involvement? Does this differ by target population?
16. Are the state established timelines for completing the individualized service plans (ISPs) accurate and reasonable?
17. How do service plans take into account the availability of informal care? What methods do you use to support informal caregivers?
18. What are the terms established by your CMO under which family members or other informal caregivers can be paid for providing care?
19. What standards or other methods for monitoring quality will you use with informal supports?

VII. CONSUMER DIRECTION (*If available, please provide Lewin with copies of outreach and/or instructional materials related to the SDS option in your county)*

1. What aspects of consumer direction are supported by the CMO?
2. Are members required to call the CMO when they have a problem with a provider or do they contact the provider directly?
3. Please comment on your process to date with regard to your self-directed support (SDS) option plan. Has your SDS plan been approved by the Department? (If available, please provide Lewin with copies of outreach and/or instructional materials related to the SDS option in your county)
4. Were there any contract requirements with regard to consumer direction that were difficult to meet? Please explain.

5. What training has been provided to staff and members/families on the option? What training has been effective?
6. Were there any contract requirements with regard to consumer direction that were difficult to meet? Please explain.
7. What services can members self-direct? Are there plans to expand those service options?
8. What committees have you formed to support the SDS option?
9. About how many individuals are using independent care providers? How are providers paid? (i.e. fiscal intermediary, agency) Is this option only open to individuals using the SDS option? If so, do you have plans to extend the individual provider option to other members?
10. Please explain your plans for back-up for individual providers.
11. What barriers to consumer direction exist in your county? In Family Care in general?

VIII. QUALITY

1. Has your quality plan been approved by the Department? Probe: months from CMO start date.

2. Please comment on your plans for quality with regard to the following:

   - Progress in relation to the established timeline;
   - New goals set annually by governing board;
   - CMO member advocate in place; and
   - Staff, member, and provider input into the plan.

3. Were there any contract requirements with regard to quality that were particularly difficult to meet? Please explain.

4. Please check the functions that the Independent Advocacy program in your county serves currently.

   - Facilitate appropriate service access and use: ___
   - Improve access for potential FC enrollees: ____
   - Enhance CMO ability to foster member independence, knowledge and dignity:___
   - Protect members through individual advocacy: ____

- Increase member and family members ability to be self advocates: ___
- Other: ____

5. How many hours a week does the independent advocate work?

6. Please comment on the overall usefulness and progress of the Independent Advocacy in Family Care? Are there mechanisms in your county that will likely serve this function if it is eliminated in the state budget?

7. Please comment on provider's awareness of policies and procedures regarding Family Care. Probe: MA providers

8. Please comment on the state reporting requirements regarding grievance procedures. Has your grievance procedure plan been approved by the Department?

9. What barriers to quality exist in Family Care?

10. Please state what you feel are the most effective means of achieving quality in Family Care

11. On what criteria do you base your decision to renew provider contracts? Probe: competitive bidding, plans for the future

12. How have you or what plans do you have for educating providers about the importance of member outcomes?

IX. CAPITATION

1. Please comment on the adequacy of capitation amounts determined by the state.

2. How did the retrospective adjustments affect your county?

3. Please comment on cost share amounts for persons not financially eligible for Medicaid calculated using the Department's formula. Do you feel they result in a fair amount?

4. What measures does your county take to ensure that costs remain within budget? Which are the most effective measures? How could the measures be improved?

X. CONCLUSIONS

1. What are the most innovative aspects of the long-term care system in this county?

2. Do you feel that Family Care service delivery and planning is developing more toward a medical, social or other model?

3. If you could change one aspect of Family Care, what would it be and why would you change it?

4. How do you believe that Family Care will evolve over time?

Number of Providers under contract with the CMO, by Type of Service

Type of Service	Number of Providers
Adaptive Aids	
Adult Day Care	
Adult Family Home	
Assisted Living Facility	
Case Management	
CBRF	
Congregate Meals	
Daily Living Skills	
Day Services/ Treatment	
Employment-related	
Guardianship/Money Management	
Home Care (medical & supportive)	
Home Modification	
Interpreter Services	
Meal Delivery	
Medical Equipment	
Mental Health	
Nursing Facility	
Rehabilitation/Therapy	
Respite Care	
Speech & Language Path.	
Substance Abuse	
Transportation	

NOTE: Please place an "NT" if the CMO does not have a contract with this type of provider.

Site Visit Protocol for Evaluation of Wisconsin Family Care Program
Resource Center Staff

County:

Date:

Respondents:

Name	**Title**
1.	
2.	
3.	

I. SYSTEM DESCRIPTION

Overview

1. Please note the major turning points in the development of the Family Care model in your county (i.e., contract changes).

Administrative Structure

2. Please discuss any changes in the administrative structure of the RC since November 2000.

3. Please describe your relationship with the county board. What has been helpful in obtaining their support? What strategies have not been successful?

Information Technology (IT) System Development

4. Please describe any major revisions to your IT plans. (*Lewin will ask county specific questions here*)

5. How well do you think the system supports various agency functions? What internal reports do you produce? How are they used?

Relationship with the State and Federal Government

6. Does current federal law restrict your programs' operations?

7. Are there any Family Care contract requirements that you find restrictive? What have been the most useful requirements? How receptive is the State to suggestions for adaptations to the contract?

8. How would you characterize your county's relationship with the State with regard to the on-site review process? Have the reviews been helpful? How could the process be improved?

Staffing (*Lewin will ask county specific questions here based on information known about each county*)

9. What have been the significant changes in the staffing structure since the beginning of Family Care? Are your staffing levels sufficient?

10. Where could you use additional staff?

11. Please fill in the following chart with the ratio of workers to average number of contacts per month.

	Current	**Goal**	**Date goal set**[32]
RN	:	:	
SW	:	:	
Other workers	:	:	

12. Please fill in the following chart with staffing levels (# of full-time employees) to perform the identified RC functions.

	Functional Screening			**Options Counseling**		
	Current	**Goal**	**Date goal set**[33]	**Current**	**Goal**	**Date goal set**
RN						
SW						
Other workers						
	I and A			**Other (Please list)**		
	Current	**Goal**	**Date goal set**	**Current**	**Goal**	**Date goal set**
RN						
SW						
Other workers						

13. Please describe staff training efforts. Probe: types, cost, frequency, perceived usefulness, and future plans

14. What efforts have been initiated to ensure cultural competency of the RC staff?

[32] This date should be in months from the RC start date.

[33] Ibid

II. FUNDING

1. What start-up funding did the RC receive? Probe: source, dates received, adequacy

2. Does the system's sources of funding (e.g., Medicaid) present any barriers to operating the program? What are they and how could they be eliminated?

III. GOVERNANCE *(Lewin will ask county specific questions here based on information known)*

1. When did your county establish separate governing boards for the RC and the CMO? Probe: Any unresolved issues?

2. What has been the role of the governing boards? Probe: major accomplishments

3. When did (will) your county achieve the separation of the level of care and enrollment functions? Probe: Any unresolved issues?

4. What role has the county LTC Council played in the development of Family Care? Do you feel that your county LTC Council has been effective? In what ways could the function of the Council be improved?

IV. OUTREACH

1. Please provide detail on your outreach efforts. Are you operating according to a scheduled timeline?

2. What have been the most and least effective means of outreach?

3. Which populations have been difficult to reach?

4. Have you met your goals for the number of contacts for each target population?

5. Are there any issues surrounding the follow-up procedures for contacts?

6. Is the CMO referring individuals back to the RC appropriately?

7. What changes have you made to your initial PAC phase-in plan? Probe: reasons for the changes

8. Please describe the timeline in months from the start date of the RC for phasing-in facilities? What facilities are currently required to refer?

9. From which agencies do you receive the most referrals? the least?

10. What have been effective strategies for ensuring appropriate referrals?

11. Please describe any problems that exist with the referral process.

12. Please describe your plans to deal with unmet needs that arise from effective outreach efforts.

V. ENROLLMENT

1. What are the strengths and weaknesses of the functional screen?

2. What is the average time it takes to complete the functional screen? Has this changed since the beginning of the RC? Does the time vary among workers?

3. Are you able to meet the screening timeline requirements established by DHFS? Why or why not?

4. When will an individual no longer be able to choose whether he or she wants regular MA services or the CMO?

5. Describe the process for determining financial eligibility. Comment on the timeliness of eligibility determination.

6. How frequently do you enroll individuals while financial eligibility is still pending? Are there any issues surrounding this process? What happens to individuals if they are not eligible for FC? How often do consumers choose the cost-share option?

7. Describe your working relationship with the Economic Support Unit (ESU).

8. Please describe the process through which enrollment information is transmitted from the RC to the CMO. Comment on major past, present and/or future challenges with this process? How have you dealt with those challenges? Are there plans for electronic transfer?

9. How quickly are consumers seen by the CMO after being screened?

VI. ACCESS TO SERVICES

1. Please place an X by all the types of information that the RC provides to consumers.

Types of Information Provided									
Target Population Expertise	Residential Capacity	Whether Taking New Business	Hours of Service	Eligibility Requirements	Fees/Rates	Languages Spoken	Other Details	Contact Person	Electronic Address (web, email)

2. Please fill in the chart at the end of this protocol regarding the number of providers known by the RC.

3. In what format do you keep information about providers and services? Is this source consumer-searchable?

4. For what services do consumers have unmet need? Do you have a method for quantifying identified need?

VII. CONSUMER DIRECTION

1. How does the RC incorporate consumer-direction into service delivery? How does this differ for each population?

2. What are the barriers to consumer-direction in Family Care?

3. Tell us about the development of your grievance procedure plan. Please comment on the State reporting requirements and the interaction with the State regarding grievance procedures.

4. Do you expect or would you recommend that state or federal policy regarding consumer-direction change? If so, how?

VIII. QUALITY

1. What role does the RC play in quality assurance? How could that role be enhanced? When was your quality plan approved by DHFS (in months from RC contract start date)?

2. Please describe your strategy for ensuring member input on the development of the quality plan.

3. Please describe the main components of your quality plan. Please describe your focused quality improvement project. Probe: licensure, use of outcome measures, compliant hotline, long-term care ombudsman

4. What have been the results of your efforts to obtain feedback on the RC?

5. Please describe the technical assistance and feedback from DHFS with regard to your quality plans.

6. Are there any contract or timeline requirements surrounding quality that you find restrictive or difficult to meet?

7. What barriers to quality exist in Family Care?

IX. CONCLUSIONS

1. What are the most innovative aspects of the long-term care system in this county?

2. Do you feel that Family Care service delivery and planning is developing more toward a medical, social or other model? Why?

3. If you could change one aspect of Family Care, what would it be and why would you change it?

4. How do you believe that Family Care will evolve over time?

Number of Providers Known by the RC, by Type of Service

Type of Service	Number of Providers
Adaptive Aids	
Adult Day Care	
Adult Family Home	
Assisted Living Facility	
Case Management	
CBRF	
Congregate Meals	
Daily Living Skills	
Day Services/ Treatment	
Employment-related	
Guardianship/Money Management	
Home Care (medical & supportive)	
Home Modification	
Interpreter Services	
Meal Delivery	
Medical Equipment	
Mental Health	
Nursing Facility	
Rehabilitation/Therapy	
Respite Care	
Speech & Language Path.	
Substance Abuse	
Transportation	
Other (please list)	

NOTE: Please place an "NT" if the RC does not have information about this type of provider.

Site-Visit Protocol for Evaluation of Wisconsin Family Care Program
County Long Term Care Council Representatives

County:

Date:

Lewin Research Team Interviewers:

Respondents:

Name	**Affiliation**

I. BACKGROUND

Consumer and Provider Representatives

1. Please describe your affiliation with the LTC system in this county (i.e. provider [include capacity], family member of service recipient, service recipient, etc.)

LTC Council Members

2. Please comment on the development of the LTC Council.
3. How often does the Council meet?
4. How are the meetings run? Who facilitates?
5. Please describe the responsibilities of the Council.
6. Do you feel you have an important role in guiding the LTC system in your county? Please provide examples of your impact on the system.

LTC Council Not Yet Formed

7. Please comment on the status of the development of the LTC Council.

II. SYSTEM DESCRIPTION

1. Please comment on the purpose and goals of the Family Care Program.
2. How well do you think Family Care has met those goals?

Describe the communication you receive from State and/or County officials regarding Family Care.

III. ELIGIBILITY

1. How do provider agencies determine if a consumer is eligible for Family Care?

2. Please comment on prior authorization rules, if any, under Family Care.

IV. CARE MANAGEMENT AND SERVICE PLANNING

1. What are the strengths and weaknesses of the care management system under Family Care?

2. How well are members' and family members' preferences incorporated into the service plan? Are there any differences by target populations?

3. Please comment on the extent to which consumers are actively involved in the care planning process. Probe: What, if any, changes do you anticipate in the future?

4. Please comment on appropriate service use under Family Care. What is needed for service use to become more appropriate?

5. How well do current service plans promote continuity in service delivery and funding?

V. SERVICES

1. How has Family Care changed the way agencies provide and consumers receive services and supports? Probe: flexibility of service provision with regard to hours of service, options for cost-sharing

2. Are you providing any additional services under Family Care that you did not provide under the previous system? (providers)

3. Have you increased your capacity in certain service areas as a result of becoming a Family Care provider? If so, how and why? Probe: staffing level and skill, IT systems (providers)

4. Please describe the coordination, if any, between the CMO assessment and care planning procedures and the service agencies.

5. In what areas are consumers experiencing unmet need?

6. Are there limitations in how services are delivered under Family Care?

VI. CONSUMER DIRECTION

1. How well do you think Family Care has expanded consumer choice to date? What is needed for Family Care to continue to expand consumer choice?

2. Does the consumer make/initiate changes to the care plan?

3. To the best of your knowledge, please comment on the accuracy of the information that the Resource Center makes available to consumers.

4. Please comment on the self-directed support option. Have you had any input into the development of the option in your county?

5. Please comment on your awareness of the Independent Advocacy Service in your county.

VII. REIMBURSEMENT (PROVIDERS)

1. Please comment on the adequacy of reimbursement rates under Family Care versus the previous system.

VIII. QUALITY ASSURANCE

1. Please comment on the strengths and weaknesses of quality assurance in Family Care compared to the previous system. What improvements, if any, could be made?

2. What are the most effective means of addressing quality in Family Care?

3. Please comment on your awareness and assessment of the effectiveness of the grievance and appeals process.

4. Please describe any changes in the contracts process with regard to quality assurance? Are there any provisions that are difficult to meet or problematic? What external monitoring do providers receive from the CMO, if any?

IX. CONCLUSIONS

1. What do you consider to be the strengths and weaknesses of Family Care compared to the previous long-term care system?

2. Are certain populations better served than others are by the county's long-term care system?

   - MR/DD vs. Aged vs. Physical disabilities
   - Urban vs. Rural
   - Severe vs. moderate functional disabilities
   - Individuals with complex medical needs

3. What are the most innovative aspects of the long-term care system in this county?

4. If you could change one aspect of Family Care, what would it be and why would you change it?

5. How do you believe that Family Care will evolve over time? What do you see as your role?

APPENDIX C

Provider Telephone Interview Protocol

Date:_____ ..... Lewin Interviewer:_____

Pilot County:_____	Interviewee:_____
Provider Type:_____	
Agency Name:_____	Tenure with Agency:_____
Position:_____	Tenure in Position:_____

Interviewer: Please answer the following questions based on your experience with the Family Care program to date.

I. PROVIDER INVOLVEMENT IN FAMILY CARE PROGRAM

1. Are you currently under contract with *{insert county name}* CMO? Are you under contract with any other CMO? When did you sign the contract(s)?
2. Were you a provider under the previous county long-term care system?
3. What services do you provide to Family Care members?
4. What Family Care target populations do you serve (i.e. elderly, developmentally disabled, physically disabled)?

II. SYSTEM DESCRIPTION

1. Please describe the goals of the Family Care program as you understand them.
2. 6. How well do you think Family Care has met or will meet its goals for transforming the LTC system?
3. Describe the communication between your agency and county and/or state officials regarding policy and procedures associated with Family Care.
4. Was training and education provided on the procedures and policies? Probe: adequacy of training, suggestions for improvement, reason for not attending training, if applicable.

III. ELIGIBILITY

1. How do you determine if a consumer is eligible for Family Care? (only relevant for providers not contacted by the care manager. i.e. SMV34)
2. Please comment on prior authorization rules, if any, under Family Care.

[34] Specialized Medical Vehicle

IV. SERVICES

1. How has Family Care changed the way that your agency provides services and supports to people? Probe: flexibility of service provision with regard to hours of service, options for cost sharing
2. Are you providing any additional services under Family Care that you did not provide under the previous system?
3. Have you increased your capacity in certain service areas as a result of becoming a Family Care provider? If so, how and why? Probe: staffing level and skill, IT systems
4. When coming into contact with your agency, do Family Care members seem to have accurate and comprehensive information about the services expected?
5. Please describe the coordination, if any, between the CMO assessment and care planning procedures and the procedures of your agency.
6. Do you receive the member's plan of care? Probe: Do consumers you see under Family Care have less unmet need with regard to what is specified in the care plans under this system? Why or why not?
7. Are there limitations in how you deliver services under Family Care?

V. CONSUMER DIRECTION

1. Does the CMO make requests as to the type/day/hours of service? If so, are you able to meet those requests?
2. Does the consumer make/initiate changes to the care plan in your area of service?
3. To the best if your knowledge, please comment on the accuracy of the information that the Resource Center makes available to consumers about your services.
4. Please comment on the self-directed support option. Have you had any input into the development of the option in your county?
5. Please comment on your awareness of the Independent Advocacy service.

VI. REIMBURSEMENT

1. Please comment on the rates the CMO has negotiated with you versus the rates paid by the county under the previous system. Probe: Do the rates cover your costs?
2. How has the payment/ billing system changed since the beginning of Family Care? Does it continue to change? Probe: IT system compatibility with CMO, suggestions for improvement
3. Please comment on the timeliness of claims processing and payment. Probe: What is the average time?

4. Are there any services that your agency could provide but would not contract with the CMO to provide due to reimbursement issues?

VII. QUALITY ASSURANCE

1. Please describe the process by which your agency deals with clinical problems that arise between your agency and the CMO and/or the consumer. Probe: written policies and procedures
2. Please describe the process by which your agency deals with administrative problems that arise between your agency and the CMO and/or the consumer. Probe: written policies and procedures
3. How responsive is the CMO if there are any concerns? (i.e. billing, consumer care)
4. Does the CMO inform you of changes to the consumer's care plan as expected?
5. Please describe any changes in the contracts process with regard to quality assurance? Are there any provisions that are difficult to meet or problematic?

VIII. CONCLUSIONS

1. What do you see as your role as Family Care evolves over time?
2. Please comment on your overall communication with the CMO.
3. Please feel free to add any summary comments that you may have.

APPENDIX D

Departments' Quality Efforts

Family Care Outcomes Monitoring – Gather information directly from the CMO members on whether Family Care is helping members achieve their outcomes.

CMO Member-Centered Service Plan Review – A review of the CMO's capacity for supporting members to meet their service needs while respecting their individual preferences and desired outcomes.

CMO Certification – Each potential contractor is evaluated using a set of structure and process standards derived from FC legislation, administrative rules and the Health and Community Supports contract.

CMO Performance Reporting – A review/assessment of the CMO's self-reported performance on seven contractually required performance measures and improvement projects that are tied to the Family Care outcomes.

Resource Center Annual Site Reviews – The site reviews involve monitoring key Resource Center Functions.

Resource Center Performance Reporting – A review/assessment of the Resource Center's self-reported performance from Information and Assistance, Pre-Admissions Counseling, screen data and disability benefit specialist.

Technical Assistance – A plan developed with the CMO/RC and based on information/data from a variety of sources. Assist CMOs and RCs to address problem areas and improve performance.

Quality Indicators – Indicators of quality outlined in the CMOs contract. The CMO will report the indicators directly to the Department. The Department intends to use the results of the first year of reporting to refine the indicators by analyzing the validity of the data and setting standards and benchmarks. The indicators will consist of data from the following sources: HSRS, functional screen, provider surveys, and individual CMO data.

APPENDIX E

Fidelity Measure

The chart below displays a prototype fidelity measure for Family Care. The Fidelity Measure Matrix presents the baseline assessment of Family Care implementation by county for each of the core domains and program components. The measure includes components under the Family Care **core domains,** as well as **sample ranges** for some components.

The **core domains** identified reflect the fundamental features of the Family Care model and will most likely remain constant. Lewin solicited feedback from the Department, all pilot counties, and state-level stakeholders on the adequacy of the core domains used to report on Family Care in the first Implementation Process Report and received affirmation.

The **sample ranges,** however, reflect a dynamic definition that has been and will continue to be refined with input from the Department and the Family Care pilot counties. It is important to note that for this initial assessment, we have used primarily yes/no responses to reflect the presence/existence of an element in the implementation of the model. For example, "CMO caseload goals met for all target populations" is an indicator related to the domain "Staffing Level." For each county, there is a "yes" or "no" indicating whether or not the county has met its caseload goals at this time. Ultimately, using data over time, this Fidelity Measurement Matrix will contain data depicted (where appropriate) as ranges within categories. Some areas are blank since this is the first measurement point and we did not ask questions to be able to calibrate each county within a range for these areas. As the evaluation continues with the impact evaluation we will monitor the counties in these areas. Some of these components are required elements of the Family Care contract, while others have emerged as critical components in the course of program implementation. Required components are defined as specified in the Family Care contract. The definitions or ranges associated with the other components will be derived empirically from information collected from each of the pilot programs. Listed under the sample ranges in *italics* are specific data items that will help make a determination of fidelity within the range.

Fidelity Measure for Family Care: Current Status of Family Care County Implementation

Core Domain and components	Indicator and Example Definition or Range	Contract Requirement [35]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
CMO, RC and ES Relationship	Effective collaboration between CMO and RC and ES in transferring client information in enrollment process and entity responsible for financial eligibility determination → Smooth enrollment processes	Yes					
	Delayed enrollment plans		Y	Y	N	N	N
	Resource Center contact made within timeline (October 2000-March 2001)		63%	94%	43%	95%	57%
	Establishing set meeting time for ES, CMO and RC or having availability to meet when problems arise		Y	Y	Y	Y	Y
	Degree of involvement of ES from the beginning of implementation – ES workers devoted solely to FC eligibility determination – information sharing between ES and RC staff		Y	Y	Y	Y	Y
	Re-certification policies in place and approved by DHFS		Y	Y	Y	Y	Y
	Process of information transfer from RC to CMO → plans for computerized transfer of information	Yes	N	N	N	Y	Y
	Web-based functional screen – DHFS will begin in Fall 2001		N	N	N	N	N
	Timelines for financial eligibility – 14 days or less	Yes	96%	93%	100%	100%	100%
Staffing Level	Have staff in all required roles → Staffing level sufficient to carry out functions						
	All positions filled		Y	Y	Y	Y	Y
	RC contacts over FTEs		21	39	62	166	23
	CMO functions - caseload goals met for all target populations	No	N	N	N	N	Y

[35] Based on the 2001 RC and CMO contracts.

Fidelity Measure for Family Care: Components and Ranges

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement [36]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
IT System	IT development plans → fully developed IT system supporting functions of RC and CMO.	Yes					
	I and R outcomes	Yes	Y	Y	Y	Y	Y
	Functional Screen	Yes	Y	Y	Y	Y	Y
	Assessment		Y	N	Y	Y	Y
	Case Notes		Y	N	Y	Y	Y
	ISP and outcomes	Yes	Y	Y	Y	Y	Y
	Prior authorization		Y	Y	Y	Y	Y
	Billing Internal		Y	Y	Y	Y	Y
	Provider Claims Processing		Y	Y	Y	Y	Y
RC and CMO separation	Establishment of separate governing board with no overlap in membership		Y	Y	Y	Y	Y
Role of Governing Bodies	Established with correct make-up→ integral in CMO and RC operations	Yes	Y	Y	Y	Y	Y
Targeting	Slightly under contact goals → Exceeding contact goals, innovative strategies to reach target populations	Yes	Y	Y	Y	Y	Y
	Exceeding contact goals		Y	Y	Y	Y	Y
PAC Referrals	Receiving referrals from facilities according to PAC plan > referrals are appropriate[37]	Yes	Y	Y	Y	Y	Y
Functional Screen	Consumers screened within 14 days of contact	Yes	96%	95%	100%	100%	100%

[36] Based on the 2001 RC and CMO contracts.

[37] Most facilities may not be determining appropriateness.

Fidelity Measure for Family Care: Components and Ranges

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement [38]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Type of Information Provided by RC	Broad range of services	No	Y	Y	Y	Y	Y
Format of Provider Information at RC	Paper brochures → searchable database – consumer searchable	No					
	Consumer searchable database		Y	N	N	N	N
Consumer Unmet needs	Pilot identified consumer unmet needs → addressed unmet needs	Yes	Y	Y	Y	Y	Y
Prior authorization	Procedures established → procedures followed and understood by providers (verbal, written)	No	Y	Y	Y	Y	Y
Community Alternatives Developed and Supported	County has options available for all target populations	Y	Y	Y	Y	Y	Y
	Institutional relocations occurring		Y	Y	Y	Y	Y

[38] Based on the 2001 RC and CMO contracts.

Fidelity Measure for Family Care: Components and Ranges

Core Domain & Components	Indicator and Example Definition or Range	Contract Requirement [39]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
CMO Provider Network	Provider network meets consumer needs → meet quality requirements in provider contracts	Yes					
	Information about network – availability to care management team (format, types of information)i.e. residential capacity, taking new business, hours of service)						
	Number of providers under contract with the CMO						
	Provider relationship positive		Y	Y	Y	Y	Did not assess
	Quality language beginning in provider contracts		Y	Y	Y	Y	Y
Composition of CM Team	County developed goal → followed through with goal evaluation of effectiveness of composition	No					
	Teams in place		Y	Y	Y	Y	Y
RN to Consumer Ratio	At least one RN per 80 consumers	No	N	N	N	N	Y
RN Responsibility	Assessment/ consultation → prevention→coordination of nursing with other IDT members	No					
	Role moving beyond assessment		Y	N/A	N/A	Y	N
RAD Method	RAD training given to all CMs → documented use by all CMs	No					
	Training and documentation of use		Y	Y	Y	Y	Y

[39] Based on the 2001 RC and CMO contracts.

Fidelity Measure for Family Care: Components and Ranges

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement [40]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Consumer Participation in Care Planning	Ability to participate in the care plan communicated to the consumer by the CMO → Documented participation in the care plan by CMO and providers	Yes	Y	Y	Y	Y	Y
Provider participation in Care Planning	Providers receiving prior authorization receiving ISP helping to create ISP		N/A	N/A	N/A	N/A	N/A
Relationship to acute and primary care	Collaboration w/ acute primary care meeting w/ local hospital staff information sharing occurs		Y	Y	Y	Y	Y
Quality Plan	Plan created and approved by DHFS – moving forward on agenda	Yes	Y	Y	Y	Y	Y
Internal Advocacy	Member handbook developed – member relations coordinator in place or individual with member relations duties		Y	Y	Y	Y	Y

[40] Based on the 2001 RC and CMO contracts.

Fidelity Measure for Family Care: Components and Ranges

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement [41]	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Degree of Consumer Involvement	Limited involvement of LTC council/consumers → extensive input from LTC council/consumers into day-to-day operation (i.e. Self Directed Support Option committees)	Yes	Y	Y	Y	Y	N[42]
Consumer Choice Supported	Degree to which consumers have choices about their care in comparison to the old system						
Self Directed Support Option	Self directed support option available → documented use of the SDS Option developed according to standards	Yes	N	Y	Y	Y	N
Local LTC Council Function	Defined role, major accomplishments, member opinion – influence Council has on program	Yes	Y	Y	Y	Y	N
Independent Advocacy	Handles complaints and grievances; serves an informative and preventative function						
	Independent Advocate in place		Y	Y	Y	Y	Y
Pilot Viability	Pilot county ability to manage the rates – factors such as adequacy of rate set by DHFS, management of services, track adjustments in the rate, rate compared to national average	No					

[41] Based on the 2001 RC and CMO contracts.

[42] Recently organized (May 2001).

Appendix F

Acronyms and Glossary of Terms

ACRONYMS AND GLOSSARY

ADL — **Activities of Daily Living:** Refers to the ability to carry out basic self-care activities. Activities include such tasks as bathing, dressing, walking, transferring (getting in and out of bed or chair), toileting (including getting to the toilet), and eating.

ALF — **Assisted Living Facilities:** A popular name for a place where five or more adults reside which consists of independent apartments and which provides each tenant with up to 28 hours of supportive, personal and nursing services per week. The 1997 Wisconsin Act 13 amended statutes to change official name to **Residential Care Apartment Complex.**[43]

AAA — **Area Agency on Aging:** A public or private non profit organization designated by the state to develop and administer the area plan on aging within sub-state geographic planning and service area. AAAs advocate on behalf of older people within the area and develop community-based plans for services to meet their needs and administer federal, state, local and private funds through contracts with local service providers.

BOALTC — **Board on Aging and Long Term Care:** An independent state agency that advocates on behalf of elderly and disabled persons who are receiving long-term residential care, mainly by monitoring development and implementation of policies and programs and investigating complaints about care. As part of the Family Care initiative, BOALTC's responsibilities were expanded to provide advocacy services to potential or actual recipients of the Family Care benefit and authorized to contract for the external advocacy service.

CARES System — C**lient Assistance for Re-Employment and Economic Support:** The CARES system uses data supplied by an applicant for public assistance benefits to determine an applicant's eligibility for MA, Wisconsin works, food stamps and child care programs, to issue public assistance benefits and to track program participation.

CBRF — **Community-Based Residential Facility:** A place in which five or more unrelated adults live and where they receive care, treatment, or services, but not nursing care on any permanent basis, in addition to room and board. CBRFs are licensed by DHFS under ch. HFS 83 rules. [44]

CIP — **Community Integration Program:**

- CIP-IA is for developmentally disabled persons relocated or diverted from DD centers;

[43] Definition from (http://www.legis.state.wi.us/1997/data/acts/)

[44] Ch HFS 83 - DHFS administrative rules for community-based residential facilities for 5 or more adults

- CIP-IB is for developmentally disabled persons relocated or diverted from nursing homes;

- CIP II is for elderly and physically disabled persons diverted or relocated from nursing homes to appropriate community settings with the assistance of home and community-based care and with continuity of care. Care in the community is financed by MA (Medical Assistance).

CMO — **Care Management Organization:** Entity that provides or arranges for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. The Care Management Organization must coordinate care across different delivery systems (including primary health care, long term care [LTC], and social services) and funding sources (including Medicaid fee-for-service and other commercial health insurance, Medicare, and funding sources for vocational and social services).

COP-W — **Community Options Program Waiver:** In January of 1987, Wisconsin received approval of the COP-Waiver request from the federal government. The waiver permits the use of federal Medicaid funds to finance services provided to eligible persons in the community, as an institutional alternative.

COP — **Community Options Program:** A DHFS financed, county-administered program to support individuals who desire to remain in the community setting. The program involves assessing the need of Medical Assistance eligible persons faced with nursing home placement and assisting them via a range of available supportive services in the community, care planning and management, and paying for gap-filling supportive services to make continued or new community residence possible.

CSDRB — **Community Services Deficit Reduction Benefit**: a program under which counties, tribes, and local health departments are able to claim the federal matching dollars to cover approximately 60% of their deficits for certain Medicaid-covered services. These public agencies are responsible for providing the non-federal matching dollars (approximately 40% of total costs) with local funds.[45]

DD — **Developmentally Disabled:** See MR/DD definition.

DHCF — **Division of Health Care Financing:** Responsible for administering the Medical Assistance (Medicaid), Chronic Disease Aids, WisconCare, Health Insurance Risk Sharing Program (HIRSP) and General Relief programs.[46]

[45] Definition from the DHFS cost model November 1999.

[46] Definition from http://www.dhfs.state.wi.us/aboutdhfs/DHCF/dhcf.htm

DHFS **Department of Health and Family Services (DHFS):** Wisconsin State Department of Health and Family Services, began July 1, 1996 and oversees Medicaid and other health programs and social service programs.[47]

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

DME Durable Medical Equipment – Covered by the Family Care benefit and includes items such as wheelchairs, canes, etc.

DMS **Disposable Medical Supplies:** A benefit included in the Family Care program that supplies members with disposable medical supplies intended for one-time or temporary use, such as cotton balls, dressing materials, etc.

ES **Division of Economic Support:** Directs the Eligibility process for the Economic following programs:

Child Care	Child Support Enforcement
Food Stamps	Medical Assistance
Temporary Assistance for Needy Families (TANF)	Welfare to Work
W-2 Welfare Initiative	

The Division of Economic Support (DES) and the Division of Workforce Excellence (DWE) will be consolidated into a new division of Integrated workforce programs tentatively named "Workforce Solutions."

ESU **Economic Support Unit:** County unit responsible for fiscal resources in the county.

FC **Family Care:** A voluntary long-term care managed care program. The State contracts with Care Management Organizations (CMOs) that provide or arrange for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. Family Care will foster recipients' independence and quality of life, while recognizing the need for support to remain independent.

FDD **Facility for the developmentally disabled:** A type of nursing home primarily for developmentally disabled persons. State centers for developmentally disabled persons are FDDs. Licensed under ch. HFS 134 rules.[48]

[47] Definition From http://www.dhfs.state.wi.us/aboutdhfs/BiennialReport9799

[48] HFS 134 - DHFS administrative rules for facilities for the developmentally disabled (FDDs)

FFES	**Functional and Financial Eligibility Screen:** A tool developed by DHFS used to determine functional and financial eligibility for Family Care conducted by trained Resource Center staff.
HCBS	**Home and Community-Based Services:** Alternatives to nursing home care that provide services to people living in the community. With further developments in community supports and technological advances, there is an increased opportunity for individuals at many levels of disability to be effectively served in the community.
HCFA	**Health Care Financing Administration:** The federal agency that administers Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP).
HIPAA	**Health Insurance Portability and Accountability Act of 1996:** The act offers improved portability and continuity of health insurance coverage and regulations to guarantee patients rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information.
I & A	**Information and Assistance:** Service provided by the Resource Centers using a telephone number that is toll-free to all callers in its service area. Information provided is related to aging, physical and developmental disabilities, chronic illness and long-term care, including referrals to and assistance in accessing services.
IADL	**Instrumental Activities of Daily Living:** Refers to tasks required to maintain an independent household. Activities include such tasks as meal preparation, light housework, using the telephone, arranging and using transportation and the ability to be functional at a job site.
ICF-MR	**Intermediate Care Facilities for individuals with Mental Retardation:** An ICF serving only or mainly mentally retarded residents providing active treatment for residents, and certified under 42 Code of Federal Regulations (CFR) 435 and 442. In Wisconsin, these are called facilities for the developmentally disabled (FDDs).
ICF	**Intermediate Care Facility:** A federal Title XIX term for Medical Assistance reimbursement purposes to a lower level of nursing care than that provided in a skilled nursing facility (SNF).
ISP	**Individual Service Plan:** A plan of care developed by the CMO and the Family Care member. It is based on a comprehensive assessment of the individual and reflects the individual's values and preferences for care.
IT	**Information Technology:** Information Technology (IT) refers to information and businesses regarding computers, software, telecommunications products and services, as well as, Internet and online services.

LAB	**Legislative Audit Bureau:** A non-partisan legislative service agency created to assist the Legislature in maintaining effective oversight of state operations. The Bureau conducts objective audits and evaluations of state agency operations to ensure financial transactions have been made in a legal and proper manner and to determine whether programs are administered effectively, efficiently, and in accordance with the policies of the Legislature and the Governor. The LAB is the agency administering the contract to the Lewin Group for the independent evaluation of Family Care.[49]
LTC	**Long Term Care:** A range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self-care. Services may be continuous or intermittent but are delivered for sustained periods to individuals who have a demonstrated need, usually measured by some index of functional incapacity.
M.A. Card	**Medical Assistance Card:** Card provided by Wisconsin Medicaid and covers a broad range of health care services, including home health and nursing facility care as well as the Personal Care option.
MA	**Medical Assistance:** Wisconsin's term for the Medicaid (Title XIX) program which pays for necessary health care services for persons whose financial resources are not adequate to provide for their health care needs.
MOU	**Memorandum of Understanding:** Document clearly defining respective responsibilities of multiple entities.
MCO	**Managed Care Organization:** Any system that manages healthcare delivery to control costs.
MR/DD	**Mentally Retarded/Developmentally Disabled** **Mentally Retarded:** Individual with subnormal intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following: (1) maturation, (2) learning, (3) social adjustment. **Developmentally Disabled:** Disorder in which there is a delay in development based on that expected for a given age level or stage of development. These impairments or disabilities originate before age 18, may be expected to continue indefinitely, and constitute a substantial impairment.[50]

[49] Definition from http://www.legis.state.wi.us/lab/AgencyInfo.htm

[50] © On-line Medical Dictionary at http://www.graylab.ac.uk/omd/

PAC	**Pre Admission Consultation:** Consultations designed to inform individuals of available long-term care options and counsel them regarding their options before making permanent decisions on their LTC. It is also an opportunity to determine if they are eligible for family care.
PD	**Physical Disability:** A physical condition, including an anatomical loss or musculoskelatal, neurological, respiratory or cardiovascular impairment that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person.
RAD	**Resource Allocation Decision Method:** Developed as a tool for the care management team to determine how best to use resources and serves to identify individual outcomes and derive cost-effective options to meet these outcomes.
RAP	**Resource Allocation Program:** Under ch. 150, Wisconsin Statutes*, and ch. HSS 122 rules* the program of adjusting caps on nursing home and FDD beds, distributing newly available beds, and prior review of capital expenditures of nursing homes and facilities for the developmentally disabled (FDDs). [51]
RC	**Resource Center:** Entity offering a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers that are available in the local communities. The RCs also provide counseling about long-term care options and eligibility determination for the Family Care benefit and serve as a clearing-house of information designed to assist service personnel working with populations in need of long-term care services.
RCAC	**Residential Care Apartment Complex:** New name for Assisted Living Facility. (1997 Wisconsin Act 13 amended statutes to change official name to Residential Care Apartment Complex.)
RFP	**Request for Proposal:** Document that solicits proposals from outside parties in a competitive bidding process.
RN	**Registered Nurse:** A graduate trained nurse who has been licensed by a state authority after qualifying for registration.
SNF	**Skilled Nursing Facility:** A federal Titles XVIII and XIX certification term and state licensing term for long-term care facilities that provide care to residents who no longer need the type of care and treatment provided in a hospital but do require some medical attention and continuous skilled nursing observation.

[51] Definition from http://www.legis.state.wi.us/rsb/stats.html

WCA	**Wisconsin Coalition for Advocacy:** An independent non-profit agency with experience in consumer advocacy especially around advocacy issues to protect and promote the interests of developmentally disabled persons and mentally ill persons.

GLOSSARY OF TERMS

Direct Services	Services provided directly to people by agency staff rather than purchased by the agency from an outside provider.
Indirect Services	Services to people provided by DHFS through various public and private agencies under contract.
Nursing Home	A facility that provides 24 hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care. Nursing homes are licensed by DHFS under ch. HFS 132 rules (Health and Family Services).
Personal Care	Refers to assistance with activities of daily living such as eating, dressing, bathing and walking.
Selective Contracting	The process by which CMOs will begin to include quality requirements as part of the contracts process with providers.
Supportive Home Care	Care provided to elderly and disabled persons residing in their own homes; consists of assistance with daily living needs, including household care and personal care.
Community Aids	Community Aids provides core funding to counties for basic community services to people with developmental and other disabilities and other needs. When the Community Aids system was established in 1974, the state used a combination of state and federal dollars to provide approximately 90 percent of the funding for county-run human services. Counties had to provide a "match" of approximately 10 percent in order to capture funding. Over time, the amounts contributed by some counties has grown larger than 10 percent.