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Section 9131(3m) of 1999 Wisconsin Act 9 requires the Legislative Audit Bureau to contract with an organization to evaluate the cost-effectiveness, access to services, and quality of care provided by the Family Care pilot projects. In collaboration with staff from the Department of Health and Family Services, the Legislative Audit Bureau released a request for proposals and, from among the five competitive proposals submitted, selected The Lewin Group to evaluate the Family Care program. As contract administrator, the Legislative Audit Bureau approves each work product delivered by The Lewin Group to ensure objectivity and independence. However, the findings, conclusions, and recommendations in the report are those of The Lewin Group.

The evaluation process has three stages. The first stage was the development of the enclosed Wisconsin Family Care Implementation Process Evaluation Report. The second stage will be the development of an impact evaluation, which will assess the extent to which the pilot projects are meeting the stated goals of Family Care. That stage is currently scheduled to begin in June 2001. The final stage of the evaluation will assess the benefits and costs of the program. Work on it is currently scheduled to begin in January 2002.

The enclosed report is the first of five The Lewin Group will develop on the status of Family Care implementation. The report contains background information on the Family Care program as a whole, as well as evaluative information on the development of each pilot project. The report also contains a glossary of terms and a research methodology section that demonstrates the contacts made by The Lewin Group in the five pilot counties—Fond du Lac, La Crosse, Milwaukee, Portage and Richland—in order to assess the current status of the Family Care program.

Through contact with these pilot projects and numerous interviews with staff from the Department, The Lewin Group advances the following key findings about the implementation of Family Care:

- In the five pilot counties, enrollment in the Care Management Organizations (CMO) that arrange and manage services for individuals enrolled in Family Care was essentially limited to the conversion of Community Options Program (COP) clients and the removal of individuals from existing waiting lists. Through September 8, 2000, 1,513 individuals were enrolled in Family Care in the four pilot counties with fully operational CMOs. (Richland County is not yet operating its CMO.) The pilot projects were not able to enroll new consumers from all target populations as efficiently as they had anticipated.

- The number of actual contacts made by Resource Centers, which provide one-stop shopping for information and assistance in obtaining long-term care services, exceeded projected goals. From March to June 2000, 15,734 contacts were made by the Resource Centers in Fond du Lac, La Crosse, Milwaukee, and Portage counties. The projected goal was 3,223. The extensive use of the Resource Centers indicates that they are meeting a need for information about long-term care choices.

- While the Resource Centers have improved consumers' ability to make informed choices about long-term care, there is significant variation among pilot projects in the manner in which information is organized and provided. There are also some needs that the pilot projects report are unmet. These include transportation, short-term case management, and supported employment for the developmentally disabled population.

- Consumer direction and advocacy are important components in the structural design of Family Care. However, these components have yet to be fully implemented. The pilot projects have been focused on administrative issues such as staffing and case conversion and are just beginning to concentrate on incorporating other requirements. Similarly, quality assurance and improvement efforts are just beginning in the pilot projects.

- Pilot projects are making progress in integrating the management of medical and social care. However, it is too early to discern when changes in care management will actually occur. Pilot projects have reported that care management is much more time-intensive than expected because of the need to develop a care plan with significant consumer input and because there are more services to manage and monitor under the Family Care model.

- A capitated rate-setting methodology has evolved over time, and the Department appears to have made an effort to include the pilot counties in the process. The report chronicles the creation and refinement of the methodology and defines its components in detail.

- Unresolved governance issues have emerged as a central issue in the implementation of Family Care. The Department continues to work to resolve issues involving potential conflicts of interest when a county board oversees both the entity that receives capitated funds to provide Family Care services and the entity that determines the necessary level of care and provides enrollment counseling.

The report is available on the Legislative Audit Bureau's Web page at http://www.legis.state.wi.us/lab. If you are interested in receiving a copy, please contact our office and request the Family Care report. If you have further questions, please contact Kate Wade at (608) 266-2818.

LEGISLATIVE AUDIT BUREAU

Wisconsin Family Care Implementation Process Evaluation Report

Prepared for

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EXECUTIVE SUMMARY

Background

Family Care is an innovative, system redesign experiment designed to improve Wisconsin's long-term care (LTC) system. The redesign is being watched closely both within Wisconsin and across the nation. Although the existing WISCONSIN LTC system is already viewed as a national model, the goal of the redesign is to eliminate some of the problems of the current system, such as the structural bias towards institutional care and a fragmented and often confusing array of funding streams for services. Family Care creates two new community organizations, a Resource Center (RC) to provide one-stop shopping for information and assistance in obtaining services, and a Care Management Organization (CMO) to help arrange and manage services. The program also introduces managed care principles to control escalating costs. If the program achieves its goals, the new long-term care system will provide elderly and adult individuals with physical or developmental disabilities with greater access to flexible services that promote independence and facilitate a higher quality of life.

The Department of Health and Family Services (DHFS) was authorized to pilot the Family Care Program in five counties by 1999 Wisconsin Act 9, the biennial budget. Fond du Lac, Portage, La Crosse and Milwaukee Counties began the implementation of Family Care during CY 2000, while Richland, Kenosha, and Marathon Counties are expected to begin the implementation in 2001 and 2002. The tri-county consortium of Forest, Vilas, and Oneida Counties, known as the Human Service Center, submitted a proposal to serve the developmentally disabled population and are deciding whether to proceed as a Family Care pilot. Jackson and Trempealeau are currently piloting the RCs, but are not planning to pilot the CMOs at this time.

Guiding principles driving the success of Family Care include the following:

- Counties must perform effective outreach to target populations and adequately inform consumers of their long-term care options;
- Reimbursement rates must be reasonable and reflect legitimate variations in care needs;
- Counties must be able to manage the provision of long-term care services within the capitation rates set by DHFS;
- Counties must be held accountable for providing adequate services and consumer choice; and
- Counties must have adequate quality assurance mechanisms that complement Departmental quality assurance efforts to assure that quality services are provided and that consumer outcomes are met.

Purpose

The Family Care program is being evaluated by both DHFS and an independent evaluator (The Lewin Group). The two entities are coordinating their evaluation efforts to prevent duplication and undue burden on the counties involved, as well as to preserve the independence of the external evaluation.

DHFS is the state entity responsible for implementing the program and has budgeted funds to evaluate the program by monitoring program quality and cost-effectiveness, and conducting research on program and policy issues as they emerge during the program. DHFS is monitoring and reviewing the quality of services and outcomes for consumers, including consumer satisfaction, complaints, and grievances; the status of the Family Care budget and compliance with Federal budget neutrality requirements; the capacity of the pilots' provider networks to meet service demands; patterns of service utilization in Family Care; and pilots' compliance with contract requirements and financial status. DHFS also is planning to survey recipients of community-based care in both Family Care and non-Family Care counties.

The legislation authorizing Family Care required an independent evaluation of the program. The Lewin Group was awarded the contract for the independent evaluation by the Legislative Audit Bureau in response to a competitively bid RFP. The Lewin Group evaluation is intended to inform the Legislature in making decisions regarding the future of Family Care. This evaluation also serves to meet requirements of the Federal Health Care Financing Administration for an independent evaluation of the Medical Assistance waiver for Family Care.

The Lewin Group is assisting the State with a three-part evaluation of Family Care, which includes:

1. An Implementation Process Evaluation;

2. An Impact Evaluation; and

3. A Cost-Benefit Evaluation.

The implementation process evaluation aims to document and assess the process of implementation by examining organizational, service delivery, contextual factors, and other information to understand how the counties are implementing Family Care and to build a data baseline that will be used to assess the impact of the program in the later stages of this evaluation. This part of the evaluation will identify key issues that are shaping the current implementation efforts in Family Care pilot counties and will provide a framework and lessons learned for future counties that might implement the program.

The impact evaluation will examine the extent to which the program is meeting the goals of Family Care. The primary goals of this phase of the evaluation will be to ascertain whether or not the program is: preventing or delaying the need for long-term care services; facilitating access to appropriate use of long-term care services and supporting consumer choice; providing quality services to foster consumer independence, enhancing knowledge and dignity and

protecting consumers; and promoting the efficient use of services to increase the number of individuals for whom long-term care services will be available.

The cost-benefit evaluation will assess the extent to which the benefits of the program justify the costs using cost and outcome data compiled as part of the impact phase of the evaluation.

This report provides the first of five updates from the Lewin Group on the status of the implementation of Family Care. The goal of this report is to establish a baseline for assessing key aspects of the implementation process among the pilot counties that will be tracked and reported on in future implementation evaluation updates. Information for this report was collected through site visits, telephone interviews, state and county documents, and the Wisconsin DHFS website. Documents reviewed included county organizational charts, assessment tools, consumer direction materials, contracts, and written reports and plans submitted to the State.

Please note that there is a glossary of terms and acronyms in *Appendix A* to use as a reference for understanding the Family Care vernacular.

Principle Findings

A primary issue affecting the implementation of Family Care (FC) concerns conflict of interest issues related to program governance. There is a potential for conflict of interest if there is not adequate separation between the functions of level of care assessment/ enrollment counseling and service provision. To date, this issue has not been resolved, which has delayed the implementation of some fundamental structures of Family Care in the pilot counties. DHFS has identified four alternative approaches (with variations possible) that could lead to an affirmative response from the Health Care Financing Administration (HCFA). Structures that meet HCFA requirements need to be considered carefully because some may induce problems that Family Care was designed to ameliorate.

Despite early setbacks, the pilot counties have been able to implement some aspects of the program. It is our assessment that the current issues faced by the pilot counties are consistent with what would be expected during the start-up phase of a program's implementation. Although there have been some contentious issues, DHFS and the pilot counties appear to be engaged in a high level of collaboration and coordination. The following key findings and trends have emerged from our evaluation of their implementation efforts thus far:

- County views differed on how much change was required with the inception of Family Care. Counties that viewed Family Care as a more incremental change rather than an entirely new system, placed an emphasis on minimal disruption to current programs. In contrast, counties that perceived Family Care as the development of a new MCO (managed care organization) emphasized separating the RC from the CMO more quickly, hiring business staff, and directing resources into an aggressive marketing strategy. It is too early in the evaluation process to assess which approach is more effective or successful.

- The overwhelming response to the RCs indicates that they are meeting a large and previously unmet need for information about long-term care choices. The number of

actual contacts greatly exceeded projected contact goals for both the aged and the disabled populations. Counties reported that additional resources were required to meet this demand. As such, the assumptions used for funding the RCs should be examined in light of the consumer response. Additional resources have been requested in the 2001-03 budget that DHFS submitted to the Governor on September 15, 2000.

- The Family Care Resource Centers greatly improve consumers' ability to make informed choices about long-term care; however, there is significant room to improve how information is organized and provided. RCs vary in the extent to which they provide information about their services and there is considerable difference in the type of providers for which RCs maintain information. Nevertheless, consumers appear to have a wide range of choices among different providers for most types of services. Counties identified a few services for which consumers continue to have unmet needs: 1) transportation; 2) short-term case management; and 3) supportive employment for the developmentally disabled (DD) population.

- Enrollment in all counties followed the enrollment pattern detailed in the counties' business plans in that it was primarily limited to the conversion of waiver clients and the removal of individuals from existing waiting lists. However, the original enrollment projections in each county needed to be modified to account for start-up issues that caused enrollment efforts to be less aggressive than originally projected. Separating parts of eligibility and enrollment with the creation of the RC and the CMO created problems related to handing-off information. Efforts are currently being developed to alleviate the issues. It is too early to determine if the timeline requirements for Pre-Admission Consultation (PAC) referrals, eligibility determination, and enrollment are realistic, but DHFS should continue to monitor the requirements carefully.

- Family Care must result in the reorganization of care management by CMOs if it is to achieve its goals, namely: 1) Care managers must prescribe services in a cost-effective manner; 2) Care management must facilitate consumer direction; and 3) Care management must consider acute and primary care needs to a greater degree than in the past. Since pilot counties are still developing the care management model, particularly the role of the RNs, it is too early to determine whether the intended transformation in care management will occur. Pilot counties appear to be making the most progress in integrating the management of medical and social care. The Resource Allocation Method (RAD) tool developed by DHFS for the care management team to allocate resources cost-effectively has been generally well received by the CMO care managers. However, it is too early to tell if the RAD will result in more efficient care delivery. Counties expressed that care management is more time-intensive under Family Care due to the increased time allotted for the development of a care plan with significant consumer input and because of the expansion of services to manage and monitor under Family Care. It is important to note that pilot counties reported trying to lower caseloads, especially for the MR/DD population.

- Consumer direction and advocacy are central components in the structural design of Family Care, however they are not yet fully implemented. The pilots have been overwhelmed with administrative issues such as staffing and converting cases and are now starting to concentrate on incorporating the contract requirements for consumer

direction in Family Care in their counties. County Long Term Care Councils are being formed, but have yet to play a major role in shaping implementation.

- Since the counties have been preoccupied with case conversions, training, and other immediate concerns, many of their Quality Assurance and Improvement efforts have just begun.

- Setting capitated rates is a complex and difficult process and DHFS has invested a great deal of time and effort to establish fair and adequate rates. Even though DHFS sought input from the pilot counties while developing the rate setting methodology, all of the counties expressed concerns about the adequacy of the rates. One of the major challenges is that the adjustment for individuals without a spending history may not reflect the experience individuals who enter Family Care. It should be noted that the rate setting methodology and data used for calculating payment rates is an evolving process. As such, the payment system will be modified over time to more accurately represent true and experience-based program costs, and, ultimately, to tie reimbursement to a functional needs.

Future Issues

This report raises important issues to be addressed in the subsequent implementation evaluation efforts. Once there is resolution around governance requirements, we will be able examine county motivations for adapting particular organizational structures and the progress they make in implementing main components of Family Care. Among other issues, we will closely monitor the transformation of care management, county investment in Information Technology (IT), and the DHFS efforts to refine the rate setting methodology. We will be particularly interested in the experiences of Richland County since serious questions remain regarding whether capitation can work in small counties.

I. OVERVIEW OF PROGRAM HISTORY

A. Family Care Is an Innovative Experiment Being Watched Closely Both Within Wisconsin and Across the Nation.

The Wisconsin Family Care demonstration redesigns the state's long-term care system. Family Care involves several major innovations:

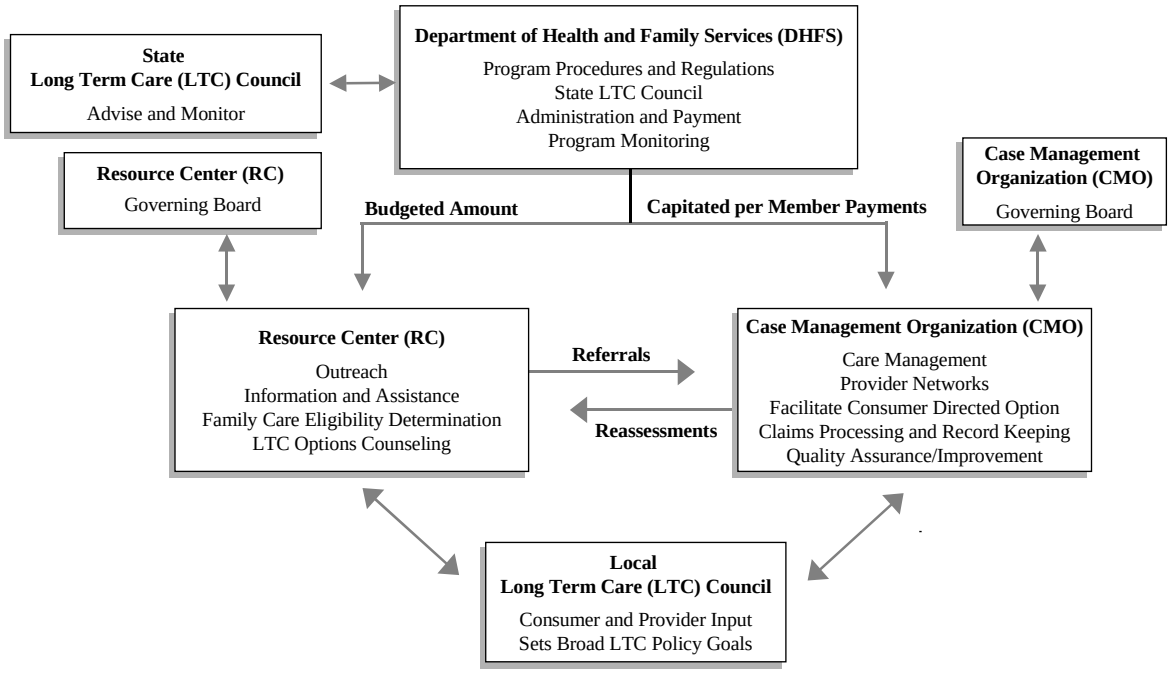
- Family Care transforms home and community-based services (HCBS) into an entitlement for individuals eligible for Medicaid. Previously, these individuals were entitled to institutional care, but in many cases were placed on a waiting list for HCBS.
- Family Care incorporates managed care principles into long-term care. The use of capitated payments for Medicaid-funded long-term care in Wisconsin is one of a few experiments watched closely by other states and the federal government.
- Family Care creates a single entry point resource center that provides information and education to all individuals in need of long-term care regardless of Medicaid eligibility.
- Family Care includes strong requirements for consumers to have the option of directing their own care.
- Family Care unifies service delivery systems for three target populations, older adults, younger adults with physical disabilities (PD), and adults with mental retardation or other developmental disabilities (MR/DD).

B. Family Care Creates Two New County-based Community Organizations, a Resource Center (RC) and a Care Management Organization (CMO).

Each county that is piloting the full Family Care model has developed both an Aging and Disability Resource Center (RC) *and* a Care Management Organization (CMO). These counties include Fond du Lac, La Crosse, Milwaukee, and Portage. With the exception of Milwaukee, which serves only the elderly population, the full models target the elderly, physically disabled and developmentally disabled populations. Some counties including, Jackson, Kenosha, Marathon, and Trempealeau, currently operate RCs only. Richland is expected to begin operation of a RC in January 2001. (See ***Exhibit 1.1*** for roles of the participating entities)

Resource Centers provide assistance to individuals seeking information about long-term care services and service personnel working with populations in need of long-term care services. They offer 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. In addition, the RCs provide counseling about long-term care options and eligibility determination for the Family Care benefit. Services are provided to consumers via telephone or home-visits. Resource Centers are responsible for implementing and monitoring the quality of their operations. County RCs receive an annual budget from the DHFS in the form of prepayments equal to one-twelfth of the grant amount for each of the first three months of the contract. This may be recovered if it is determined by DHFS that the payments are in excess of the RC's actual expenses. Future monthly payments made by DHFS are based on expense reports submitted by the RC.

Exhibit 1.1
Wisconsin Family Care (FC) Functions and Roles



County **CMOs** are care management organizations that receive per member per month payments to deliver services to individuals receiving the Family Care benefit.[1] The CMOs must develop a provider network sufficient to provide services to the target populations enrolled in Family Care in their respective counties. CMO staff perform comprehensive interdisciplinary assessments of consumer needs and preferences and work with consumers to develop a plan of care. CMOs are also responsible for monitoring and assuring the quality of services provided.

The legislation authorizing FC specifies that initially DHFS could contract only with a county, a Family Care district[2], or the governing body of a tribe to form RCs and CMOs. These entities must prove that they meet the requirements set by DHFS for operating a FC program. As of June 30, 2000, the statute indicates that DHFS also can begin contracting with private non-profit organizations to form RCs if these organizations have no significant connection to an entity that operates a CMO, and if the county does not apply or does not meet the performance requirements of a RC. After December 31, 2002, DHFS may contract for a CMO with a private organization if the county or Family Care district fails to meet the requirements under the contract or if they fail to develop the capacity to serve the target populations. However, after December 31, 2003, DHFS may award a CMO contract to a private organization that has no significant connection to an organization that operates a RC.

[1] To receive the Family Care benefit an individual must qualify functionally and financially. Cost-share options are available for individuals who do not meet financial requirements.

[2] Identified as a special purpose district created under s. 46.2895(1) stats.

C. Family Care was Created to Improve a Long-Term Care System that was Already Viewed as a Model Program.

Prior to the implementation of Family Care, Wisconsin's long-term care system was already considered a national model because of the State's longstanding commitment to offering a broad and flexible range of services.[3] Nevertheless, there were concerns about the system, which included the fragmented and confusing array of funding streams, as well as a structural bias toward institutional services. Evidence of this institutional bias is especially apparent in the patterns of service utilization among the elderly and disabled populations. Of the approximately 71,000 elderly and disabled Wisconsin residents receiving publicly funded long-term care, two-thirds of this group were receiving care in an institution during the fiscal 1998/9 budget period.[4] The problem is less evident among individuals with MR/DD in Wisconsin. In 1998, approximately 30 percent of these individuals receiving Medicaid funded care reside in intermediate care facilities for individuals with mental retardation (ICF-MRs) or other institutions.[5]

With regard to the fragmented assortment of funding streams and services, currently there are more than forty state and locally-administered programs that offer various services with differing eligibility requirements.[6] Under this system, adults in need of care receive funding from various sources, including:

> **COP-R:** The Community Options Program, monitored by the Department of Health and Family Services, is administered by local county agencies to deliver community-based services to Wisconsin citizens in need of long term assistance. Any person regardless of age, with nursing home level of care is eligible for COP. The program began as a demonstration in eight counties in 1982 and was expanded statewide in 1986.
>
> **COP-W:** The Community Options Program Waiver provides Medical Assistance funding for home and community-based care for elderly and physically disabled citizens who have long-term care needs and who would otherwise be eligible for Medical Assistance reimbursement in a nursing home. County participation was mandated effective January 1, 1990.
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> **CIP IA:** The Community Integration Program IA is a Medical Assistance funded program to provide community services to persons who are relocated from the State Centers for the Developmentally Disabled. County participation was mandated effective January 1, 1996.

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[3] General Accounting Office (1994c). Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO-HEHS-94-167) Washington, D.C.: Health, Education and Human Services Division.

[4] Wisconsin Legislative Audit Bureau. (1999, May). *An Evaluation: Community Options Programs: Department of Health and Family Services.*

[5] Data files sent to The Lewin Group by Charlie Lakin of the University of Minnesota.

[6] Request for Proposal for the Evaluation of the State of Wisconsin Family Care Program Department of Health and Family Services: RFP: LAB-0199. (1999, September). Issued by the Wisconsin Legislative Audit Bureau. Madison, WI.

CIP 1B: The Community Integration Program IB is a Medical Assistance funded program to provide community services to persons with developmental disabilities who are relocated or diverted from nursing homes and Intermediate Care Facilities-Mental Retardation (ICFs-MR) other than the State Centers for the Developmentally Disabled. County participation was mandated effective January 1, 1996.

CIP II: The Community Integration Program II is a Medical Assistance funded program to provide community services to elderly and physically disabled persons after a nursing home bed is closed. County participation was mandated effective January 1, 1990.[7]

Medical Assistance Card: Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for healthcare services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements. Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS), Division of Health Care Financing (DHCF). Wisconsin Medicaid covers a broad range of health care services, including home health and nursing facility care as well as the personal care option. However, limitations apply that are designed to ensure the provision of only medically necessary services.[8]

Older Americans Act: Since 1965, the Older Americans Act (the Act) has gained recognition as a unique and highly regarded statute that has contributed greatly to enhancement of the lives of people 60 years and older. State Agencies on Aging receive Title III funds, which are made available to the States on a formula basis upon approval of State Plans by the AoA Regional Offices. States then allocate funds to the Area Agencies on Aging, based on approved Area Plans. The Older Americans Act supports the elderly nutrition program and meals-on-wheels, the county and area offices on aging, and the benefit specialists. The Act also supports nursing home ombudsman and elder abuse prevention, as well as up to 85 percent of the costs of supportive services, senior centers, and nutrition services.[9]

These concerns over system fragmentation and institutional bias fueled a strong desire in Wisconsin to improve and redesign the system. Stakeholders wanted to find a way to expand home and community-based services while reducing unnecessary institutionalization and fragmentation to ensure consumer choice, quality, and flexibility of services. The State had an additional goal of implementing a managed care model that could control costs. These interests led to the development of Family Care.

D. Evaluation and Reporting

The legislation authorizing Family Care required an independent evaluation of the program involving three major components: (1) an implementation process evaluation (2) an impact

[7] Adapted from www.dhfs.state.wi.us

[8] Adapted from www.hcfa.gov

[9] www.aoa.dhhs.gov

evaluation; and (3) a cost-benefit study that will serve the interests of the State and assist in meeting Health Care Financing Administration (HCFA) requirements.

This report provides the first of five updates from the Lewin Group on the status of the implementation of Family Care. The goal of this report is to establish a baseline for assessing key aspects of the implementation process among the pilot counties that will be tracked and reported on in future implementation evaluation updates. In addition, the implementation evaluation will identify issues, obstacles and lessons that will assist in implementing the program in other parts of Wisconsin, as well as in other states. The implementation evaluation will also inform the impact and cost-effectiveness evaluations. Subsequent updates of this report are scheduled to be delivered to the Legislature on: June 29, 2001; January 15, 2002; August 30, 2002; January 1, 2003

The impact evaluation, currently scheduled to begin June 2001, will assess the extent to which the program is meeting the goals of Family Care, which include: preventing or delaying declines in functioning and the need for long-term care services; facilitating access to and appropriate use of LTC services, and supporting consumer choice; providing quality services to foster consumer independence; enhancing knowledge and dignity, and protecting consumers; and using services efficiently to increase the number of individuals for whom LTC services will be available.

The cost-benefit study, currently scheduled to begin January 2002, will assess whether the benefits of the program exceed the costs. The State requested that this evaluation encompass the viewpoints of all the major stakeholders, including program participants, the State, the CMO and RC administrators and providers, the nursing home industry, as well as, society as a whole. The study will include both quantitative and qualitative data and project benefits and costs into the future.

II. METHODOLOGY

This report examines the implementation of Family Care up to the end of July 2000 based on information collected from:

- Site-visits;
- Telephone interviews;,
- Review of the documentation provided to us by DHFS and the Family Care pilot counties;
- Follow-up telephone interviews; and
- An analysis of the pilot provider availability and networks.

A. Site-visits and interviews

1. Timing and structure of the site-visits

The first site-visit was conducted during the week of March 27 through 31, 2000. During this site-visit, we met with representatives from the counties scheduled to begin CMO enrollment in 2000: La Crosse, Portage, Fond du Lac and Milwaukee. In addition, we obtained input regarding the evaluation design from: 1) the Interim State Long Term Care Council, which includes consumer, provider, and state representatives, 2) representatives of consumers and providers in the four counties implementing a CMO in 2000; and 3) representatives of non-participating counties. We also monitored the development of the program through our biweekly calls beginning in April 2000, as well as through other calls to DHFS and listening via conference calls to state meetings with the counties. The remaining site visits are scheduled to occur approximately one month prior to each of the Implementation Process Evaluation Update reports.

During the visits to each of the counties, we interviewed representatives from the RC and the CMO. We also tried to obtain the consumer and provider perspective at the county level by interviewing members of the county Long Term Care Council or other individuals recommended by the county. We talked with COP/CIP program staff to obtain a description of how the program operated in the county prior to Family Care and to evaluate staff perceptions of the transition. A list of interviewees appears in ***Appendix A.***

2. Description of protocol development

Prior to the site-visits, Lewin drafted protocols for the first site-visit and forwarded them to DHFS and LAB for comment. Suggested changes were incorporated, and the protocols were forwarded electronically to the pilot counties so they could be read prior to the interviews with Lewin.

We have attached copies of the protocols used for the first site-visit in ***Appendix B.*** These protocols will continue to evolve as new implementation issues arise. For example, in response to input obtained during the first site-visit, we amended the protocols for future phone calls and site-visits.

3. Focus of interviews

Interviews focused on describing the basis of the intake system, care delivery processes, and quality assurance mechanisms by addressing the following:

- Organizational operations;
- Factors that influenced DHFS decisions concerning key aspects of program implementation;
- Other internal and external environmental factors that affected the development of the program; and
- Differences across programs and sub-populations.

System Description. We gathered information about the following components of the program design:

- Targeting, outreach and recruitment, including how individuals learn about the program and the level of involvement of other players in the long-term care network;
- Eligibility requirements;
- Point of access, such as the number of places individuals can and must access the system, and efforts to establish a single point of entry;
- Staffing requirements, including training requirements and number and type of staff required for providing various types of care;
- Services offered;
- Care management models, including by whom case managers are employed, and who is responsible for providing oversight; and
- Innovative practices and initiatives.

Quality Assurance. While consumers generally prefer care in the home or in the community[10], it is more difficult to monitor the care provided in these environments. We assessed the following issues:

- Strategies for promoting quality;
- Standards and regulations for different provider types, and procurement procedures;
- Mechanisms for monitoring quality and strategies for intervening when problems are detected; and
- Procedures for addressing grievances, and providing for participant input and feedback.

[10] Weiner, Joshua M. and Raymond Hanley. "Caring for the Disabled Elderly: There's No Place Like Home," in *Improving Health Policy and Management,* Volume 335, Number 5, August 1, 1996: 324.

B. Documentation review

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

- County organizational charts;
- State assessment tools;
- Educational materials and procedures for educating consumers and members;
- Descriptions of emergency and protective procedures;
- Contracts;
- Quality assurance and improvement plans;
- Grievance procedure plans;
- Information technology plans; and
- Written reports and plans submitted to the State.

In reviewing these documents, we assessed the accuracy and likely effectiveness of county procedures and plans. County compliance with state contract requirements was verified where possible. Likely effectiveness was based on criteria such as the following: timeliness of eligibility determination, staff training, and organizational structure.

C. Follow-up Interview Process

We conducted follow-up interviews with staff, consumer representatives, and provider representatives in the four counties implementing both the RC and the CMO in 2000 to update and enhance our understanding of the implementation process. We also conducted interviews with FC staff in the counties in the planning stages of FC. In addition, interviews were conducted with Waukesha County, which withdrew as a pilot in May 2000. Protocols for these interviews are in ***Appendix* C.**

D. Provider Analysis

One of the goals of the evaluation is to assess the effectiveness of Family Care in providing outreach, education, and access to long term care resources, as well as to determine if CMO enrollees have access to and adequate choice in the types of services they receive. To address these goals, we have started, as part of the process evaluation, to track the availability of providers contracting with the CMOs.

1. Identifying Data Resource Contacts In The Counties

We contacted individuals responsible for keeping track of the database of providers in the four counties that currently operate both a CMO and a RC. In mid-June 2000, we requested data on providers listed by the RC and providers contracting with the CMO.

2. Resource Center Databases

We analyzed the provider listings compiled by the RCs in the pilot counties to assess: (1) the types of information being collected and how consumers can access it; and (2) the number and types of providers in the county (we will track this information over time in later reports). Each of the four RCs in the pilot counties indicated that they have compiled and will be updating lists that they feel include all providers in their counties. The RCs use these lists to inform consumers about their LTC options. Not all of the counties keep provider information in a comprehensive, computerized database. Some counties use lists, pamphlets, and brochures in addition to information stored electronically and/or on web-sites about providers.

This report provides a baseline of the number and types of providers existing in the Family Care counties at the time of the implementation of the CMO. In later reports, we will track changes as the program matures. In this report, we only comment on the manner in which the information is stored and the number of HCBS providers in each area. We assessed the strengths and weaknesses of the type and format of information each RC is maintaining.

3. Database of CMO Network Providers

We obtained data from the CMOs about which providers are included in their provider networks. Network restriction might be a means of quality assurance as CMOs begin to assess quality of providers and contract with providers who have proven expertise and experience with the populations. It is too premature for this information to provide an indication of the extent to which the CMO is restricting the network given available providers, if at all. Most CMOs currently do not restrict the provider network. In Milwaukee, providers are being transitioned into the CMO network due to the high volume of providers with which the CMO has to contract. In cases where a contract has not yet been procured, Milwaukee's CMO has been required to offer the enrollee needed services via certified providers.

In this report, we list the number of providers that each pilot CMO is contracting with for each type of HCBS. We include both consumer and HCBS provider perspectives about the choice of HCBS providers offered by the CMO. In addition, we provide a comparison of providers known by the RC to providers available through the CMO.

III. OVERVIEW OF IMPLEMENTATION

A. Contractual Requirements For Family Care

DHFS has negotiated contractual requirements with both the RCs and the CMOs in the pilot counties. Below we supply a brief summary of the *major* requirements in the RC and the CMO contracts.[11] For additional information, these contracts are maintained by DHFS at http://www.dhfs.state.wi.us/ltcare/pdf/RCContract.pdf (RC contract) and http://www.dhfs.state.wi.us/ltcare/pdf/CMOcontract.pdf (CMO contract).

1. RC Contractual Requirements

Services

The RCs are required to provide a broad array of counseling and information services, including:

- **Outreach and public education** through an ongoing program of marketing and outreach to the target populations, community agencies, and service providers to inform them of the availability of RC services. The program must include: outreach to isolated and hard to reach target populations; outreach and training to police and fire departments, postal employees, pharmacists and others in contact with the target populations; outreach to children with disabilities and their families; notification of all facilities in the service area that are required to make referrals for the functional and eligibility screen; and plans for monitoring the effectiveness of outreach efforts.
- **Information and assistance** to the target populations, their friends, family and caregivers and the general public.
- **Long-term care counseling** and advice about options available to meet long term care needs and about factors to consider in making long term care decisions to members of the target populations and their families.
- Benefit specialist services.
- Access to Family Care benefit, SSI, SSI-E, Medicaid and Food Stamps.
- Immediate advice and assistance in a crisis situation.
- Elder abuse and adult protective services need identification.
- **Transition assistance for young adults** in the target populations to the adult long-term care system.
- **Prevention and early intervention** activities and assessments, including developing and maintaining, and providing public education information on risk and safety.

[11] We have adapted the text from the year 2000 contracts.

Facilitation of Access to the Family Care benefit.

The RCs must develop and implement a **Family Care access plan,** approved by DHFS, to ensure that people who are eligible for Family Care have access to the benefit. Individuals may either refer themselves or be referred by a long-term care provider for Pre-Admission Counseling (PAC). Resource Centers offer a functional and financial screening process, which includes the following components:

- **LTC Functional Screen** for eligibility determination; a person qualifies for Family Care. ***Exhibit III.1*** defines the two levels at which a person may qualify for Family Care.

Exhibit III.1
Qualifications for Family Care

	Comprehensive Functional Level	Intermediate Functional Level
Population	Entitled to the Family Care benefit	Entitled to the Family Care benefit if at least one of the following applies: • In need of Adult Protective Services • Qualify for Medical Assistance • Grandfathered from an existing LTC program
Functional Criteria	Unable to safely perform any of the following: • 3 or more ADLs • 2 or more ADLs & one or more IADLs • 5 or more IADLs • One or more ADL(s) and 3 or more • IADLs and has a cognitive impairment • 4 or more IADLs and has a cognitive impairment	Unable to safely perform any of the following: • One or more ADL(s) • One or more of the following critical IADLs: ➢ Management of medications and treatment ➢ Meal preparation and nutrition ➢ Money management

- **Financial declaration** to assess whether the client is eligible for the Family Care benefit or would qualify for public assistance within six months of entering a nursing home, Community-based residential facility (CBRF), Residential care apartment complex (RCAC), or adult family home. Results of the financial declaration are used in LTC options counseling, but are not used for making the financial eligibility determination.

- **LTC options counseling** provides clients with information and counseling before they make decisions about long-term care;

- Financial eligibility and cost share determination and redetermination for the Family Care benefit performed by the RC or by an appropriate agency;

- RCs must **refer individuals** who are functionally eligible, but whose financial eligibility is pending, to the CMO for **urgent services** as needed. The RC must inform the individual that if he/she is determined not to be eligible, he/she will be liable for the cost of services provided by the CMO; and

- **LTC options counseling** before disenrollment from the CMO.

RCs Must Meet Organizational and Procedural Standards.

The RCs must:

- Develop and implement a plan for phasing-in mandatory PAC referrals from facilities required to refer individuals with a long-term care need of 90 days or more. The plan must detail a strategy for informing providers of the referral requirement, as well as educating about the process and timeline for phase-in.
- **Constitute a governing board** that reflects the ethnic and economic diversity of the RC's service area and is at least one-fourth consumer representatives.
- **Jointly develop with the CMO a plan for separating** the eligibility and enrollment functions of the RC from the CMO.
- Inform people of their rights and responsibilities in ways that they can understand and use.
- Implement a written due process procedure for the review and resolution of complaints and grievances that is consistent with applicable administrative rules set by DHFS.
- Link clients with advocacy resources.
- **Identify community needs** for segments of the target population(s) that may be either unserved or underserved and types of services or facilities that may be in short supply in order to target outreach, education, prevention and service development efforts.
- Implement a DHFS approved quality assurance plan.
- Meet data reporting requirements set by DHFS.
- **Meet civil rights**, **cultural competency** and **accommodation** requirements for persons with disabilities.

2. CMO Contractual Requirements

Consumer and Member Involvement in CMO operations: CMOs are required to ensure significant consumer and member involvement in the development and implementation of policy including:

- **Governing Board** representation that reflects the ethnic and economic diversity of the CMO's service area and is at least one-fourth consumer representatives.
- Procedures to include an authorized representative (e.g. guardian, power of attorney for health care) in significant communications between the CMO and the member (e.g. member rights and responsibilities, development of Individual Service Plan), and in providing significant documents to the member (e.g. member handbook). The CMO shall allow the member's authorized representative to facilitate care or treatment decisions when the member is unable to do so.
- Documentation of the member's choices and desired outcomes for each identified need during the initial assessment.

- Member rights promotion, including implementing policies to ensure this happens.
- Provision of a self-directed care option, which allows a member to arrange, manage and monitor services in the LTC benefit package directly or with the assistance of another person chosen by the member.
- Implementation of a safety and risk policy that expressly prohibits and reports all forms of abuse, neglect, exploitation, and mistreatment of members by CMO employees and providers.
- Performance **expectations** that the CMO will achieve certain consumer-centered outcomes.

CMO Functions: Enrollment and Disenrollment

The CMO has the following enrollment and disenrollment functions:

- **Enrollment** into the CMO must be open (the CMO must enroll everyone who is eligible) and voluntary. In addition, the CMO must have a Memorandum of Understanding (MOU) or other written agreement with the RC that describes the circumstances in which the CMO will provide services to an individual who is functionally eligible but whose financial eligibility is pending. The CMO assumes responsibility for all pre-existing conditions.
- **Disenrollment** from the CMO may result from voluntary disenrollment on the part of the Family Care member, involuntary disenrollment as a result of a physical assault on a CMO employee or provider, or loss of eligibility. In all of these cases, the CMO is responsible for referring the member to the Resource Center for counseling. If it is a voluntary disenrollment, the RC will review the reason for disenrollment and review service and program options if the member chooses to disenroll. If it is an involuntary disenrollment, the RC shall inform the member about the grievance procedure and, if disenrollment occurs, offer to assist the member in accessing long-term care services. The CMO is to continue providing services until the effective date of disenrollment.

CMO Functions: Service

The CMO must promptly provide or arrange for the provision of services to individuals meeting either the intermediate or comprehensive functional eligibility criteria if consistent with the Individual Service Plan (ISP).

Exhibit III.2 compares the Medicaid-covered services that the CMO must include in the Family Care benefit package to the Medicaid services not covered in the benefit package but which the CMO must arrange for and instruct all members on where and how to obtain them.

Exhibit III.2
CMO and MA card covered services

Medicaid Services Included In The Family Care Benefit	Services Coordinated Through Medicaid Fee-For-Service
Care Management Home Care Services Home Health Aide Personal Care Skilled Nursing Physical Therapy Occupational Therapy Speech Therapy Language Pathology Mental Health/Substance Abuse Services Day Treatment Child/Adolescent Day Treatment Community Support Program Services In-Home Intensive Psychotherapy In-Home Autism Treatment Nursing Facilities (includes ICF/MR & IMD) Supplies and Equipment Disposable Medical Supplies Durable Medical Equipment (DME) Repair and Maintenance of DME Orthotics Transportation by Specialized Medical Vehicle Providers	Ambulance Transportation Audiology Chiropractic Crisis Intervention Services Dentistry Eyeglasses Family Planning Services Hearing Aids Batteries, Accessories, Devices Repair and Maintenance Hospice Hospital Inpatient (except DME) Outpatient (Except Physical Therapy, Occupational Therapy, Speech Therapy, Mental Health, Substance Abuse Treatment) Independent Nurse Practitioner Services Lab and X-ray Mental Health Services (MD; Inpatient) Nurse Midwife Services Optometry Pharmaceuticals Physician Services Podiatry Prenatal Care Coordination Prosthetics School-Based Services Transportation by Common Carrier

Additional requirements related to CMO service provision include:

- Members at the intermediate level, who are not residing in a nursing facility or ICF/MR at the time of enrollment, do not have access to care in a nursing facility or ICF/MR for longer than 90 days.
- Case management must be provided through a designated care management team which, at a minimum, consists of a social service coordinator and a registered nurse.
- The initial ISP must be developed by the CMO and signed by the member within 10 days of enrollment. The comprehensive assessment must be completed within 30 days, and the complete ISP must be completed within 60 days. The CMO conducts re-assessments and updates the ISP as needed or requested based on: (1) previous screens

and assessments; (2) changes in the member's condition; or (3) requests by the member or other interested parties.

- The CMO must coordinate with other services not included in the benefit package. This mandate includes a wide variety of mandates, including assessing members within one week of hospitalization, developing plans to ensure medication compliance, and sharing relevant clinical and ISP information with acute and primary care providers.
- Adult protective services must be involved, as necessary.
- The CMO is responsible for payment of all services in the LTC benefit package.
- The CMO must provide private pay care management to individuals who are functionally eligible but not financially eligible to be members of the CMO.
- 24 hour coverage, seven days a week must be provided.
- A CMO employee must be designated to serve as a member advocate.
- The CMO must have a prevention and wellness program.
- The CMO must provide interpreter services for members as necessary.

Complaints and Grievance Procedures.

The CMO must also implement written complaints and grievances procedures that are approved by DHFS.

CMO Functions: Service Providers.

The CMO must comply with the following requirements when subcontracting with service providers:

- The CMO must ensure choice of providers, including free choice of medical and other providers that remain fee-for-service.
- For services in the LTC benefit package that involve providing intimate personal needs or when a provider frequently comes into the member's home, must consider the consumer's preference. The CMO must purchase services from any qualified provider that the consumer selects who will accept and meet the provisions of the CMO's subcontract.
- The provisions of these subcontracts must focus on quality and cost effectiveness, and not be constructed in such a way so as to limit the network of providers.
- The CMO must maintain a process for contracting with non-CMO providers requested by a member.
- The CMO must allow a member to change care management teams up to two times per calendar year if the CMO has available care management teams.
- The CMO must maintain subcontracts with a network of providers that meet standards set by DHFS and are approved by DHFS.

- The CMO cannot pay its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the LTC benefit package unless DHFS approves a higher level of payment.
- The CMO must maintain a claims retrieval system that can, on request, identify date service was received, action taken on all provider claims (i.e., paid, denied, other), and when action was taken.
- The CMO must set competency standards for CMO staff providing services in the LTC benefit package, arrange for training for CMO employees to meet competencies, and establish a system for monitoring to assure for the provision of quality services.
- The CMO will pay family members if certain conditions are met.
- Members will have the choice of being the direct employer of attendants for supportive home care.
- Cultural competency must be encouraged and fostered among CMO staff and providers.

CMO Functions: Quality Assurance/Quality Improvement.

The CMO must have a written quality assurance/quality improvement (QA/QI) plan and program that includes the following components:

- Member-defined outcomes.
- Additional measures of quality that DHFS may establish.
- Oversight by the CMO governing board and a designated senior manager.
- At least annual effort by the CMO to seek formal member input, through member surveys, face-to-face interviews or other means.
- Assistance to DHFS and the external quality review organization in identification of provider and member information required to carry out on-site or off-site member record reviews.

CMO Functions: Administration.

CMOs are required to have certain key administrative infrastructure including:

- Financial management infrastructure necessary to ensure cost-effective delivery of services, including information and accounting systems and a business plan.
- A system for maintaining member records and for monitoring compliance with policies and procedures.
- The CMO must coordinate with the Local Long Term Care Council, including providing certain information specified in the contracts and receiving and giving consideration to the Council's recommendations.
- The CMO must submit an annual financial audit.

- The CMO must have management information system capable of supplying accurate data and reports required by DHFS in a timely manner. The management information system should have the capacity to monitor enrollment and disenrollment, ensure that provider data is accurate, and maintain a member level record of the services covered under Family Care.
- The CMO must submit the reports specified by DHFS.

Contractual Obligations of the State in the CMO Contract

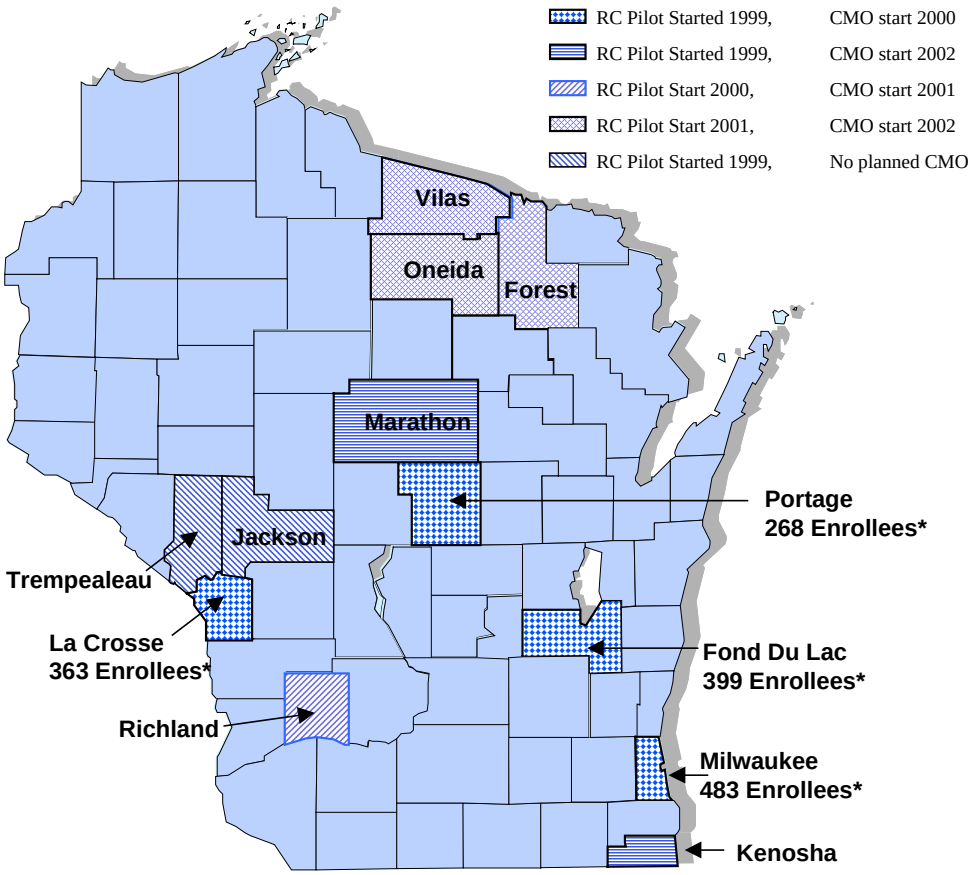
The CMO contract also specifies several functions and duties that the DHFS must fulfill, including:

- Maintain a **State Long Term Care Council** that assists DHFS in developing policies and procedures, monitors and reviews the progress of the program, and sends an annual report to the legislature and the governor.
- Review and analyze reports and data and respond as appropriate.
- Notify the CMO about all members enrolled and who disenroll. Medicaid ID cards, also known as Forward cards, will be issued to Family Care members who qualify for Medicaid coverage.
- Calculate and pay a per member per month payment rate that is prospectively designed to be actuarially fair and no more than the cost of providing the same services covered under the Family Care contract to a comparable Medicaid population on a fee-for-service basis.

B. Stages of Implementation

Currently there are four counties that operate the full model of Family Care (both a Resource Center and a Care Management Organization). ***Exhibit III.3*** presents cumulative enrollment for each of these counties from inception of Family Care to the beginning of September, as well as the implementation plan for the remaining Family Care pilots.

Exhibit III.3
Family Care Enrollment



*These figures are taken from the Monthly Monitoring Report and reflect cumulative CMO enrollment from 2/1/00 to 9/8/00.

C. Overview of the Four Pilot Counties Implementing the CMO in 2000

Because counties have responsibility for implementing Family Care, there are distinct differences in the ways used by the four pilot counties implementing CMOs in 2000 have designed their programs. The pilot counties are currently in a period of transition and the ultimate structure of Family Care is not likely to emerge until key questions around governance have been resolved and other infrastructure is developed.

Exhibit III.4 provides a brief overview of each of the four pilots operating CMOs. The table lists demographic information, the administrative structure of Family Care, and progress in reducing waiting lists. Later in the report, we provide more in-depth discussions of key issues.

All four counties currently implementing a CMO serve all three of the target populations with the exception of Milwaukee County, which only serves persons over the age of 60.

Exhibit III.4
Overview of Pilot Counties In Full Implementation

County	Population[12] Race and Ethnicity	Population Demographics	CMO Administration	RC Administration	Waiting Lists[13]
Fond Du Lac	**Total: 94,329** White: 98.7% Black: 0.4% AI/E/A: 0.4% Asian/PI: 0.7% (Hmong): (31%) Hispanic: 1.4%	70% of target population in city of Fond du Lac 30% in rural areas[14]	Department of Social Services	Department of Social Services	12/31/99 Status: Elderly: 0 DD: 79 PD: 0 Current Status: Eliminated for all populations[15]
Portage	**Total: 64,748** White: 98.2% Black: 0.3% AI/E/A: 0.5% Asian/PI: .7% (Hmong): (30%) (Chinese): (27%) Hispanic: 1.3%	37% of total population in Stevens Point 63% in rural and suburban areas	Health and Human Services Department	Department on Aging	12/31/99 Status: Elderly: 8 DD: 37 PD: 2 Current Status: Eliminated for all populations
La Crosse	**Total: 102,279** White: 95.5% Black: 0.6% AI/E/A: 3.6% Asian/PI: 3.6% (Hmong): (73%) Hispanic: 0.9%	Majority of target population in rural areas	Human Services Department – Long Term Support Section	Human Services Department – Long Term Support Section	12/31/99 Status: Elderly: 0 DD: 45 PD: 0 Current Status: Reduced for DD
Milwaukee	**Total: 908,940** White: 74.5% Black: 24.1% AI/E/A: 0.8% Asian/PI: 2.1% *(Hmong):* *(22%)* (Asian Ind): (15%) Hispanic: 5.9%	Majority of target population in city of Milwaukee	Department on Aging	Department on Aging	12/31/99 Status: Elderly: 2,849 Current Status: Reducing waiting list - goal to enroll 100 people from the waiting list each month

Staffing

Counties incorporated staff from existing county programs such as the COP program and other waiver programs into the Family Care program staff. However, the increases in clients and new

[12] Population source is USA Counties General Profile 1998 (includes population data for 1997 and 1996) taken from U.S Census website at http://www.census.gov/statab/USA98/55/000.txt

[13] In preparation for Family Care counties were given additional funds for waiver programs to reduce waiting lists. This contributed to the elimination of some waiting lists prior to Family Care.

[14] Fond du Lac has also experienced a small increase in demand for services from people who moved from other counties to receive the Family Care benefit.

[15] Prior to Family Care, Fond du Lac did not experience a major problem with waiting lists for the aged and the physically disabled populations. The waiting list for the DD population, however, was four to five years.

responsibilities associated with the program also required counties to hire new staff. Counties hired new social workers, nurses, managers, and fiscal staff.

IT systems

Counties had the flexibility to structure their own IT systems in accordance with their needs. Although DHFS did not provide a template for a specific IT system, counties were provided technical assistance to set up systems that were compatible with Family Care reporting requirements. The pilot counties are in varying stages of IT infrastructure development and employed different approaches to set-up their systems. For example, Fond du Lac invested approximately $318,000 to develop a new IT system to meet the needs of their RC and CMO. Portage County gathered staff input around IT issues and has since installed software. La Crosse County contracted with an outside agency to develop software and contracted with county computer services to track PAC referrals. The Milwaukee CMO recently contracted with Keylink for a web-based system to track enrollment, authorization, and service use. In addition, the Milwaukee RC has a networked database up and running. Later implementation reports will provide more detail about county IT systems as they are further developed.

D. Status of the Remaining Pilot Sites

Exhibit III.5 provides a brief overview of each of counties in the planning stages of Family Care accurate as of the beginning of August 2000.

Exhibit III.5
Overview of Pilot Counties in Planning Stages of Family Care

County	Population[16]	Population Demographics	CMO Administration	RC Administration	Waiting List time period
Richland	**Total 17,920** White: 99.6% Black: 0.1% AI/E/A: 0.2% Asian/PI: 0.3% Hispanic: 0.4%	Concentrated in Richland Center	Not determined yet	Commission on Aging	12/31/99 Status: Elderly: 2 DD: 11 PD: 0 8/00 Status: 2 month wait for all populations 10-12 individuals in 8/00
Marathon	**Total 122,450** White: 96.1% Black: 0.5% AI/E/A: 0.2% Asian/PI: 2.8% (Hmong): 2.2% Hispanic: 0.5%	Half in rural areas	Marathon County Social Services North Central Community Services Commission on Aging	Marathon County Social Services North Central Community Services Commission on Aging	12/31/99 Status: Elderly: 102 DD: 166 PD: 39
Human Service Center[17] (Forest, Villas, Oneida)	**Total 66,395** White: 94.1% Black: 0.3% AI/E/A: 4.6% Asian/PI: 0.3% Hispanic: 0.4%	Rural	Human Service Center	Human Service Center	12/31/99 Status: Elderly: 30 DD: 47 PD: 40 Current Status: Six months to one year wait

[16] Population source is USA counties general Profile 1998 taken from the U.S. Census website at http://www.census.gov. AI/E/A = American Indian/Eskimo/Aleut; A/PI = Asian/Pacific Islander.

[17] At this time, Human Service Center is only planning to serve the DD population.

Exhibit III.5 (continued)
Overview of Pilot Counties in Planning Stages of Family Care

County	Population	Population Demographics	CMO Administration	RC Administration	Waiting List time period
Kenosha	**Total 142,872** White: 93.1% Black: 5.0% AI/E/A: 0.4% Asian/PI: 0.7% Hispanic: 5.6%	Suburban	Human Services Department Elderly/PD – Division of Aging DD – Division of Disability Services	Human Services Department	12/31/99 Status: Elderly: 225 DD: 38 PD: 89 8/00 Status: 425 individuals
Trempealeau	**Total 26,354** White: 99.0% Black: 0.1% AI/E/A: .1% Asian/PI: 0.3% Hispanic: 0.3%	Rural	Department of Social Services	No CMO planned	12/31/99 Status: Elderly: 11 DD: 19 PD: 8 Current Status: Elderly – 2 months PD- 7 months DD- more than 7 months
Jackson	**Total: 17617** White: 93.5% Black 0.4% American Indian/ Eskimo/Aleut: 4.2% Asian/Pacific Islander: 0.2% Hispanic: .0%	Rural	Department of Health and Human Services	No CMO planned	12/31/99 Status: Elderly: 8 DD: 4 PD: 4 8/00 Status: One year wait for all populations 19 individuals

Waukesha (no longer part of Family Care)

Waukesha has a population of 358,442 people. The potential Family Care target population in Waukesha County is mostly situated in Waukesha, the largest city with a population of 60,000. The majority of the county's population is white; however, the county also serves both Hispanic (2%) and Asian (1.2%) minority groups.

The planning stages for a RC in Waukesha County began in 1997. The county identified a structure and examined a potential design. As waiting lists in the county grew rapidly over the past 10 years due to the reduction of Community Aid dollars, county officials hoped that Family Care would eliminate waiting lists for services for all target populations, especially for the physically and developmentally disabled. Furthermore, the county hoped to have the opportunity to be innovative and creative in integrating funding streams as becoming a FC pilot county promised.

However, as of May 1, 2000, Waukesha County withdrew from the FC pilot program. County staff cited three main reasons for not participating in the program at this time. The primary reason for withdrawing was that they had a problem with the vendor that was contracted to set up the IT system. The county did not want to proceed with an IT system unable to handle Family Care's requirements and needs. The county has since identified and contracted with another IT vendor. Secondly, Waukesha planned to operate both a CMO and a RC, however they did not want to start both entities simultaneously, as was required by the State. Finally, County officials were dissatisfied with requirements around rate setting, governance, and contracts. Waukesha reported that their decision to withdraw from Family Care was based on the unclear response they received from the DHFS around these issues.

E. Start-up Funding

The pilot counties received start-up funding from various sources to plan, develop, and implement the Resource Centers and Care Management Organizations. ***Exhibits III.6, III.7 and III.8*** present the breakdown of funding by county.

Exhibit III.6
Resource Center Start-Up Funding

COUNTY	RC Planning Grant 1/98- 12/98	RC Planning & Implement Grant 1/99- 12/99	RC Start Up Grant 1/00- 12/00	RC Contract 1/00 – 12/00	Total RC Funding
Funding Source	*#1310, from COP lapse funds*	*#1310 for Jan-June, Budget bill for July-Dec (reallocated)*	*Budget Bill (reallocated funds)*	*Budget Bill (reallocated funds)*	
Fond du Lac	**$104,000**	**$251,883**	**NA**	**$432,097**	**$787,980**
LaCrosse	**$105,044**	**$280,505**	**NA**	**$614,525**	**$1,000,074**
Milwaukee	**$255,000**	**$503,681**	**NA**	**$1,590,308**	**$2,348,989**
Richland	NA	$9,989	$101,452	NA	**$111,441**
Human Service Center (FOV)	NA	NA	TBD	NA	**$0**
Kenosha	$201,306	$324,195	NA	$727,139	**$1,252,640**
Marathon	$147,513	$330,253	NA	$1,198,385	**$1,676,151**
Jackson	$45,471	$60,911	NA	$317,598	**$423,980**
Trempealeau	$55,366	$95,324	NA	$290,349	**$441,039**
Oneida Tribe	$20,000	NA	NA	NA	**$20,000**
TOTALS	**$1,011,700**	**$1,969,699**	**$101,452**	**$5,488,799**	**$8,571,650**

Source: Information provided to The Lewin Group by the DHFS Policy Monitor and Grant Specialist

Exhibit III.7
Care Management Organization Start-Up Funding

COUNTY	CMO Planning and Development Grant 11/98-12/99	CMO Information Technology Allocations 1/99- 12/99	CMO Phase 2 Capacity Building Service Funds 4/99- 12/99	CMO - One Time Start Up Grant/Loan 1/00- 12/00	CMO Planning and Development Grant 1/00-12/00	Total CMO Funding
Funding Source	***Annual Budget and COP/COP-Waiver funds***	***Annual Budget Bill***	***COP and COP-Waiver funds***	***COP and COP-Waiver funds***	***Budget Bill***	
Fond du Lac	$274,485	$89,500	$172,271	$384,052	NA	**$920,308**
LaCrosse	$202,021	$45,500	$660,980	$320,728	NA	**$1,229,229**
Milwaukee	$315,779	$70,000	$1,235,138	$2,456,613	NA	**$4,077,530**
Portage	$337,641	$75,000	$149,971	$346,880	NA	**$909,492**
Richland	$291,489	$75,000	$279,995	$600,365	NA	**$1,246,849**
Kenosha	NA	NA	NA	NA	$420,000	**$420,000**
Marathon	NA	NA	NA	NA	$238,000	**$238,000**
TOTALS	**$1,421,415**	**$355,000**	**$2,498,355**	**$4,108,638**	**$658,000**	**$9,041,408**

Source: Information provided to The Lewin Group by the DHFS Policy Monitor and Grant Specialist

Exhibit III.8
Combined RC and CMO Start-Up Funding

County	RC Funding	CMO Funding	Total Funding
Fond du Lac	$787,980	$920,000	**$1,707,980**
LaCrosse	$1,000,074	$1,229,229	**$2,229,303**
Milwaukee	$2,348,989	$4,077,530	**$6,426,519**
Portage	$509,356	$909,492	**$1,418,848**
Richland	$111,441	$1,246,849	**$1,358,290**
TOTALS	**$4,757,840**	**$8,383,100**	**$13,140,940**

IV. GOVERNANCE

Governance has emerged as a central issue in the implementation of Family Care because of conflict of interest issues. Both HCFA and the State have concerns about the potential for conflicting interests if the entity that receives capitated funds to provide Family Care services also sets the level of care and/or provides enrollment counseling. HCFA has determined that the current Family Care legislation does not fully address this potential conflict of interest and requires that this issue be resolved prior to the approval of 1915(b) and (c) waivers. The State has been in negotiations with both HCFA and the Family Care Pilots for the past two years in an attempt to resolve this issue. To date, there has been no final resolution[18] and the governance structure has varied considerably across counties as a result of the confusion. Pilot counties are still expected to meet the following State statutory requirements by January 1, 2001:

- Proof that the County board passed a resolution about the separation;
- Establishment of separate consumer-controlled governing boards for the CMO and the RC;
- Separation of the level of care and enrollment counseling by either of two specified means; and
- Contractual assurances to assure compliance.

In discussions about approving 1915(b) and (c) waivers, HCFA has mandated that the entity that determines eligibility for services and counsels the consumer about which service provider to choose is separate from the entity that provides services. DHFS had originally assumed that locating the RC and the CMO within separate parts of the county government and requiring separate contracts and separate governing boards for Resource Centers (RC) and Care Management Organizations (CMOs) would be sufficient to meet separation requirements. HCFA felt this did not provide enough separation. Several Family Care statutes were subsequently written that defined governance options including the development of State and Local LTC Advisory Councils with majority consumer membership. Again, HCFA requested that there be more separation from the county board. In the meantime, negotiations continue and viable alternatives are being considered.

The potential for conflict of interest in Family Care is real. Conflicting interests could exist in a variety of forms, including the following scenarios:

- An entity, such as the CMO, that receives a capitated payment has a financial interest in who is eligible and at what rate. If the county controls both the CMO and the RC, and the CMO is facing a shortfall in funds, the county could pressure the RC to admit more individuals at the higher comprehensive rate; or
- In cases where a county controls the CMO and also owns service providers, the county has a financial incentive to pressure the CMO to direct consumers to these providers. For example, county ownership of a nursing facility and the CMO could act as

[18] The Lewin Group contacted the HCFA staff and they deferred discussing this issue with us until the waiver application has been approved.

a strong disincentive for deinstitutionalization that would lower occupancy and hurt county finances.

Although we found no indication that counties acted or planned to manipulate eligibility or enrollment counseling functions to improve the financial standing of the CMO, the potential does exist if separation is not adequate.

The lack of resolution regarding the conflict of interest issue has delayed plans to separate the RC from the CMO in three of the four Family Care pilot counties (Fond du Lac, LaCrosse, and Milwaukee) until they obtain greater clarification regarding governance requirements. Currently, these counties house both entities within the same section of county government, although separate staff operate each program. Portage County, on the other hand, has created separate governing boards wherein Health and Human Services governs the CMO and the Commission on Aging governs the RC.

Counties reported that the lack of resolution around governance also has caused delays in staffing. Some of the RCs have postponed hiring staff until these issues are resolved while others who have hired staff are concerned that it is only a temporary arrangement. Counties hesitated to make staffing changes in the event that discrete functions such as eligibility determination are contracted out to another entity. Overall, counties resisted expending effort to set up separate structures given the level of uncertainty surrounding its future state.

Structures that meet HCFA requirements need to be considered carefully because some may produce problems that Family Care was designed to overcome. A major concern extending from the separation of functions is that the goal creating a centralized long-term care information center with direct access to services (one-stop shopping) could be jeopardized. Though the intent of Family Care is to increase consumer direction and bring decision-making as close to the consumer as possible, the fragmentation of access points has the potential to cause more confusion and complexity in navigating the system and ultimately, be an undue burden for both consumers and workers. In addition, new structures may necessitate additional outlays for wages, training of existing staff, hiring new staff, and training new staff.

To date, the following four alternatives have been identified (with variations possible) that could lead to an affirmative response from HCFA:

- **DHFS would contract with one or more private entities to do both level of care assessment and enrollment counseling outside the Resource Center contract.** This option has already been approved by HCFA and could be implemented by January 1, 2001, the date that state statutory requirements for separation must be met. This arrangement would provide an unbiased level of care assessment thereby protecting state financial interests. It also assures unbiased enrollment counseling and assistance to benefit consumers. However, separating these functions raises several issues. For one, the separation might undermine FC's goal of one-stop shopping as consumers are "bounced" from staff person to staff person. The separation also might require additional funding and some counties might experience difficulty identifying a private entity with no conflicts. Finally, this type of arrangement could produce adversarial reactions from county employees and unions who would object to the "privatization" of these service functions.

- **Use workers in Economic Support Units to do both financial eligibility determination and level of care assessment while contracting with a private entity for enrollment counseling and assistance.** HCFA would likely approve this option as it assures unbiased level of care determination, as well as unbiased enrollment counseling and assistance for consumers. Since major functions of the Resource Centers would remain intact, there would be less need for additional funding and less opposition to "privatization." It could also be viewed positively by the Economic Support workers as they gain skills and proficiency. Although it would probably not disrupt the one-stop shopping concept considerably, the possibility would still exist. Locating workers with the knowledge and experience to perform both level of care assessment and financial eligibility determination also might prove to be difficult. This approach might also result in increased costs to cover training and wages for these workers. In addition, it may not be possible to have workers trained in time to meet the January 1, 2001 statutory requirements.

- **DHFS contracts with one county to be either a Resource Center or CMO for another.** This option would most likely be approved by HCFA if the structure allows for the functions to be truly separate. It would preserve the ideals of a single point of entry and avoid any opposition to "privatization." However, this approach would interfere with a historical deference to county control and may cause competition over resources among counties. It could also create an undue burden for consumers and employees, given the expanded geographic scope. The constraints are most likely too great to meet the statutory requirement deadline.

- **Revise Wisconsin statutes to make the proposal of a Family Care District acceptable to HCFA and ensure that the District is more independent from the county board.** For example, there could be state or local LTC Council approval of initial appointments of District Board members, longer terms, fewer County Board representatives, or reappointment of members by the District Board itself. These provisions could allow for unbiased eligibility determination and enrollment counseling for consumers. Under this arrangement, Resource Center functions would be retained with the RC while disruptions to one stop shopping for consumers would be minimized. For counties that create a district to operate a CMO, they could insulate county tax levy from risk. The technicalities make this option more time-intensive and would not allow for the Wisconsin statutory deadline to be met. Furthermore, some counties may not be equipped or willing to create a separate government entity.

DHFS wants to ensure that the counties are given flexibility to determine which plan for separation will work best in the individual counties. It should be noted that Family Care pilots are opposed to any changes that would cause fragmentation of the Resource Center, as well as contracting out for level of care assessment and enrollment counseling. DHFS is planning a two-phased approach: 1) require pilots to meet initial state statutory requirements by January 1, 2001, and 2) continue to explore options that meet HCFA requirements.

It is evident that a resolution to this issue is necessary for implementation of the full Family Care model. The longer the delay in determining where the agencies will be located and what responsibilities will be contracted out, the greater the distraction from the other tasks of implementing Family Care.

V. OUTREACH

Family Care seeks to raise awareness of options for receiving long-term care and to enroll individuals in need of care as smoothly as possible. Local Aging and Disability Resource Centers (RC) provide broad information and assistance to older adults, people with disabilities, and their families. The RC is also responsible for providing long-term care options counseling, determinations of functional and financial eligibility for the Family Care benefit, assistance in enrolling in a CMO if appropriate, and eligibility determination for other defined benefits, including Medicaid. Because the RC plays such a critical role in the accessibility of long-term care resources under Family Care, pilot outreach efforts need to effectively connect all the possible referral sources and recipients to the RC.

In each of the pilot counties, the Family Care RCs use several means for targeting individuals. RCs proactively advertise services through TV, radio and printed materials, conduct meetings in settings that serve their target populations (e.g., senior centers), and network with other community organizations that serve the target populations. In addition, the Family Care legislation requires that nursing homes, community-based residential facilities, adult family homes, residential care apartment complexes, and hospitals in Family Care pilot counties inform and provide contact information to prospective residents about the RC services.

The response to the RCs indicates that they are meeting a large and previously unmet need for information about long-term care choices. The number of individuals contacting the RCs has greatly exceeded projections for both the aged and disabled populations. From February 2000 to July 2000, the majority of the RC contacts were inquiries concerning disability and long term care-related services, basic needs and financial-related information, and long term care living arrangements. RC contracts state that for the first six months after the contract is signed, the RC should receive four contacts per month for every 1,000 people in each target population served (target populations are divided into two groups: (1) aged and (2) younger adults with physical and developmental disabilities). The expectation for number of contacts increases over time until June 2001, when each RC is expected to be receiving 20 calls per month per 1,000 people in each of the two target populations.

Exhibit V.1 shows the effectiveness of pilot outreach efforts by comparing the actual number of contacts with the RCs from March to June 2000 to the initial expected number (4 contacts per month/1000 persons). Also displayed is a comparison of actual contacts to the ultimate target (by June 2001) for expected number of contacts (20 per month/1000 persons). The exhibit also shows the number of RC contacts referred to the functional screen.

Exhibit V.1
Resource Center Activity, March – June 2000

	RC Contacts	Initial Contact Goal (4 per 1,000)	Percent of Goals Met	Contact Goals at 20 per 1,000	Percent of Goals Met at 20 per 1,000	Referrals to Screening	Percent of Contacts Referred
Milwaukee							
60+	9,781	2,552	383%	12,770	77%		
18-59	162	NA	NA	NA	NA		
Subtotal	**9,943**	**2,552**	**390%**	**12,770**	**78%**	**1,574**	**16%**
Other	2,560	NA	NA	NA	NA		
Total	**12,503**	**2,552**	**490%**	**12,770**	**98%**		
Fond du Lac							
65+	320	216	148%	1,076	30%		
18-64	160	72	222%	364	44%		
Subtotal	**480**	**288**	**167%**	**1,440**	**33%**	**394**	**82%**
Other	234	NA	NA	NA	NA		
Total	**714**	**288**	**248%**	**1,440**	**50%**		
La Crosse							
65+	465	156	298%	1,045	44%		
18-64	63	63	100%	412	15%		
Subtotal	**528**	**219**	**241%**	**1,457**	**36%**	**212**	**40%**
Other	231	NA	NA	NA	NA		
Total	**759**	**219**	**347%**	**1,457**	**52%**		
Portage							
65+	646	116	557%	577	112%		
18-64	160	48	333%	244	66%		
Subtotal	**806**	**164**	**491%**	**821**	**98%**	**108**	**13%**
Other	952	NA	NA	NA	NA		
Total	**1,758**	**164**	**1072%**	**821**	**214%**		
All 4 Pilot Counties							
65+	11,212	3,040	369%	15,468	72%		
18-64	545	183	298%	1020	53%		
Subtotal	**11,757**	**3,223**	**365%**	**16,488**	**71%**	**2,288**	**19%**
Other	3,977	NA	NA	NA	NA		
Total	**15,734**	**3,223**	**488%**	**16,488**	**95%**		

Source: Information received from DHFS compiled from monthly Information and Assistance reports.[19]

In analyzing the reasons for RC contact, we found that a large number were categorized as "other." RC representatives reported that this category is capturing a large number of callers who requested information, but for whom the RC staff did not believe it was appropriate to

[19] Contact goals for the elderly are based on the county-specific projected Year 2000 population of people 65 and older (60+ for Milwaukee) obtained from the State of Wisconsin website. Contact goals for the disabled population (which combines PD and DD individuals) are based on county-specific 1998 projections of the disabled population aged 16-64 obtained from the Wisconsin DHFS Division of Supportive Living, Bureau of Long Term Care Resources.

collect target population information. RC staff indicated that these contacts tended to be brief and they did not feel that it would be appropriate to ask them for personal information. Analyses of the contacts for which the RC had information about the target population showed that actual contacts were nearly **four times larger than projections** for this time period. When considering contacts falling into the "other" category, actual contacts were almost five times larger than expected contacts.

Overall, the number of contacts during this first period of implementation is approaching what was expected at full implementation (20 contacts per month per 1,000). Milwaukee and Portage have been experiencing an especially high number of contacts relative to expectations. In all counties, except Fond du Lac, actual contacts for the elderly exceeded the initial expected number of contacts at a slightly greater rate than for the disabled. Milwaukee received a small number of contacts from the disabled population even though the Milwaukee RC only targets the older population.

We identified several innovative practices that pilots used to market their Resource Centers and the services they provide. For example, the Marathon County web-site provides information, links to other service providers, online information requests, online PAC referral, a chat room, and a discussion board, thus enabling isolated persons access to information and services provided by the RC. In La Crosse County, the RC serves as the central contact for Neighbor Care, a program that aids businesses in identifying potential RC customers. The Kenosha County RC for Aging/Physically Disabled offers screening for Family Care at locations other than the Resource Center, such as a pre-vocational education site. This service allows potential consumers greater access to Family Care with minimal burden.

The assumptions used for funding the RCs should be re-examined. Based on their experience thus far, the counties reported that the funding they received for outreach efforts was insufficient to meet the community demand and potential need. They assert that DHFS should review their funding in light of the following:

- The number of contacts to the RC have far exceeded projections and expectations for both the aged and disabled populations during this implementation period;
- RCs do not have sufficient capacity to handle the need for short-term case management in situations when a caller was in crisis; and
- DHFS may have underestimated the amount of time allocated for contacts, screenings and counseling.

Conducting an independent accounting review of the RCs' budgets was beyond the scope of this evaluation. We note that DHFS is aware of these issues and is reviewing the budget assumptions in consideration of the aforementioned factors.

The RCs' experiences with staffing and with PAC referrals from hospitals may be early indicators of the difficulties of integrating long-term care with acute care. Because of the multidimensional nature of aged and disabled patients, processing long-term care referrals can be a complex process. For example, integrating the acute-care focus of hospital discharge planning with the long-term care focus of the RC requires a different approach and knowledge level for both sectors. RC staff need to have the ability to assess which settings will meet the medical and long-term care needs for medically complex referrals. Although hiring RNs is not a contract

requirement for RCs, it is important to note that many RCs have hired RNs to address these assessment needs.

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.

VI. ENROLLMENT

Each county submitted a business plan to DHFS that detailed monthly enrollment projections by target population. ***Exhibit VI.1*** presents the actual, cumulative enrollment figures for the four counties with fully operational CMOs. The data were extracted from DHFS' September Monthly Monitoring Report. We are unable to present a comparison of actual enrollment with projected enrollment at this time, however, since the actual enrollment figures reported by DHFS reflect cumulative data that are accurate as of September 8, 2000 while the figures on the business plans reflect a full month of enrollment. For future updates of the implementation evaluation, we plan to collect monthly enrollment data directly from each county so that a comparison of actual versus projected enrollment can be reported. Such a comparison will be valuable in understanding any differences across counties.

Exhibit VI.1
CMO Enrollment Cumulative Enrollment as of September 8, 2000

	Fond du Lac	La Crosse	Milwaukee	Portage
Start Date	Feb – 00	Apr – 00	Jul – 00	Apr – 00
Elderly				
Comprehensive	187	211	483	103
Intermediate	0	0	0	3
Total Elderly	187	211	483	106
Disabled				
Comprehensive	212	152	N/A	158
Intermediate	0	0	N/A	4
Total Disabled	212	152	N/A	162
Total Enrolled	**399**	**363**	**483**	**268**

Source: Monthly Monitoring Report and information provided by DHFS.

According to program requirements, everyone meeting the comprehensive level of functional eligibility is assured of receiving services in a timely manner. In addition, everyone who meets the intermediate (lower) level of functional eligibility and who is Medicaid-eligible or has a confirmed need for adult protective services is assured prompt access to the Family Care services. Others at the intermediate level not meeting the above state criteria are eligible for services, but may be placed on a waiting list if funding is not immediately available.

Setting enrollment projections is a difficult process for any new program. Although accurate comparisons of actual to projected enrollment are not currently available, our discussions with CMO representatives indicate that actual enrollment has approached the targeted estimates. DHFS allowed pilots to make amendments to enrollment projections submitted in the business plans as the program unfolded. The revised business plans for the 2001 contracts will be available for analysis at the end of calendar year 2000 and we will comment on the amendments made to enrollment plans in future reports. The Lewin Group will continue to monitor the progress of enrollment issues listed below that may offer explanations about the number of Family Care enrollees.

Enrollment efforts have been primarily limited to the conversion of waiver clients and the removal of individuals off the waiting lists. Counties reported that the majority of individuals being screened for Family Care are currently enrolled in other public LTC programs and then transitioned into Family Care. Other enrollees were transitioned from the waiting lists. In addition, a small proportion of the Family Care enrollees are from institutions. For example, Portage relocated approximately six to eight individuals from institutions to the community. La Crosse reported that they deinstitutionalized a few individuals. Fond du Lac has relocated at least seven individuals from state centers for the developmentally disabled, and Milwaukee has assisted 44 individuals with relocation. Most counties have not aggressively enrolled new consumers since they are concentrating on caseload conversions and providing services to individuals from the waiting lists. Hence, resources were not available to aggressively enroll new entrants. In addition, Family Care stakeholders suggest that Wisconsin estate recovery laws might have deterred individuals from enrolling since the laws are stricter than federal requirements. Individuals who hope to pass their estate on to their heirs may be reluctant to enroll knowing that the State can recover Medicaid funds upon their death.

The true impact of Family Care may not be realized until individuals new to the long-term care system account for a substantial portion of enrollees. Existing clients that are converted to the CMO may be much less likely to enter an institution unless they have a major change in their long-term care needs or informal care network. In addition, these individuals are likely to currently have a plan of care that care managers might be reluctant to alter.

First-time seekers of long-term care services are at a crossroads in which they must determine if they can find adequate supports to remain in the community or enter an institution. In the past, barriers, such as the waiting lists for the waiver programs, may have prevented these individuals from having adequate support to remain in the community. The entitlement nature of Family Care may decrease the use of institutions for these individuals. In addition, care managers may have more latitude to design cost-effective care plans because they will not be supplanting an existing plan.

Separating parts of eligibility and enrollment with the creation of the RC and the CMO has created problems related to handing-off information, but current efforts may alleviate the problems. Prior to Family Care, pilot counties had mostly centralized eligibility and enrollment functions. Enrollment procedures were unique to each long-term care program. Waiting lists existed for most programs, which meant that delays in eligibility determination did not necessarily affect delays in initiating client services. Under Family Care, enrollment procedures will be standardized. Furthermore, timely eligibility determination is pertinent because delays in functional determination can translate into further delays for the consumer in receiving services. In addition, delays could require the use of county funding to provide for short-term services to individuals with immediate need prior to official enrollment.

Counties reported that the separation of functions has made the transfer of information more burdensome for employees, care recipients, and their families. They noted that recipients may be asked the same set of questions three times by three different individuals (the functional screen by the RC, the assessment by the CMO, and questions from a home health agency necessary for their own reporting requirements under the OASIS system). County and consumer representatives argue that this duplication is cumbersome since some of these interviews can last several hours. According to the pilot counties, the functional screen takes approximately four hours to administer. In addition, the counties expressed concerns about violating the privacy of

individuals in eliciting personal information, such as questions asked by multiple assessors concerning toileting assistance.

It was also reported that the transfer of information is complicated by the use of different information systems at the RC and the CMO. Currently, the pilots are transferring paper copies of assessments from the RC to the CMO, but all of the counties are moving towards electronic transfer of this information. Electronic transfer could help reduce the time it takes to administer the CMO assessment. Some county representatives expressed an interest in investigating information sharing and compatibility with home health agencies in the future, while others were more hesitant due to privacy concerns. Although this issue has not been explored by DHFS to date, they emphasize that if such information sharing were to exist, strict rules regarding informed consent, consumer confidentiality and access to information would be required.

It is too early to tell if the timeline requirements for PAC referrals, eligibility determination, and enrollment are realistic, but DHFS should continue to monitor the requirements carefully. Implementation issues have made it difficult for some pilot counties to meet the timelines set for Family Care. Pilot counties continue to set up the staffing structures for Family Care as the program develops to serve more clients. This has made it difficult for RC staff to be trained and ready to respond to PAC referrals in the required three days and to follow-up with contacts to the RC. County staff are also learning the processes of enrollment and working with economic support units to coordinate eligibility. As the outreach and enrollment processes mature, it will be important to note if RCs and CMOs have adequate capacity to serve contacts and additional members, respectively. We will also want to observe the extent to which the RCs and CMOs are in compliance with set timelines. DHFS is planning on implementing a monitoring system to track timelines.

VII. ACCESS TO SERVICES

Family Care is expected to increase consumer access because it will create an entitlement to HCBS and will provide information about the availability of HCBS through the Resource Centers. For a consumer to have enhanced access to HCBS under Family Care, the following need to occur:

- The consumer must know about what services are available to meet his or her needs;
- The consumer must have a choice of providers for each type of service needed; and
- If the consumer is enrolled in a CMO, the CMO must contract with a number of providers.

To assess whether the above conditions for consumer access to HCBS are being met, we requested several pieces of information from each of the pilot counties operating both a RC and a CMO in 2000. The counties supplied us with a description of the types of information the RC was using to counsel consumers regarding their long-term care options and the format in which that information is maintained. In addition, we received a list maintained by the RCs of all available providers in their respective county. The provider lists enabled us to determine the relative scope of provider networks among the counties, as well as the type of information available to consumers through the RC. Likewise, we were supplied with a list of all providers with which the CMO in each county contracted. The CMO lists provided us with comparative provider network data as well as an indication of the use of existing providers in each county.[20]

The Family Care Resource Centers appear to improve consumers' ability to make informed choices about long-term care; however, there is significant room to improve how information is organized and provided.

All of the four RCs in the counties operating both a CMO and a RC provided consumers with basic information about long-term care providers in their area including: the name of the business, the type of service offered, its location, and phone number. Fond du Lac is currently the only county that provides a contact name and direct telephone number for most providers. Overall, we found substantial variance in the amount of additional information available. ***Exhibit VII.1*** presents available provider information that RCs offer to their consumers.

[20] The RCs stated that they believed their databases contained all the providers in the county. However, we found a few instances in which a CMO contracted with providers that were not listed by the corresponding Resource Center.

Exhibit VII.1
Provider Information Available from Family Care Resource Centers, by county

County	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)
Fond du Lac	X			X	X	X	X	X	X	X
La Crosse	X			X	X	X		X		
Milwaukee	X			X	X	X	X	X		X
Portage	X	X		X		*		X		

Note: All Resource Centers provide the provider name, type of service, address, and phone number. *Fees and rates are available for a limited range of services.

Exhibit VII.1 shows that all the RCs are providing information about the population served (i.e., MR/DD, older adults), hours of service, and fees. The Portage RC is the only one that provides details on residential capacity (i.e., the numbers of beds or private rooms available). The CMO in La Crosse does track this information, but it is intended for internal (care management) use and is not readily available to the general public. With the exception of Portage, all the RCs note the eligibility requirements for particular services. Milwaukee and Fond du Lac provide information on whether providers speak other languages. Fond du Lac and Milwaukee allow consumers with electronic access to view provider contact information when it is available (e.g., e-mail and Internet addresses), which may be of particular use to disabled persons.

There is considerable variation in the type of providers for which RCs maintain information. Some RCs provide information concerning only a small number of long-term care services, while others offer information on a larger scope. In general, Portage and Fond du Lac counties offer a limited range of HCBS information, while Milwaukee and La Crosse counties offer a broader scope to include many other services, organizations, and supplementary sources of information.

Consumers appear to have a wide range of choices among different providers for most types of services. ***Exhibit VII.2*** presents what types of services the RCs are tracking and the number of providers active in each of the four pilot counties for several different types of services.

Exhibit *VII.2*
Number of Providers Known by Resource Center, by County and Type of Service

Type of Service	Fond du Lac	La Crosse	Milwaukee	Portage
Adaptive Aids	3	1	NT	NT
Adult Day Care	1	7	NT	6
Adult Family Home	11	2	61	NT
Assisted Living Facility	10	8	5	NT
Case Management	NT	22	19	1
CBRF	60	17	180	33
Congregate Meals	19	9	64	NT
Daily Living Skills	NT	2	NT	NT
Day Services/ Treatment	2	7	33	1
Employment-related	5	19	27	2
Guardianship/Money Management	1	4	37	NT
Home Care (medical & supportive)	17	21	121	12
Home Modification	NT	5	28	NT
Interpreter Services	NT	5	NT	NT
Meal Delivery	2	12	14	2
Medical Equipment	15	22	55	8
Mental Health	42	84	45	2
Nursing Facility	23	7	63	2
Rehabilitation/Therapy	39	26	10	NT
Respite Care	NT	14	46	NT
Speech & Language Path.	NT	8	NT	NT
Substance Abuse	46	53	21	NT
Transportation	18	12	42	11

NOTE: An "NT" indicates that the resource center does not track this type of provider.

RCs vary in the extent to which they provide information about their services. Fond du Lac County offers a detailed on-line listing of LTC providers that can be searched by anyone with access to the Internet. This may increase the ability of some recipients and families to direct their own search without having to access RC staff to obtain information. However, we suggest that the site be examined to determine how accessible it is for individuals with disabilities.[21] Milwaukee and La Crosse both have extensive databases of HCBS providers, but these are only accessible through employees at the RC. The Portage Resource Center does not use a database at all, but rather, provides consumers with various pamphlets listing HCBS in the area. ***Exhibit VII.3*** presents the different provider information formats among pilot RCs.

Exhibit VII.3:
Format of Provider Information at RCs, by County

County	Brochures	Database, Employee-Searchable	Database, Consumer-Searchable
Fond du Lac	X	X	X
La Crosse	X	X	
Milwaukee	X	X	
Portage	X		

The pilot CMOs are focused on trying to replicate the provider network that operated under the previous system. Each pilot county was required by contract to hire a Network Developer to strengthen and expand the provider availability within the CMO network, yet the CMOs each pursued different strategies in constructing their networks. The CMOs in Fond du Lac, La Crosse, and Portage counties currently have a complete provider network for consumers. They have established contracts with the providers currently serving clients in their respective systems. Because of the large volume of providers with which the CMO needed to contract, Milwaukee has been transitioning providers into their network and consumers are not restricted access to needed services. Even if the CMO does not yet have a contract in place for a particular service, they are required to offer that service to the enrollee through a certified provider. Milwaukee has thus far contracted with a spectrum of long-term care services, including: home health care, durable and disposable medical equipment, transportation, rehabilitation, and nursing homes. DHFS has been closely monitoring Milwaukee's procurement process to ensure that they have a complete network by December 31, 2000.

Exhibit VII.4. displays the number of providers in each HCBS area that are under contract with the CMO and how that number relates to the total number of providers in the area.

[21] We did not observe any certification for an organization that assesses whether the website is accessible to individuals with disabilities, such as Bobby (www.cast.org/bobby/).

Exhibit VII.4
Absolute and Relative Size of the CMO Provider Networks, by Type of Service and County

Type of Service	Fond du Lac		La Crosse		Milwaukee		Portage	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Adaptive Aids	6	100*	3	100*	2	NT	6	NT
Adult Day Care	0	0	9	100*	28	NT	2	33
Adult Family Home	17	100*	Unspec	NT	28	46	29	NT
Assisted Living Facility	3	30	0	0	0	0	0	NT
Case Management	1	NT	1	5	10	53	1	100
CBRF	25	42	15	88	98	54	16	49
Congregate Meals	0	0	3	33	4	6	1	NT
Daily Living Skills	1	NT	5	100*	15	NT	5	NT
Day Services/Treatment	3	100*	5	71	6	18	4	100*
Employment-Related	4	80	5	26	9	33	6	100*
Guardian / Money Mgmt.	0	0	5	100*	7	19	1	NT
Home Care (medical and supportive)	20	100*	13	62	58	48	18	100*
Home Modification	2	NT	Unspec	NT	0	0	4	NT
Interpreter Services	0	NT	Unspec	NT	0	NT	3	NT
Meal Delivery	1	50	3	25	6	43	2	100
Medical Equipment	5	67	9	82	7	13	13	100*
Mental Health	3	7	15	18	1	2	6	100*
Nursing Facility	12	52	8	100*	11	18	3	100*
Rehabilitation/Therapy	7	18	13	50	0	0	15	NT
Respite Care	1	NT	4	29	0	0	17	NT
Speech & Language Pathology	0	NT	4	50	0	NT	8	NT
Substance Abuse	0	0	2	4	2	10	3	NT
Transportation	2	11	10	83	20	48	9	82

* Denotes that percentage has been capped at 100. The CMO contracted with more providers of a particular type than were listed by the RC.

NT =The resource center did not track providers of this type of service.

As ***Exhibit VII.4*** indicates, the CMO's for Portage and La Crosse have contracted with a full range of providers. They both have contracts with at least one provider (and usually more) in each of the types of service we surveyed, except for assisted living facilities (ALFs). It is possible that certain ALFs are classified under a different residential category, which we will investigate further. The Milwaukee and Fond du Lac CMOs have more limited provider networks (e.g., they each contract with three providers of mental health or substance abuse care, despite larger numbers of these types of providers active in the county).

It is premature to determine the effect of selective contracting by CMOs on access to services because the Network Developers have faced several challenges in building the initial provider networks. These challenges include:

- Low unemployment rates across the state of Wisconsin have resulted in a shortage of workers. This is especially relevant for personal care. Often, potential personal care workers have other employment opportunities that offer more competitive wages. La Crosse has noted that although the number of provider agencies is deemed adequate, staffing shortages within agencies persist. Moreover, cases that are exceptionally difficult or undesirable have proven particularly difficult to staff.

- Counties identified a few services for which consumers have unmet needs, including transportation, short-term case management, and supportive employment for the DD population. Counties reported that they provided more short-term case management than expected which has been very time-intensive. Counties also reported an overall need for more supportive employment services for the DD population. The counties expect growth in the demand for transportation services since the increased outreach and enrollment efforts of the Resource Centers are likely to increase awareness of transportation options, which will increase demand for this service. In addition, increases in demand for other services associated with Family Care may induce demand for transportation to and from those services.

- CMO staff expressed problems among M.A. providers in the notification of consumer Family Care enrollment. Fond du Lac's CMO reported that many M.A. Card providers, particularly those of personal care, medical supplies, and transportation, first learned of the Family Care program when one of their claims was denied or when they checked eligibility at the point or service. The CMOs' efforts to retroactively contract with these providers were described in the quarterly report as time-consuming and frustrating for both parties. To avoid future delays and to ensure that providers' billing information is adjusted appropriately, case managers are proactively sending provider notices when a person enrolls in the CMO. To improve the level of understanding of Family Care among M.A. providers, DHFS has held training, sent invitations to participate in Family Care, sent mailings, and wrote about changes through Provider Updates.

- Counties reported difficulties with service definitions used in association with provider reimbursement. For example, Fond du Lac reported some confusion among staff and transportation providers over the distinction between medical and non-medical transportation for billing providers. They commented that some CMO members were using specialized medical vehicles to go to the drugstore.

Despite these concerns and issues, representatives from the pilot counties reported that they enjoyed the opportunity to work collaboratively in solving network deficiencies and in trying to improve the strength of the provider networks. Counties have been innovative and responsive in their efforts to tackle problems and enhance access. For example, to facilitate the application process for inclusion in the provider network, the Milwaukee CMO is developing a web-based online application.

All counties reported that most providers are being patient with and supportive of the new Family Care program and its concomitant disruptions. The counties all conducted meetings and question-and-answer sessions with providers in order to explain the new program and clear up

questions. The most frequently asked questions from providers concerned reimbursement policies, claims submission procedures, prior authorization, eligibility, and the contracting process. None of the counties reported significant numbers of providers declining to join the CMO networks. However, some CMOs reported reluctance to participate among large national chains, primarily because they are unwilling to change their billing mechanisms to adapt to the needs of the CMO.

VIII. CARE MANAGEMENT

Care management serves a pivotal role in the delivery and financing of long-term care services. Meeting individualized needs while maintaining cost-effectiveness is central to the managed care model of Family Care. Family Care must result in a reorganization of care management if it is to achieve program goals. Care management under Family Care must differ from the previous long-term care system in the following ways:

- **Care Management must control costs.** If CMO spending exceeds the capitated amount, the CMO is at significant financial risk and enrollment might be suspended. Thus, the viability of Family Care relies on the CMO to provide appropriate services and care managers to make care planning decisions in a cost-effective manner. Capitated payments for consumer care require fiscal responsibility in the care planning process and creativity in combining informal and formal resources.

- **Care management must facilitate consumer direction.** Family Care calls for a greater emphasis on consumer-centered care wherein members manage their own services to the degree that they are willing and able. The care management team must be prepared to communicate information about residence and service options to consumers so that they can make informed choices. With the expanded number of options under Family Care, care managers need to be knowledgeable of all existing benefits.

- **Care management must consider acute and primary care needs to a greater degree than in the past.** Medical needs relating to acute and primary care have traditionally been outside the domain of long-term care managers for publicly funded programs in Wisconsin. In recognizing that both the medical and social needs of the consumer should be considered, care managers need to build expertise around medical issues and move towards an interdisciplinary focus that will allow for collaborative planning. Care Managers need to learn about Medicaid Card services that are now covered under the Family Care benefit, as well as Medicaid services outside of the package that they are responsible for coordinating, and they need to keep current with any changes to Title XIX services.

It is premature to determine whether Family Care will transform care management in the pilot counties. At this time, care management efforts are focused on maintaining services for current program recipients who are being enrolled into the CMOs. Once the transitional period is complete, CMOs expect to focus greater resources towards changing care management practices.

The pilot counties have made a commendable effort to maintain the same level of service to current and new clients under Family Care. The pilot counties face the triple challenge of expanding the number of people they are serving, expanding the scope of services they are providing, and adapting to new practices, such as including an RN on each care management team, and adapting to new information systems. During this initial implementation period, care managers had a number of extra burdens placed on their time, such as enrolling current clients in Family Care and learning new information systems and forms. At the same time, they were trying to develop expertise in providing services that were previously financed through the M.A. Card. In addition, many workers were newly hired to meet the demands of Family Care.

The pilot counties appear to be making the most progress in integrating management of medical and social care. Prior to Family Care, the management of long-term care services primarily involved arranging social and personal support services to provide assistance with activities of daily living (ADLs), such as bathing and dressing, and instrumental activities of daily living (IADLs), such as preparing meals and household chores. This model of care management is commonly known as the "social model."

In recognizing that a large portion of the long-term care population also has medical needs, some programs are considering both social and medical needs to better manage care for these individuals. This "chronic care" model emphasizes integrating acute and primary care with more traditional long-term care services to address the full spectrum of individual need. This enables the providers to work together towards the prevention, delay, and reduction of disabling chronic conditions and the improvement of health outcomes. One example of a chronic care program is Minnesota Senior Health Options. The State received waivers that allowed them to combine the purchase of Medicare and Medicaid services into one contract. This enables the integration of primary, acute, and long-term care providers for adults 65 and older eligible for both Medicare and Medicaid by combining Medicare and Medicaid financing and acute and long-term care delivery systems.[22] Family Care moves towards a "chronic care" model by mandating a greater medical component to the program with the goal of resulting in better coordination of care and more appropriate service use. This new emphasis is reflected in the expansion of coverage for many medical services not available in the previous program such as, disposable medical supplies, and the inclusion of a registered nurse as part of the care management team.

Pilot counties are still developing the care management model, particularly the role of RNs. The four pilot CMOs all reported that the mandated addition of a nurse has been very helpful, though the CMOs are still in the process of hiring additional RN capacity and determining the best way of integrating the RNs with the care managers. As the program evolves, it will be advantageous to monitor county experience with CMO staffing to meet the "chronic care" needs of members. ***Exhibit VIII.1*** documents county progress on this issue.

Exhibit VIII.1
Development of the RN in Family Care

	Fond du Lac	La Crosse	Milwaukee	Portage
Approximate RN to CMO member ratio	1:100 – Elderly/PD 1:125/150 –DD	1:120	~1:100	1:100
County RN to member goal	1:100 – Elderly/PD 1:125/150 –DD	1:80	Still developing	Still developing

Fond du Lac and La Crosse have stated goals for RN staffing. Fond du Lac's goal is population-specific. They plan to contract for more nursing staff by the end of the year as they expect to have 600 CMO members and only three nurses on staff. They hope to maintain one RN for every 100 elderly/PD members and one RN for every 125-150 DD members. La Crosse has not been able to meet their goal of having one RN for every 80 members because of the concern about the

[22] Source: http://www.nccconline.org/

retrospective rate calculation which will result in less funds then they anticipated for staffing. This issue is further discussed in *Section XI Capitation* of this report.

Milwaukee and Portage are still developing goals for the number of RNs to members. The Portage CMO believes that the role of the RN is evolving and they are planning a needs assessment based on the functional status of the members enrolled. By the end of 2000, Portage County expects to employ four full-time RNs with a projected CMO membership of 408. The Milwaukee CMO hired four nurses during the second quarter of 2000 and a RN trainer to aid the administration in the development of the nursing model.

As counties assess the role of RNs based on experience, the RN may move beyond involvement in initial assessments and consultation and expand into prevention and wellness planning. With additional RNs on staff in the future, it is expected that they will tend to provide more skilled medical services.

The pilot counties reported trying to lower caseloads, especially for the MR/DD population because care management is believed to be more time intensive under Family Care. The pilot counties that we interviewed indicated that Family Care would provide the opportunity to serve smaller caseloads, which was key to delivering more cost-effective care. The theory behind this decision is that by devoting more time, care managers can find more cost-effective ways of arranging services.

Counties expressed unfamiliarity with more medically related services which led to some confusion about billing procedures. In particular, counties reported difficulty with the management and payment for disposable medical supplies (DMS). The DMS benefit was previously provided via the M.A. Card and is now folded into the Family Care benefit package. The CMOs had to replicate much of the authorization and billing infrastructure that had previously been done by the State. The CMOs have also been negotiating with M.A. Card providers who are used to submitting electronic bills to the State and now must submit paper invoices to the CMOs because of a lack of capacity on the part of the CMO.

Care management efforts to facilitate consumer direction have been stalled as a consequence of pressing administrative issues such as staffing and case conversions. It is thus too early to comment on consumer direction initiatives. It is interesting to note, however, that Portage consumer representatives we interviewed felt that Family Care allows for an expansion of choices and that greater consumer participation in the care planning process will enable consumers to be more aware of the cost of services and spending practices. In contrast, Milwaukee consumer representatives interviewed felt that a managed care approach inherently implies less choice. These conflicting opinions highlight the delicate role care managers must assume as an advocate for consumer-driven care while also acting as the "gatekeeper."

The Resource Allocation Decision Method (RAD) developed by DHFS has been generally well received by the CMO care managers, but it is too early to tell if it will result in more efficient care delivery. Because the care management team is responsible for care provision and its associated cost, the RAD was developed as a tool to guide the team in determining how best to use resources. The RAD serves to identify individual outcomes and derive cost-effective options to meet these outcomes. It provides logic for the care management team to follow when making service decisions. The RAD steps include:

1. Identify the need, goal, or problem;
2. Determine if it relates to the client's assessment, service plan, and desired outcomes;
3. Determine ways in which the need could be met;
4. Verify if there are policy guidelines to guide the choice of option, and if so, following them;
5. Discover which option the member (and/or family) prefer;
6. Determine which option(s) is/are the most effective and cost-effective in meeting the desired outcome(s); and
7. Explain, engage in dialogues, negotiate with the client.

Care managers generally thought the tool would be useful, but had little experience with it in the field. The pilot CMOs reported receiving training on the RAD methodology that was very helpful. As care managers become more familiar with RAD, it will be easier to assess appropriate service use.

IX. CONSUMER DIRECTION AND ADVOCACY

A. Consumer Direction

Consumer direction and advocacy are central in the structural design of FC, but they have yet to be fully implemented. Consumer direction allows clients to take an active role in managing their own care on a number of different levels. It encompasses decision-making, personal choice, self-advocacy, self-determination, and self-expression. It gives consumers control over the selection of services, provider agencies, and individual support providers. The different levels of consumer direction include: the ability to choose care providers; the ability to choose and change care providers, the ability to hire and fire care providers; and cash payments.[23]

A component of consumer direction in Family Care refers to consumer choice, an individual's right to determine the setting for and type of care that they receive. One of the main goals of the Family Care redesign is to expand consumer choice by offering more options and allowing consumers to make informed and independent choices from those options. The pilot counties are required by contract to form committees to address these issues. However, this is in process and few policy changes have been implemented to date. It is therefore too premature to comment on the success of counties' consumer direction initiatives.

The pilot counties report that they have been overwhelmed with administrative issues such as staffing and converting cases and are now starting to concentrate on incorporating the contract requirements for consumer direction in Family Care in their counties. Pilot counties are mandated by contract to address consumer direction in the CMO member handbook. DHFS provided the pilots with technical assistance documents outlining the requirements for CMO member handbooks. The member handbook must include procedures on how to file a complaint, information about the provider network, member rights and responsibilities, and a statement from the county verifying that individuals from the target population participated in the development of the handbook. All pilot member handbooks have been submitted to and approved by DHFS.

Another contract requirement is that pilot counties must address key issues regarding how to allow for consumer direction, while still controlling for costs and ensuring quality. For example, the pilots must develop policies and procedures to allow for informal caregivers to be reimbursed without increasing overall costs and ensuring that appropriate care is received.

County Long Term Care Councils are being formed, but have yet to play a major role in shaping implementation. The councils were intended to serve as a conduit for consumer input independent from the county as required by HCFA. During implementation, these local councils were to enhance consumer direction by ensuring adequate consumer advisory input into the implementation of Family Care in their respective county. Thus far, the councils have largely played a passive role during the implementation. The LTC councils in Fond du Lac and La Crosse have held some initial meetings. The council members in Milwaukee have been appointed and will hold their first meeting in November 2000. Portage plans to have a council formed by December 2000. It appears that the councils have not been active in advising the

[23] Alecxih, L., Lutzky, S., Duffy, J., and Neill, C. (June, 2000). A Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Data. Prepared for the Health Care Financing Administration.

structure of the program in individual counties. It remains to be seen whether the LTC Councils will play a major role in shaping the direction of Family Care in the future.

The pilot counties are devising their initial plans for a self-directed support option under Family Care in an effort to expand consumer direction. Self-directed support (SDS) is a program component in Family Care that helps support self-determination for CMO members. The SDS option is intended to be offered to each enrollee in Family Care and provides a mechanism for enrollees to arrange, manage, and monitor his or her care independently, or with assistance as dictated by the enrollee. Enrollees who choose to participate in this option agree to accept a fixed budget based on the individual's identified long-term care needs. Each CMO must develop a SDS implementation plan that details a strategy and a timeline describing the CMO's plan for implementing all of the SDS contract standards over the next three years. The SDS plans are due to the state at the end of October 2000. Pilot counties have been working on their own best practices to structure the self-directed support option. Both Milwaukee and Fond du Lac have hired an employee specifically to develop the option. The plan includes obtaining consumer input into the process. Fond du Lac has an advocate advisory committee selected to begin development of the option.

Portage County organized a self-directed support option committee comprised of two representatives from each target population and Family Care staff. The committee meets every two weeks and has been devising methods for consumer education around self-direction. They have contracted with Milwaukee Center for Independent Living to act as a fiscal agent. A self-directed support option began in La Crosse prior to Family Care with a Robert Wood Johnson Foundation grant for individuals with developmental disabilities. La Crosse is now expanding the option to all the target groups. The CMO member has the right to choose their own provider and uses a fiscal intermediary and an employment agency to reduce the risk for consumers. Both Portage and La Crosse reported that some CMO members are already using the SDS option.

B. Advocacy

The Family Care legislation mandates that an entity external to the program act as an independent advocate for program recipients. To fulfill this requirement, the Wisconsin Board on Aging and Long Term Care (BOALTC), an advocacy body created by the Wisconsin Legislature in 1982, contracted with the Wisconsin Coalition for Advocacy (WCA) in April 2000. Independent advocacy offers a viable option to the consumer for a non-governmental resource to assist them. The local advocates are to assist consumers in conflicts surrounding benefits and services. There are four main goals of independent advocacy in Family Care:

- Facilitate access to and appropriate use of long-term care services in the Family Care pilot counties through the provision of individual case advocacy services;
- Improve access for potential Family Care enrollees through the provision of information, technical assistance, and training to individuals about how to obtain needed services and support;
- Enhance the capacity of Family Care to foster consumer independence, consumer knowledge and dignity, and to protect consumers through the provision of individual consumer advocacy; and

- Increase the capacity of consumers and family members to be self-advocates within the Family Care system.

The independent advocacy contract provides funds to hire advocacy staff at the local level. The Wisconsin Coalition for Advocacy has been in the process of awarding local contracts for these services in each of the pilot counties. Local advocacy is still early in its implementation. To date, Fond du Lac is the only county with determined roles for the advocacy staff. Local entities are in the process of contacting the RC and CMO in the county to discuss how members should be made aware of their services. Wisconsin Coalition for Advocacy holds the contract in Milwaukee and the county has not received notification of their services yet. The Northern Area Agency on Aging was awarded the contract in Portage County. They hired a full time advocate in October who has not started yet. Options for Independent Living holds the contract in Fond du Lac. A 30-hour per week advocate has been hired to serve the RC and the CMO. In addition to responding to complaints, this person will advocate for consumers in guardianship cases and serve as an additional source of information about Family Care. The advocate may also participate in outreach about Family Care to individuals in institutions. In La Crosse, two contracts were awarded: Age Advantage will advocate for the elderly population and Independent Living Services will serve both disabled populations. Prior to the hiring of staff in the counties, WCA has been responding to telephone requests for advice and information about rights for all consumers in the Family Care system.

X. QUALITY ASSURANCE

Quality assurance and improvement are key components of Family Care. Quality assurance has traditionally focused on process rather than outcomes. As such, providers have traditionally been reimbursed on the basis of service units delivered, not on how well the service was delivered and the recipient's outcome. Essentially, the emphasis in the reimbursement methods has been an exclusive focus on quantity to the exclusion of quality. In Family Care, quality is to be measured in part by assessing how well consumers do with the care they receive and verifying that safety and rights are protected. A multi-level Quality Assurance/Improvement (QA/I) system was designed to ensure effective service quality control that, ultimately, serves to protect individual rights, preferences, and decision-making while promoting maximum quality of life for those individuals. DHFS, CMOs, and RCs all play vital roles in promoting quality assurance.

A. DHFS Responsibility

Exhibit X.1 summarizes the components and the progress of the DHFS plans to monitor quality. Since quality plans are still developing, subsequent reports will provide a more detailed status and analysis of quality efforts.

Exhibit X.1
Progress of DHFS Multi-level Quality Plan

	CMO	CMO Status	RC	RC Status
System Level Review	**CMO certification**	Ongoing – Richland January 1, 2001	**RC certification**	Ongoing
	Annual site reviews	La Crosse – 10/00 Portage – 10/00 Milwaukee – 11/00 Fond du Lac – 11/00	**Annual site reviews**	La Crosse – 10/00 Portage – 10/00 Milwaukee – 11/00 Fond du Lac – 11/00
	CMO performance reporting	Monthly data submissions will occur after one complete year of CMO operation Data from complaints and grievances	**RC performance reporting**	Reported in Monthly Monitoring Reports since March 2000
Member Level	**Family Care outcomes monitoring** [24]	Goal to have 533 interviews completed by February 15, 2000	**No DHFS responsibility** RC responsible for assessing consumer satisfaction	Ongoing
	CMO service plan review	Will begin implementation with the new waiver in January 1, 2001		
Technical Assistance	**A plan developed with the CMO**	*Ongoing*	**A plan developed with the RC**	Ongoing

[24] Measuring outcomes will consist of interviews with CMO recipients. The interview tool is based on the work of the Council on Quality and Leadership in Supports for People with Disabilities and will assess the 14 outcomes of Family Care. DHFS currently is testing the reliability of the tool and plans to begin administering it in November 2000 if the reliability proves sound.

B. Pilot Responsibility

DHFS requires that the RCs and CMOs monitor and review their own quality data at the internal level, while the State is responsible for oversight at the external level. The premise of a multi-level QA/I system with great accountability at the internal level, is that when quality problems are detected and resolved as close to the consumer as possible, problems do not have to escalate and wait to receive attention retrospectively in audits. CMOs are accountable for the quality of care and services consumers receive, and for continually improving the quality of care and services. Each CMO and RC must have a quality plan approved by DHFS. Each pilot has a liaison from DHFS to respond to quality issues and quality is discussed in weekly conference calls between the State and each individual county.

Since counties have been preoccupied with case conversions, training, and other immediate administrative concerns, many of their QA/I efforts have just begun. As such, it is too early to adequately assess their strategies and procedures. Once these systems progress, we will be able to gather perceptions of quality from key stakeholders as well as barriers to quality as identified by the State and pilot staff. Thus far, it appears that enhanced provider communication is key to CMO efforts in controlling quality. Counties reported that because providers have the most direct contact with members, it is important to keep the lines of communication open and develop good working relationships between the CMOs and providers. Counties also expressed that their level of monitoring has increased significantly since they now have to attend to more medical issues.

Below are some of the quality assurance strategies used in the pilot counties monitor quality at the internal level:

- The CMO in Fond du Lac has a quality assurance plan in place but has not begun to implement it to date. The CMO plans to use the results from the DHFS member survey effort to capture outcome measures rather than pursuing its own survey of CMO enrollees. CMO representatives also reported that there appeared to be an inverse relationship between caseload size and the care managers' ability to monitor quality. The smaller the caseload, the more attentive care managers could be to monitoring service provision and use at the individual consumer level.

- The CMO in Portage County mailed surveys to consumers to establish a baseline of consumer satisfaction that will be compared to the DHFS measure of consumer outcomes. The survey analysis has been a formative process to help shape the county's quality assurance efforts. Through the results of the surveys, Portage identified issues of concern and addressed them in three consumer focus groups. Information from the focus groups, one for each target population, has been used to enhance quality improvement efforts. Portage has also initiated a formative process to monitor timelines by performing database queries. Since beginning Family Care, they have tripled the number of service providers and currently are developing standards for specific providers. The county plans to have these standards incorporated into the provider contracts in 2002. County staff indicated that the quality standards for providers will evolve as the program develops.

  An innovative feature of the Portage quality plan includes an advanced IT system that is intended to track individual consumer outcomes from the functional screen through the assessment, and finally to the ISP. Richland county is planning to purchase the system and Human Service Center has also expressed interest. DHFS is providing technical

assistance through site visits and an internal work group comprised of CMO staff, State staff and Richland county staff. This group is currently working on the electronic transfer of data from the RC to the CMO.

- La Crosse County has developed a Quality Assurance workgroup comprised of both consumers and county staff to provide direction on QA/I activities. The county has drafted a QA/ QI timeline which details goals and responsible individuals. A survey for CMO members has been adapted from a current La Crosse Human Services survey and will be administered via telephone. La Crosse plans to communicate expectations to providers regarding data that providers will be expected to track in order to monitor quality.

- The Milwaukee RC developed a QI Committee, which is composed of the QI Coordinator, Resource Center Manager, MCDA Assistant Director for Long Term Support, a member of the DHFS IT staff, I & R representative, Enrollment Coordinator, Access Unit Representative, PAC/Brief Services Representative, Community members and consumers. The CMO applied a thorough quality assurance method using the domains of structure, process, and outcomes in identifying QI indicators. The CMO plans to conduct chart audits in assessing if and how care managers are using the RAD method. In addition, the CMO is planning to distribute ten consumer satisfaction surveys per week to assess service quality. Milwaukee is beginning to incorporate quality standards into the contract process in developing their provider network. They have crosswalked Title XIX codes with HSRS to monitor service authorization and data integrity.

Pilot counties were required to devise their own grievance procedures to responsively address grievances. Since they are currently being written, it is premature to assess compliance issues and their effectiveness. The Interim State Long Term Care Advisory Committee was charged with monitoring the quality of Family Care pilots, including the specific patterns of complaints, grievances and appeals related to Family Care and advising DHFS on these matters. They were also responsible for providing advice as needed to the external evaluator for Family Care.

As discussed in the previous section, *Consumer Direction and Advocacy*, consumers have a channel to independent advocacy via the Wisconsin Coalition for Advocacy and their subcontractors and local advocates. At the state level, the DHFS complaint and grievance system was tested this past June when a provider complaint was filed alleging late payment by a CMO. This was properly investigated and it was found that there was indeed delayed payment due to glitches in the CMO's billing system and the provider's unfamiliarity with the billing procedure in the new system. These problems were resolved and after a further investigation, it was found that the provider's accusation that the CMO was not responding to consumer needs in a timely fashion was unfounded.

XI. CAPITATION

Our assessment of the rate setting methodology is based on a review of the methodology and process by which DHFS sets rates. This review included examination of documents describing rate setting methodology and memorandums from DHFS' primary contractor in this area, Milliman and Robertson. In addition, we interviewed key staff within DHFS and the pilot counties, as well as other key stakeholders.

The methodology and data used for calculating the payment rates for Family Care have evolved over time. ***Exhibit XI.1*** provides a brief accounting of some of the highlights. The rate methodology will continue to evolve and, ultimately, DHFS will incorporate new data from the functional screen and service use date to develop a prospective rate methodology. This evolution and refinement is normal for a new system that lacks extensive data upon which to build rates. DHFS anticipates that prospective payments with retrospective adjustments based on historical use cost bands will be in effect until 2002. At this time, they will have reliable data on functional levels and, therefore, anticipate altering the reimbursement approach such that it is tied to the functional screen.

Currently under Family Care, DHFA bases payments to counties on a capitated rate for those with comprehensive or intermediate level of care needs (see *Exhibit XI.2*). The comprehensive level is associated with the level of care requirements for nursing home care or the home and community-based programs, while the intermediate level is associated with less severe disabilities than the comprehensive level. These rates are specific to the county and made up of the components in ***Exhibit XI.3.*** ***Exhibit XI.4*** outlines the services incorporated into developing the capitated rates, which include both community-based and institutional long-term care services.

The prospective rates provide a basis upon which to provide the CMOs cashflow to serve individuals. They are based upon the distribution (or casemix) of those receiving services in 1998 in each county (see ***Exhibit XI.5***). These rates are adjusted quarterly based on historical costs of those actually enrolled based on the cost bands. Those with sufficient cost history are categorized into the appropriate cost band, while those with no history have a "new eligible" adjustment applied. The "new eligible" adjustment accounts for observed differences in the average payments per eligible per month in the calendar year following first eligibility for COP and HCBW to the average for all eligibles (including new eligibles) in that calendar year by group (elderly versus disabled). In addition to the adjustment, the acuity increase in the trend factor is excluded from the calculation. DHFS explains the removal of the acuity factor in order to prevent over-adjusting for increases in acuity reflective of a "veteran" population. DHFS actuaries explain the appropriateness of excluding the acuity increase based on: 1) one year of acuity already incorporated into the application of an adjustment based on the first full calendar year of eligibility to the first partial year of eligibility, and 2) including new eligibles in the denominator causes the factor to be greater than if the calculation were relative to only those with sufficient cost history.

Exhibit XI.1
Wisconsin Family Care Capitated Rate Setting History Highlights

June 1999	November 1999	December 1999	March 2000	July 2000
• Preliminary rates and methodology document • Base year 1997 • Trend factor based on FC Cost Model • Could not provide acuity factor nor new eligible factor due to data availability	• Updated rates and methodology document • Base year 1998 • CSDRB, TCM & CSP funding added • Trend factor (increased and based on 1995-98 MMIS/HSRS data) • Acuity factor provided • Lag adjustment factor (added) • Reduced manage care discount from 5% to 2% • New eligible and semi-new eligible factor provided	• Dropped semi-new eligible adjustment	• Updated new eligible factor	• Trend rates increased to reflect higher Medicaid payment rates for personal care services.

CSDRB = Community Services Deficit Reduction Benefits
TCM = Targeted case management
CSP = Community support program

Exhibit XI.2
2000 County Family Care Prospective Per Member Per Month Capitated Rates

	Intermediate	Comprehensive
	Historical costs for individuals with MA card only services	Historical costs for those with HCBW services
Fond du Lac	$323	$1,839
Lacrosse	$624	$1,885
Milwaukee	$311	$1,790
Portage	$404	$2,657
Richland	$389	$1,954
Entire State	$379	$2,357

Source: Family Care Rate Setting Team, "Family Care CMO Demonstration Final Fee-for-Service Equivalent Calculations and Prospective Capitation Rates for FY2000," November 8, 1999 and Tom Lawless e-mail, 10/30/00.

Exhibit XI.3
Components of the Family Care Capitated Rates

Component	Description
Prospective Base Rates	
1998 per member per month MA and COP-R	*See Exhibit XI.5* Based on Statewide data for cost bands and includes all FC covered services
County-specific weights based on historical	*See Exhibit XI.5* Based on county-specific distribution of individuals in each cost band in 1998
Community Aids Add-on	*$6 per member per month* Added for comprehensive level of care to account for the historical expenditures for this program for COP/COP-W recipients
Prospective Base Rate Calculation	*Weighted average for detailed cost bands + community aids add-on*
Adjustments to Base Rates	
HSRS Administrative Adjustment	*7.0 percent* Added to account for allowable administrative charges counties received through the COP and HCBW programs not captured in the HSRS data
Lag Factor	*0.4 percent* Added to account for MA card lag between service delivery and billing (providers have up to one year to file a claim, therefore this factor will not be necessary in the retrospective adjustment)
Community Services Deficit Reduction Benefits (CSDRB) Adjustment	*$5.37 to $350.34* • County-specific additions to incorporate federal matching funds claimed by local government authorities to reimburse deficits for certain Medicaid services and "county match" services of targeted case management and community support program • Subject to retrospective adjustment based on actual Family care enrollees
Targeted case management and community support program data adjustments	
Two Year Tend Factor To adjust 1998 data to 2000 Acuity factor Non-acuity trend factors Combined Milwaukee	Based on 1995-98 MMIS/HSRS data Comprehensive / Intermediate 10.9% 14.7% 25.0% / 2.0% 31.6% / 4.2% Milwaukee is higher because only the elderly acuity factor is used (17.1% vs. 10.9%)
General Administrative Adjustment	*2.0%* Added to account for additional administrative activities (claims processing, prior authorization, and quality assurance) now borne by the counties
Managed Care Discount	*-2.0%* Subtracted to obtain expected/desired savings; based on a DHFS policy decision

Exhibit XI.3 (continued)
Components of the Family Care Capitated Rates

Component	Description
Retrospective Adjustments	
New Eligible Factor	*Elderly 1.0 also less acuity trend factor* *Disabled 0.7 also less acuity trend factor* • For individuals with cost histories enrolled in Family Care less than 6 months • Prospective rate is re-calculated without acuity factor
Retrospective Adjustments	• Quarterly review based on the actual distribution of individuals by cost-band and the use of CSDRB and targeted case management/community support program for actual Family Care enrollees • Insufficient/excess funds are to be returned to the CMO State at the end of the year • Counties that enroll a disproportionate share of high cost cases relative to the expectation based on the 1998 data can receive a quarterly lump-sum adjustment to avoid fiscal crises
Prospective Rate Changes	At the midpoint of first contract year, DHFS determines whether retrospective adjustment exceeds ±20% and if so replaces the actual CMO casemix based on the first two quarters in order to reduce lump sum settlements during the second half of the contract year

Exhibit XI.4
Services Included in Family Care Capitated Payment Rate

Medicaid State Plan Services	Medicaid and GPR-Only HCBW Services
Nursing Facilities	Adaptive Equipment
MR Facilities – Centers	Adult Day Care
MR Facilities	Case Management
Therapies	Habilitation
Disposable Medical Supplies	Home Care Residential Care
Durable Medical Equipment	Respite Care
Home Care – Personal Care	Q Skilled Nursing
Home Care – Skilled Services	Transportation
Transportation	COP Assessment/Plan
Mental Health/AODA	Non-MA COP Other
Community Support Services	Family Support Program
Targeted Case Management	
Psych Hospital Outpatient	
Other LTC Services	

Exhibit XI. 5
Per Member Per Month Amounts and Distribution of 1998 Recipients for Cost Bands for Family Care Capitated Rates

COMPREHENSIVE POPULATION

		Statewide Average[25]	County Distributions of Recipients in 1998				
	Historical Cost Band (Average Monthly Cost)	Per Member Per Month Payments	Fond du Lac	Lacrosse	Milwaukee	Portage	Richland
1	$ 100 - 600	$ 350-422.43	41.23%	40.73%	33.40%	32.70%	49.15%
2	$ 600 - 1,200	$ 877.94	17.94%	19.19%	23.22%	19.82%	19.95%
3	$ 1,200 - 1,800	$ 1,532.31	15.77%	12.85%	15.27%	9.91%	8.37%
4	$ 1,800 - 2,400	$ 2,114.44	9.28%	10.45%	12.69%	12.80%	9.65%
5	$ 2,400 - 3,000	$ 2.645.92	4.02%	5.31%	7.91%	4.95%	3.86%
6	$ 3,000 - 3,600	$ 3,240.15	4.64%	4.11%	3.72%	4.95%	1.29%
7	$ 3,600 - 4,200	$ 3,885.59	2.17%	2.57%	1.99%	1.65%	1.93%
8	$ 4,200 - 4,800	$ 4,472.99	0.93%	1.37%	0.76%	1.65%	0.64%
9	$ 4,800 - 5,400	$ 5,068.78	1.24%	0.86%	0.47%	2.89%	1.93%
10	$ 5,400 - 6,000	$ 5,685.83	0.62%	0.86%	0.25%	1.65%	0.64%
11	$ 6,000 - 6,600	$ 6,303.14	0.62%	0.17%	0.21%	2.48%	0.64%
12	$ 6,600 - 7,200	$ 6,911.80	0.62%	0.51%	0.00%	0.83%	0.00%
13	$ 7,200 - 7,800	$ 7,498.04	0.00%	0.51%	0.00%	0.83%	0.64%
14	$ 7,800 - 8,400	$ 8,113.12	0.62%	0.00%	0.00%	0.41%	0.64%
15	$ 8,400 - 9,000	$ 8,716.75	0.00%	0.17%	0.04%	1.65%	0.64%
16	$ 9,000 - 9,600	$ 9,317.94	0.00%	0.17%	0.00%	0.00%	0.00%
17	$ 9,600 - 10,200	$ 9,884.52	0.00%	0.17%	0.04%	0.00%	0.00%
18	$ 10,200 - 10,800	$ 10,429.13	0.00%	0.00%	0.00%	0.83%	0.00%
19	$ 10,800 - 11,400	$ 10,972.43	0.00%	0.00%	0.00%	0.00%	0.00%
20	$ 11,400 +	$ 16,494.80	0.31%	0.00%	0.04%	0.00%	0.00%

[25] Based on statewide average with the exception of the $100-600; cost band. This band is based on county specific.

Exhibit XI.5 (continued)
Per Member Per Month Amounts and Distribution of 1998 Recipients for Cost Bands for Family Care Capitated Rates

INTERMEDIATE POPULATION

		Statewide Average	County Distributions of Recipients in 1998				
	Historical Cost Band (Average Monthly Cost)	Per Member Per Month Payments	Fond du Lac	Lacrosse	Milwaukee	Portage	Richland
1	$ 100 - 150	$ 122.94	19.6%	27.8%	22.7%	17.8%	35.5%
2	$ 150 - 200	$ 173.86	14.6%	15.1%	15.5%	20.5%	16.1%
3	$ 200 - 250	$ 223.83	10.1%	13.9%	10.8%	13.7%	22.6%
4	$ 250 - 300	$ 274.73	14.6%	10.4%	8.4%	15.1%	6.5%
5	$ 300 - 350	$ 322.42	11.4%	5.0%	8.0%	9.6%	9.7%
6	$ 350 - 400	$ 374.35	10.8%	5.8%	9.2%	6.8%	3.2%
7	$ 400 - 450	$ 424.24	5.1%	10.4%	7.6%	5.5%	3.2%
8	$ 450 - 500	$ 474.17	2.5%	4.2%	4.7%	0.0%	3.2%
9	$ 500 - 550	$ 524.81	4.4%	5.0%	6.4%	5.5%	0.0%
10	$ 550 - 600	$ 574.97	7.0%	2.3%	6.7%	5.5%	0.0%
11	$ 600 +	-	-	-	-	-	-

Fair reimbursement rates and management of the capitation rates by the pilots are essential for quality service provision in Family Care. Counties must be able to offer adequate reimbursement to providers in order to maintain a provider network capable of delivering quality services to consumers. If the capitation rate does not accurately reflect the costs of providing service then the county must either reduce services or fund services with county dollars.

DHFS sought input from the pilot counties while developing the rate setting methodology. The State involved the pilot counties in the development of the rate setting process to the extent possible through education and feedback. In the early stages of the planning of Family Care, the state educated the pilot counties generally about other managed care programs (i.e. Wisconsin Partnership program). Counties were not part of the rate setting group, although the State considered feedback from the pilots. After the first cut of the methodology and with each subsequent change, the State went to counties to collect comments. As a result of county feedback, they made adjustments in the areas of claims and targeted case management, and payment structure for new eligibles.

DHFS appears to have made substantial efforts to set rates in a fair manner and to involve the pilot counties as partners in that process. Unlike more traditional Medicaid managed care models, this process was reliant on full participation from the CMOs and other major stakeholders. Counties were required to sign-off on each pre-implementation stage and were given the opportunity to opt out if there was sufficient concern about either the development of the rate structure or the final prospective capitation rates.

> *...a fundamental ideological component of Family Care has always been to work with the CMOs (and other major stakeholders) as full partners. To have fully developed a rate structure prior to the selection of the participating counties would have completely undermined this value. This process was consciously different from a more traditional Medicaid managed care model, where rates may be set internally, "revealed" to a set of HMOs, and the HMOs are allowed to make their own market-based decision regarding entry*.[26]

Still, because much is at stake, rate setting is a difficult process. County representatives reported difficulty understanding the rate setting process and were unsure whether the rates they were receiving were adequate to cover the costs of the program. DHFS presented counties with a draft methodology and preliminary rates for comment. Counties pointed out several costs that were not captured in the rates and DHFS subsequently issued rates that were substantially higher.

In retrospect, the process might have been smoother if DHFS had submitted a draft methodology for comment without revealing the corresponding rates. Because of competing interests, the counties may have been reluctant to believe that DHFS was doing its best to set fair and accurate rates. The initial rates appeared to have heightened tensions, while the

[26] Communication sent from DHFS to The Lewin Group on August 11, 2000.

subsequent changes may have put the counties in a position where they feel that they can and must bargain to get the best rates they can. Ultimately, though, regardless of the details of the methodology, the final payment levels will determine whether the counties accept the payment calculations.

The four pilot counties we visited in March expressed concerns about the adequacy of the rates. The counties had to obtain approval from the county board in order to become a Family Care pilot and had to present an argument that the rates would be adequate. The counties were all successful obtaining board approval, but they still voiced concern. The counties continue to engage DHFS in discussions about improvements to the current rate methodology.

The comprehensive capitation rates appear generous in comparison to the national average spending for programs serving the aged/disabled and MR/DD populations. The statewide comprehensive capitation rate is nearly $28,000 for 2000. The Lewin Group estimates that in 1997, the national average annual Medicaid spending for HCBS waiver services to those in aged/disabled or MR/DD waivers was approximately $14,300. Using DHFS preliminary rate calculations using 1997 data coupled with the final adjustment factors with the exception of the actuarial trend, acuity, and CSDRB adjustments, The Lewin Group estimates that the comparable Family Care rate for 1997 would have been approximately $19,200. We would expect the Family Care rate to be somewhat higher because it includes MA card services. Other possible reasons for the higher Wisconsin rate include: differences in casemix between the entire U.S. and Wisconsin, differences in services available under the program, and geographic cost differences.

Setting capitated rates is an important, but difficult process. How well DHFS sets capitation rates is likely to be one of the key factors in determining the success of Family Care. If rates are set too high, costs for the program will be more expensive than anticipated. In addition, higher rates will reduce incentives for CMOs to manage care efficiently. Rates that are set too low will either result in unmet need among recipients or counties being forced to make significant contributions of their own funds. This could adversely affect the quality of service provision and have unintended consequences on the overall quality of Family Care. It is important to keep in mind that the rate methodology discussed here continues to evolve.

Other states and the Federal government have struggled to set rates for acute care costs with varying degrees of success. For example, the Health Care Financing Administration's rates for Medicare+Choice plans resulted in early overpayments, which, in turn, led to adjustments made as part of the Balanced Budget Act of 1997. Subsequently, a large number of plans have withdrawn, although it is not clear whether these withdrawals are the results of changes in payment levels or other factors related to this business decision.

Setting rates for long-term care may be more difficult because there is no agreed upon model for setting these rates. Wisconsin, like other states grappling with this issue, decided to base capitation rates on historical fee-for-service long-term care payments. This is the standard method used for Medicaid acute care programs. An alternative method to using previous fee-for-service spending would have been to calculate a needs-based amount. However, likely differences between what DHFS perceives as need and what the counties perceive as need would have made developing rates based on this method problematic. In addition, under a needs-based approach, demonstrating compliance with HCFA upper payment limits could prove difficult.

In Wisconsin, the rate setting process was complicated by the county-based long-term care system consisting of multiple programs that are funded by several different funding streams. The State currently has an extensive reporting system in place for collecting complete and comparable data from the counties (the Human Service Reporting System, or HSRS), with exhaustive guidelines to ensure accurate reporting. However, both DHFS and county representatives concede that reporting varies across counties and counties often contribute significant funds that may not be captured under HSRS. Thus, while HSRS data combined with other data on services covered under the Medical Assistance (M.A.) Card accurately reflect State funds spent on long-term care, the total public long-term care spending may be underestimated. Resolving the discrepancy between these two estimates in each of the pilot counties according to DHFS and county officials was one of the most difficult tasks accomplished during the rate setting process. The State also chose to include an adjustment to account for differences in the costs for individuals who had not previously been using publicly funded long-term care services (new entrants). In setting acute care capitated rates, this adjustment is usually included to allow for higher payments during the period after initial enrollment to account for higher observed use of services as a result of pent-up demand. In its calculation of a new entrant rate for long-term care services, the data indicated less use among new entrants relative to all enrollees. Retaining this adjustment will likely be questioned by the counties as their retrospective rate calculations for new entrants will require them to return funding to the state. We discuss the new entrant adjustment more fully in a subsequent point.

Overall, based on our discussions with both county and State officials and our review of documents, it appears that DHFS made a thorough attempt to set fair rates. This is evidenced by their:

- An apparent commitment to creating fair and adequate rates given the constraint that the average per person cost must be reduced from its current level.
- Extensive consultation with and approval by the counties at different steps in the process even though interactions sometimes may have been contentious; and

- Extensive work by qualified staff and consulting actuaries performing appropriate analyses.

Although previous fee-for-service spending was probably the best available starting point for setting rates, it is important to note that FFS HCBS spending was limited by:

1) State established rates for services funded under Medicaid that providers must accept;

2) Globally capitated county budgets for several services, including waivers; and

3) Limited types of services for individuals not on a waiver (MA card only recipients) which may have limited demand.

Requirements that providers accepting the Medicaid rate from the State must accept the Medicaid rate from the CMOs may help alleviate constraints caused by the first limitation. However, the net effect of the other two factors is that Wisconsin's HCBS per recipient costs on which the Family Care rates are based are most likely lower than what they would be if those constraints had not been in place. It is important to note that counties have the option to pay the state portion of the Medicaid match to obtain federal funding to expand services, however, this could be over and above funds they historically paid.

Family Care rates may solidify inequalities among the counties. Differences in Family Care capitation rates across counties reflect differences in historical fee-for-service spending per recipient. These differences reflect causal factors that should be reflected in the rates, such as differences in the need for service (casemix) and the cost of delivering long-term care services in the county. For example, counties that have made significant efforts to deinstitutionalize individuals with developmental disabilities will receive higher capitation rates that reflect the higher costs of this population. However, these differences also may reflect factors more extraneous to need or cost, such as the following:

- Counties that decided to use program dollars allocated to them to provide more services to fewer numbers of individuals fare better.

- Counties that contributed greater amounts of their own funds are rewarded by the capitation rates. Under the rate setting methodology, the State supplants several sources of county funding, including Targeted Case Management and Community Support Program adjustments to the capitation rate, as well as the Community Services Deficit Reduction Benefit (CSDRB) program adjustment. Thus, counties that were historically more generous will likely receive higher capitation rates.

- Counties that were better able to exploit M.A. Card funds have higher rates under Family Care. Counties could make greater use of M.A. Card services by either having more providers willing to accept Personal Care dollars or being more aggressive in accessing them.

We note that time and data availability constraints probably ruled out conducting analyses to try to identify which factors were causing differences in the rates. As data from the functional screen become available, DHFS will have a greater ability to conduct these analyses. We recommend that they be considered as the rate methodology is revised in the future.

The adjustment for individuals without a spending history may not accurately reflect the experience of individuals who enter Family Care. Because DHFS is basing capitated payments on the retrospective payment on historical costs for enrollees, it had to develop a mechanism for calculating payments for individuals who had not received Medicaid funded long-term care services in the past. DHFS developed an adjustment factor for CMO enrollees with no prior rate history based on HSRS/MSIS data that showed that "new entrants" have lower costs than individuals who had been on the program.[27] The factor is neutral for the elderly population and represents a 30 percent reduction for the newly eligible disabled population. Both populations of new eligible do not receive the acuity factor to account for changes in severity among the enrolled population between 1998 and 2000.

One concern with the new eligible factor is that these observed differences in expenditures may reflect characteristics of the existing system rather than differences in need. For example, individuals newly in need of long-term care may have been more likely to have received solely M.A. card services because of existing waiting lists for waiver services. Under the increased flexibility of Family Care, these new entrants may have very different spending patterns. DHFS proposed, and the counties rejected, an adjustment factor based on whether a new eligible had received MA card only services. Once the counties have some experience with the retrospective new eligible adjustment, they may wish to reconsider the inclusion of a MA card only service adjustment.

In addition, due to current data limitations, DHFS can not distinguish between groups among the under age 65 population with disabilities. Waiver spending for the population with MR/DD is much higher than that for the aged/disabled population. The Lewin Group estimates that in 1998, the average annual Medicaid HCBS spending nationwide on the aged/disabled was less than $6,000 per recipient.[28] In contrast, the average annual per recipient Medicaid HCBS spending for individuals with MR/DD nationwide in 1997 was approximately $29,000. However, among states serving the vast majority of this population in the community, the average annual cost was actually much closer to $35,000 to $40,000.[29] One concern would be if the observed lower spending for new eligibles among the under 65 population is the result of new eligibles under age 65 being more likely to be those with physical disabilities with a different spending pattern relative to a high cost existing and stable MR/DD population, rather than as a result of similar populations that have lower spending patterns as a result of less intense needs when services are first provided. If the mix of new eligibles among the disabled population under Family Care changes (i.e., more new eligibles are higher cost participants with MR/DD rather than the lower cost physically disabled captured in the historical data), the new eligible factor could overadjust downward.

If DHFS chooses to keep the new entrant adjustment factor, it should consider revisiting the methodology. In particular, DHFS may wish to conduct further analyses on the new entrants in need of long- care to determine if they can isolate the cause of the lower spending. Also, to the

[27] Paper sent to Lewin on August 17, 2000 entitled, "New" Medicaid Eligibles and Long-Term Care Costs.

[28] The Lewin Group analyses of HCFA form 372 which contains expenditure and recipient data for each waiver program and data on the Personal Care Option collected by Charlene Harrington at UCSF.

[29] The Lewin Group analyses of HCFA form 372 data.

extent possible distinctions between the MR/DD and under age 65 individuals with disabilities should be examined; possibly making the distinction between population based on the waiver they are enrolled in and the receipt of ICF-MR services.

An alternative to using an adjustment factor would be to base costs on individuals within the county that are comparable on a few selected variables, such as level of impairment and informal support. These data are currently not available, but as the functional screen data from FC become available, this method may be consistent with DHFS' stated desire to adopt a need based rate methodology that utilizes information from the functional screen.

The methodology for the intermediate rate will have to be refined, as more data become available. Because of data limitations that precluded the identification of individuals meeting the intermediate eligibility criteria in the historical data files, the prospective intermediate rate may differ from the historical costs of individuals enrolled in Family Care falling into the intermediate rate more than for the comprehensive rate. However, the retrospective adjustment should minimize the impact on the counties and as more data becomes available, DHFS should be able to refine the prospective rate. Nevertheless, if the prospective intermediate rate is substantially lower or higher than the ultimate retrospective rate, the projected budget for the program will be affected.

Out of necessity, several other adjustments incorporate assumptions that create a small amount of uncertainty for the pilot counties, however, the methodologies used appear to be sound and the impact on rates is likely to be minimal. These adjustments include an acuity adjustment, long-term care inflation adjustment and lag adjustment (used to account for claims that were filed late). It is important to note that the lag factor will not be applied in the retrospective rate calculation, which is the ultimate capitation rate received by the CMOs, because all of the 1998 claims will be available when retrospective rates are calculated.

Serious questions remain regarding whether capitation can work in small counties. Theoretically, manage care organizations require a large enough pool of enrollees across which to spread the risk of high cost cases. Relatively small risk pools may create problems for some counties, especially if these pools are further divided up by competition. However, the need for larger risk pools creates conflicts with the State's historic commitment to local control over service delivery.

Small counties may have difficulty investing in the infrastructure to manage risk and may be overly burdened if costs increase dramatically for one or two cases. Representatives of small counties interviewed raised concerns over the feasibility of Family Care in small counties and said they would be watching the experience of Richland County, the smallest and most rural of the pilot counties. Richland is scheduled to implement its CMO in early 2001. If the current structure of Family Care does not appear to be feasible for small counties, either DHFS can adapt its capitation methodology for small counties or risk must be pooled across counties. The capitation methodology can be adapted through a number of mechanisms, such as allowing high cost cases to be fee-for-service or having the state assume a greater portion of the risk. Pooling risk across counties may be resisted by some counties that are not willing to cede control over the provision of long-term care to another county or other entity.

Despite goals to serve as many individuals as possible in the community, counties will have strong disincentives to serve individuals in the community if it would be cheaper to serve them in an institution. The capitated rates may prohibit individuals with high needs and few informal supports from being served in the community, rather than an institution, because counties must absorb the difference between the capitation amount and the true cost of serving these clients in the community. Despite Family Care's goals to save individuals in the community, it may be more cost effective to serve them in the institutions.

Under Family Care, the pilot counties will have to make difficult cost control decisions and not rely on constraints within the system. CMOs will need to effectively manage the care of their clients and truly plan around the need for services, rather than the demand for services. If the counties do not establish mechanisms for controlling costs, Family Care may induce more per recipient demand for services because it could provide greater access to more desirable services. This could be particularly problematic for CMO enrollees that were previously only receiving the more limited M.A. card services.

DHFS will need to follow through on plans it has discussed for refining the rate setting methodology. We recommend that the following actions should be priorities:

- Review the adequacy of rates carefully considering outcomes from the survey of care recipients and contributions made by counties. DHFS is already planning on doing this.
- Explore the use of more complex risk adjusters, especially those that are based on functional impairment, chronic conditions and disruptive behaviors. DHFS also plans to pursue these analyses.
- Explore limited liability arrangements, especially for smaller counties. DHFS has had some risk sharing mechanisms in place, however, these mechanisms may be insufficient for smaller counties. In the future, the State may face a choice of either assuming a greater portion of the risk or implementing regionally based, rather than county based CMOs, which would limit local control of long-term care in smaller counties.
- Possibly re-examine provisions for allowing CMOs to serve some individuals on a fee-for-service basis. DHFS explored the possibility of offering individual stop-loss to the CMOs, but the pilot counties rejected this approach.
- Create a consortium effort among counties to hire a fair and independent actuary to review and comment on rates and rate setting process. DHFS representatives said they had previously provided funds for this effort and were planning on doing so in the future.

We caution that early comparisons of the cost of providing services in comparison to the capitated payments may not be an accurate reflection on the adequacy of rates. Currently, the pilot counties are focusing on implementing key infrastructure and are trying to maintain service delivery to the existing care population. A major concern for them at this time is trying to prevent disruptions in service while individuals are being transitioned to Family Care. The counties will be designing changes in service delivery patterns in the near future. The true test of whether the capitation rates are sufficient to ensure positive outcomes can only occur once counties have had the time to implement these changes.

XII. CONCLUSIONS AND RECOMMENDATIONS

The pilot counties appear to have made great progress in implementing the necessary infrastructure. The implementation schedule itself was ambitious given all the details the State and the counties had to resolve. Early in the process, there were several important issues that arose around fundamental program components, including capitated payments, the separation of the CMO and RC, IT system and reporting requirements, and staffing structures. Pilots have targeted most of their resources toward resolving these issues and establishing program infrastructure.

Delays in finalizing some of the key aspects of program infrastructure complicated the implementation process. Issues about governance and capitated rates caused the pilots to be tentative about implementing parts of the program. This may have led to some pilots preparing less aggressively for implementation than they would have done otherwise. Uncertainty around governance issues caused some of the pilots to delay the development of separate infrastructures for the RC and CMO. Concerns regarding the adequacy of capitated rates caused some counties to delay presenting plans to their boards for approval until the rate setting process was further along.

The focus on administration and converting current enrollment delayed other aspects of Family Care implementation. Overall, counties focused on administrative concerns and maintaining service levels for current waiver consumers, as well as reducing program waiting lists. The transitioning process has been time-intensive and has not allowed pilots to aggressively enroll new clients and fully implement quality assurance and consumer direction initiatives. In addition, the integration of medical and social care, including RN participation in the care management team, appears to require learning new skill sets and increased interdisciplinary collaboration. Contracting with M.A. Card providers, especially for disposable medical supplies, appears to have been more difficult than originally anticipated.

Once the pilots have made more progress in addressing the early implementation issues, they will need to focus their attention on addressing other goals of Family Care. For Family Care to achieve all of its goals, the pilots need to build on the progress they have made and work to transform how care is delivered. The priority for the CMOs should be to transform care management so that it is consistent with the managed care incentives enveloped in Family Care. Ultimately, the success or failure of Family Care will depend on how well care managers function with a greater scope of responsibility and use the increased flexibility they have under Family Care to provide more cost-effective care. The CMOs can support their care managers by ensuring that caseloads are low enough to allow sufficient time for care plan redesign and by developing guidelines for best practices. The RAD methodology appears to be a good first step in this transformation.

The pilots will next have to work to meet the goals of facilitating consumer direction and improving quality assurance. It is important to note that the pilots currently do not have a strong financial incentive to achieve these goals. The effort could be viewed as something that requires adding costs and takes away resources that could be devoted to improving cost-effectiveness. The monitoring of plans by DHFS should provide sufficient information to assess how much progress the pilots are making.

DHFS will need to make significant progress on resolving key issues and refining regulations. DHFS has been making a substantial effort in trying to resolve the governance issues with HCFA and already has identified specific options that counties could apply and that HCFA would likely approve. DHFS will need to continue working with the counties to refine regulations, especially in areas such as PAC requirements for hospitals, requirements for LTC councils, and timelines for completing functional screens and assessments. DHFS should monitor the adequacy of the capitation rates and revisit the rate setting mechanisms. In particular, DHFS should explore techniques of limiting risk and allowing entities serving smaller pools to be viable within Family Care. As suggested by one of the pilot counties, DHFS may want to explore having a centralized system for Information and Assistance.

DHFS should use the experiences of the pilot counties to develop models or templates that other counties can adapt for key components of Family Care. The pilot counties have made considerable investments in key aspects of program infrastructure, which could assist other counties trying to replicate the program. DHFS should play the role of cross-pollinator by identifying models and approaches developed by pilot counties that work well and transferring this knowledge to other counties. Potential areas identified by the pilots as being ripe for model development include IT systems, member handbooks and provider claims. In June 2000, DHFS applied for a grant through the Robert Wood Johnson Foundation to develop the Wisconsin Family Care Center for Excellence to function as a "best practice institute."[30] The center would be responsible for providing technical assistance to CMOs and would provide assistance to other counties as Family Care expands. The Foundation conducted a site visit in Wisconsin in September and it seemed likely that they would award the Center the grant pending some requirements on the part of DHFS.

Whether Family Care can work in small counties remains an open question and should be monitored carefully. Because Family Care requires pooling risk and investing in managed care infrastructure (most notably IT, fiscal, and contracting staff), we have serious concerns about the feasibility of the current Family Care model in small counties. Since half of the counties in Wisconsin have demographics similar to Richland County, the experience of this county should be monitored closely to determine whether and how the program should be modified.

If the current model is not feasible in small counties, the Family Care model could be adapted by either: (1) transferring some of the risk from the counties to the State and further subsidizing the development of infrastructure or (2) creating arrangements for counties to combine their CMOs, such as Family Care Districts. The first option would reduce the State's ability to control costs because they would absorb more risk and the counties would have less incentive to control cost. The second option would transfer some or all of the authority for the delivery of long-term care services away from some counties. This may be seen as a threat to the traditional county-based system.

Opening CMO contracts to competition will most likely necessitate changes to the current county-based long-term care systems. If Family Care is implemented under a concurrent 1915 (b) and (c) waiver, the State will have to award CMO contracts through a competitive bidding

[30] Term used by DHFS in grant application narrative

process, most likely with multiple awardees. These new awardees will likely operate in multiple counties and could reduce the number of clients that individual county-based CMOs serve. This may be particularly problematic for small counties, because they will not be able to exploit economies of scale to reduce costs and improve services. In the future, some counties may find it necessary to collaborate to reduce administrative costs if they face shrinking numbers of clients. This will be compounded if private sector competitors are able to identify ways to enroll more profitable clients ("creaming"). DHFS and the counties will need to factor in private sector response to the refinement of capitated rates and alterations of the structure of the program.

XIII. ISSUES TO BE FOLLOWED IN THE FUTURE

As we continue to monitor the implementation process of Family Care, in addition to providing updates on the overall process, we plan to follow several key issues that have emerged during the initial period of implementation. An ongoing issue that has stymied the implementation process is the lack of resolution around governance. We will follow how separation issues are resolved and what option each county chooses to pursue. In particular, we will track and document county motivations and approaches for adapting particular organizational structures and whether the counties submit separation plans as intended.

Once governance concerns are resolved, it is expected that counties will be able to make more progress in implementing main components of Family Care. We plan to follow the pilot counties' experiences and assess best practices associated with:

- Quality Assurance planning and strategies to monitor and promote quality;
- Strategies to foster consumer direction, including care manager facilitation of consumer direction and how pilots incorporate the self-directed support option and what challenges they face in the process;
- Transformation of the care management model, including the role of nurses as team members, the care manager experience in using the RAD, the training process for care management staff around the medical component of Family Care, and how active the consumers and families are in the care planning process;
- Development of staffing structures at both the RC and CMO and the processes of information-sharing;
- Enrollment patterns for all target populations as CMOs begin to enroll more consumers new to the system as well as following county efforts to reduce duplication in the enrollment process;
- Investment in IT systems and the capacity of these systems in relation to the reporting, monitoring, and information sharing requirements under Family Care;
- Evolution of the provider networks and the ability of the networks to meet consumers' needs;
- Provider adaptation to the Family Care requirements such as, authorization and claims procedures.

As the process for outreach, enrollment, access and provider networking begin to mature, it will be important to follow emerging sub-population differences. In addition, we will seek to capture stakeholder perceptions on how the implementation is proceeding, including the following:

- Consumers perception of Family Care as offering choice and flexibility of service;
- RC and CMO staff perception of the new reporting, information sharing and hand-off processes;

- Provider perception of RC and CMO accessibility and level of understanding of Family Care requirements; and
- DHFS perception of county compliance.

Lastly, we plan to follow the DHFS efforts in resolving key issues that surfaced during the past phase of implementation, including:

- County requests for additional RC funding;
- The need to refine regulations such as, the PAC referral process and timelines for completing functional screens and assessments; and
- Monitoring the adequacy of the capitation rates.

APPENDIX A

Acronyms and Glossary of Terms

ACRONYMS DEFINITIONS

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.**[31]

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.

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 83rules. [32]

CIP **Community Integration Program:**

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

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

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

- 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.[33]

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.[34]

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.[35]

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

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

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.
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.
Direct Services	**Direct Services:** Services provided directly to people by agency staff rather than purchased by the agency from an outside provider.
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.[36]
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).
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

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

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

	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).
Indirect Services	**Indirect Services:** Services to people provided by DHFS through various public and private agencies under aid formulas purchase agreements or contracts.
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.[37]

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

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.[38]
Nursing Home	**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).
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.
Personal Care	**Personal Care Services:** Refers to assistance with activities of daily living s such as eating, dressing, bathing and walking.

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

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.
QA/QI	**Quality Assurance/Quality Improvement**
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). 39
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.
Selective Contracting	**Selective Contracting:** The process by which CMOs will begin to include quality requirements as part of the contracts process with providers.
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.

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

Supportive Home Care	**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.
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.

APPENDIX B

Site Visits and Interview Participants

Table of Content

APPENDIX B

I. COUNTIES FULLY IMPLEMENTING FAMILY CARE

Fond du Lac

a. County Staff

Maggie McCullough	CMO Project Manager
Sandy Tryon	Resource Center, I & A
Amy Lacasse	Social Worker
Mary Koplitz	Social Worker
Pat Tulledge	Social Service Specialist
Ed Schilling	Executive Director
Debra Kurek	RN
Connie Atkinson	RN
Catherine Pipping	Social Worker – Care Manager
Joann Schneiher	Social Worker - COP coordinator
Ruth Ryan	IT and Data Systems
Jeanne Velie	Primary, IT

b. Consumer and Provider Representatives

LTC support committee, CMO advisory board	1 Representative
LTC support committee	1 Representative

La Crosse

a. County Staff

Dean Ruppert	Manager LTS
Peggy Herbeck	Resource Center, I & A
Sigrid Dooley	RN
Mary Faherty	CMO Contact
Nancy Schmidt	Network Developer
Margaret Bell	Social Worker
Laura Matti Gore	Social Worker
Jackie Newcomb	Social Worker
William Isner	Social Worker

b. Consumer and Provider Representatives

Consumer	5 Representatives
Alliance/Mentally Ill	1 Representative
County Board	1 Representative
LaCrosse County Health Dept.	1 Representative

Milwaukee

a. County Staff

Chris Hess	CMO Contact,/RC
Arlene Murray	Access Supervisor
Michelle Lameka	Resource Center, I & A
Randy Mueller	Enrollment Manager
Chester Kuzminski	Resource Center Manager
Meg Gleeson	CMO Project Manager
Carol Miller	CMO supervisor
Cathy Eschete	Family Care CMO Training Coordinator
Keith Parkansky	Network Application Specialist (former)
Arnot Heron	IT- Manager of Data Processing (former)
Mark Lucoff	Contract Administrator

b. Consumer and Provider Representatives

Commission on Aging	1 Representative
LTS Planning Committee	1 Representative
RC Oversight Committee	1 Representative
CMO Oversight Committee	1 Representative
St. Ann's Center	1 Representative

Portage

a. County Staff

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

b. Consumer and Provider Representatives

Consumers	4 Representatives
COP Advisory Committee	1 Representative
Vocational Rehab	1 Representative
Home Health	1 Representative
Adult Foster Care	1 Representative
CBRF Owner/Operator	1 Representative
Health Care at Home	1 Representative
Provider	1 Representative

II. KEY STAKEHOLDERS (STATE-LEVEL)

Survival Coalition

Maureen Ryan
Jeff Spitzer-Resnier
Anne McMahon
Lynn Breedlove
Jennifer Ondrejka
Nancy Anderson
Steve Stanek
Deb Stout Tewalt
Jean Klousia
Michael Blumenfeld

Long-Term Care Provider Coalition

Tom Moore
John Keefe
Forbes McIntosh
John Sauer
Jim McGinn
Tom Ramsey
Brian Schoeneck

Wisconsin Counties Human Service Association

Lucy Rowley
Steven Ruff
Norm Brickl
Tim Steller
John Chrest
Mary Kennedy
Jack Schad
Lu Rowley
Gerry Born

Wisconsin Coalition of Aging Groups

Tom Frazier
Gerilyn Rohrer

III. COUNTIES IN THE PLANNING STAGES OF FULL IMPLENTATION

Human Service Center (Forest/Oneida/Vilas)

Ann Cleereman	CMO Contact

Jackson

Kevin Mannel	Director, Health Human Services
Nancy Laabs	Resource Center, I & A

Kenosha

LaVerne Jaros	CMO Contact
Carolyn Feldt	Assistant Director
Martha McVey	AD Resource Center, I & A
Wren Ide	Center Manager

Marathon County

Larry Hagar	Director DSS
Tim Steller	CMO Contact
Deb Menacher	Resource Center
Leo Goede	CMO Contact
Vickie Tylka	Case manager

Richland

Kim Enders	Resource Center Contact
Marriane Stanek	Director, Health Department
Terri Buros	CMO Contact

Trempeauleau

Stacey Garlick	TC DSS, Resource Center
Becky Severson	Resource Center, I & A

IV. COUNTY NO LONGER A PART OF FAMILY CARE

Waukesha

Ernie Messinger	Health and Human Services
Russ Kutz	AD Services Manager
Cathy Bellovary	Aging Dept
Peter Schuler	Executive Director, Waukesha County
Larry Barthen	Health and Human Services

FAMILY CARE STATE STAFF

Chuck Wilhelm	Director, Office of Strategic Finance
Judith Frye	Director, Center for Delivery Systems Development
Mary Rowin	Family Care Project Manager (former)
Fredi Bove	Current and future Family Care funding
Joyce Allen	State LTC council
Monica Deignan	Supervisor-RC/CMO contracts/quality, enrollment systems
Charles Jones	Family Care waivers, separation and governance, legislation and administrative rules and other selected policy
Ruthanne Landsness	Grant writing and monitoring
Tom Lawless	Rate setting, risk management, cost effectiveness/ cost neutrality for b/c waivers
Dan McAloon	Retrospective rate calculations, management reporting
Alice Mirk	Supervisor-RC/CMO implementation. Coordinate pilot TA plans and DSL/DHCF Assistance
Paula Hogan	(former)
Sharon Hron	Financial eligibility, CARES
Dana Parpart	County IT systems development manager, coordination of technical assistance systems development and automated data reporting, BIS staff supervision
Ann Pooler	Functional Screen, assessment, interdisciplinary team development ethics and ethics committees
Greg Robbins	Family Care systems development oversight
Sharon Ryan	Access Specialist-Resource Center, interface with financial eligibility and PAC
Nachman Sharon	HSRS reporting, functional screen research
Hollister Chase	Operations and Communications coordinator; Family care newsletter
Marci McCoy	Quality monitoring, program effectiveness research and evaluation
Julie Horner	CMO quality and Family Care monitoring and oversight
Jim Hennen	CMO contracts, program and policy questions

APPENDIX C

Site Visit Protocols

Table of Contents

APPENDIX C

Site Visit Protocol for Evaluation of Wisconsin Family Care Program

Care Management Organization Staff

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. SYSTEM DESCRIPTION AND HISTORY

A. Administrative Structure

1. Please provide an overview of the county LTC system. Where do the RC and CMO fit in? Please provide organizational chart if available.

B. Evolution of the Organizational Aspects of the Program

1. Describe the planning process (Phase I) for your Family Care pilot. Can we see a copy of your phase-in plan?

- How will the transition from fee-for-service to capitated payment affect how you provide services? What are your plans for making the transition?
- Discuss any issues related to the phase-in process.
- Describe communication and feedback from the State during this process.

2. What changes had to be made in your staffing structure relative to your previous LTC system?

- How has the CMO staff reacted to the Family Care project? What has been helpful or harmful in obtaining their support? How have county board members, county executive or manager reacted?
- What training has been provided for staff to aid in the transition to Family Care? Who conducted the training?

3. Describe strengths and weaknesses related to having the RC established prior to the CMO.

4. Describe the development of your IT for Family Care. Describe staff reaction to the new system?

C. Services Covered

1. Number of recipients (estimate) enrolled as of April 1, 2000 _____

2. Estimates of number of recipients you will be serving by population . . .

   - Aged _____
   - Under 65 w/physical disabilities _____
   - MR/DD _____
   - Other _____

3. 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? Has the RC been able to refer people for enrollment in a way that has allowed you to work within your enrollment plan?

4. How has open enrollment worked so far?

   - Describe the status of your caseload conversion.
   - Please comment on the clarity of definitions for coding of services, particularly those not previously covered under COP-W?
   - How have you distinguished Medicaid card service benefits (HH) and CMO benefits?

5. Please list the services provided by the CMO in the chart below.

Population	**Family Care Services**
Aged	
Under 65 w/physical disabilities	
MR/DD	
Other	

- Which services do beneficiaries use most? Are there services you think should be covered but are not?
- Can beneficiaries receive services outside the home, for example, in the workplace and community?
- To what extent are services designed to return persons with disabilities to work?
- What residential services are available? What are the advantages and disadvantages of these options? How is the room and board portion accounted for?
- Do the programs offer services such as respite care directly to informal caregivers? Both facility-based and in-home? What are the advantages and disadvantages of such services?

II. ACCESSING THE SYSTEM

A. Outreach Activities

1. What steps did you take in developing your marketing/outreach plan submitted to the State? Can we get a copy of the plan?

2. Did the State identify any problems or errors in your plan? If so, how were they handled?

3. Describe the development of your member handbook. Can we see a copy of the handbook?

B. Provider Network Activities

1. Describe your efforts to develop a network of service providers.

   - For which areas of service do you have a strong capacity? Please define this capacity by geographic area and target group.

   - In what specific areas does your network need improvement? What is your plan to expand that capacity?

2. Please comment on the policy of notifying the State of provider changes.

   - How have provider network reviews by the state gone and what were the results?

3. How have providers reacted to the program? (residential services, home health agencies, institutions)

4. Please describe any notable changes in the county's relationship with providers since Family Care.

C. Service Planning

1. Please comment on the timeliness and accuracy of eligibility determination performed by the RC.

   - What do you feel are the strengths and weaknesses of the LTC functional screen?

   - Does the CMO get a copy of the functional screen and is it helpful in the assessment process?

   - How quickly do you see consumers after the screen is completed

2. How have you dealt with enrollment while financial eligibility is pending?

   - What are the terms outlined in your Memorandum of Understanding (MOU) with the RC under which a person meeting functional eligibility criteria may receive services while financial eligibility is pending? Can we see a copy of the MOU?

3. Please comment on the timeliness of assessments.

   - Where does the assessment take place? (ex. client's place of residence)

   - Who participates in assessments?

4. Describe the Individual Service Plan (ISP) process.

   - How would you evaluate the Resource Allocation Decision-making methodology proposed by the State? Is five days from the enrollment date enough time to complete the initial plan?

   - How often will the ISP be updated?

   - What are your thoughts on moving from 100% to 5% random and targeted reviews of Family Care service plans?

   - How useful is the EDS (claims processing vendor) prior authorization report which provides information on past years dollars and services for an individual?

5. How do service plans take into account the availability of informal care? What methods do you use to support informal caregivers?

   - What are the terms established by your CMO under which family members or other informal caregivers can be paid for providing care?

   - What are some problems in setting up this non-agency Family Care benefit? Will you use a fiscal intermediary?

   - What are your county CMO standards for subcontractors or employees providing the same service as paid family member care providers?

   - What standards or other methods for monitoring quality will you use with informal supports?

D. Care Management

1. Please describe your mechanisms for managing care? Have you set caseload requirements?

2. Who provides case management? (the interdisciplinary team concept) How are case management functions shared among them?

3. Who employs the care management teams? Who is responsible for providing oversight?

E. Consumer Direction

1. How is consumer-direction incorporated into the regular Family Care processes for developing plans of care and monitoring service delivery? How does this differ for each population?

2. How is implementation of a self-directed supports option going?

3. What are the barriers to consumer-direction in regular Family Care processes? In the self-directed supports option?

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

III. CONTEXTUAL FACTORS

Social, economic, and political forces that have a bearing on intervention or influence implementation

A. Cost Containment

1. Please comment on the adequacy of benefit amounts determined by the State.

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

2. How do you set payment rates for providers? Are the payment rates adequate?

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

4. What innovative services or programs do you have or are you planning that will help the cost-effectiveness of the program?

B. Quality Assurance

1. Tell us about the development of your grievance procedure plan. Please comment on the State's reporting requirements and the interaction with the State regarding grievance procedures. Can we see a copy of your plan?

2. Is there a shortage of home care or residential care workers? If so, what effect has the shortage had on access to and quality of services? Do you perceive it to be any different under Family Care than previously? If so how?

3. Describe the quality improvement program. Does the approach differ by type of worker – individual or agency worker?

   - Training or criminal background checks for workers
   - Licensure, conditions of participation
   - use of outcome measures
   - complaint hotline
   - long-term care ombudsman
   - role of case management team

4. How do the quality assurance systems incorporate beneficiaries' views? How does the program respond to these views?

   - consumer satisfaction surveys
   - complaint mechanisms and review of complaints and grievances
   - participation in QA/QI committees, governing board, local LTC Council

5. How are quality of care standards enforced?

   - Suspension of payment
   - Sanctions
   - Suspension of admissions
   - Adult protective services

6. In your opinion, which standards are most effective in ensuring beneficiaries receive good quality care? How could the standards be made more effective?

7. How does Family Care prevent financial fraud? How could the system be improved?

C. Relationship with the State and Federal Govt.

1. Does current federal law restrict your programs' operations? Are there any state regulations that you find restrictive?

2. How would you characterize your county's relationship with the State when it comes to implementing Family Care?

D. Relationship with the RC

1. Please describe the CMO relationship with the RC.

2. What is your perception of how quickly the RC responds to referrals for Family Care?

3. Do you have a plan for separation of the RC from the CMO? Has the State approved it? Can we get a copy?

IV. FUTURE OF FAMILY CARE

1. What do you consider to be the strengths and weaknesses of Family Care compared to the current COP program?

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?

V. EVALUATION OF PROGRAM AND DATA AVAILABILITY

1. Are there any plans for the County to evaluate the CMO? Could we get copies of the evaluation plans?

2. Please describe the program data you maintain and the format for maintaining it.

   Address the following areas:

   - Assessments
   - Reassessments
   - Plan of care
   - Prior authorization forms

- Claims

3. Are any of these data computerized? How long have the data been computerized?

4. Would it be possible to obtain a codebook for the data to determine what data you are collecting and how it is being collected?

5. Are there any other documents, reports or data that you could share with us?

Site Visit Protocol for Evaluation of Wisconsin Family Care Program

Resource Center Staff

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. SYSTEM DESCRIPTION AND HISTORY

A. Administrative Structure

1. Please provide an overview of the county LTC system. Where do the RC and CMO fit in? Please provide organizational chart if available.

B. Implementation

1. Describe the planning process (Phase I) for your Family Care pilot. Can we see a copy of your phase-in plan?

   - Discuss any issues related to the phase-in process.
   - Describe communication and feedback from the State during this process.

2. What changes had to be made in your staffing structure relative to your previous LTC system?

   - How has the RC staff reacted to the Family Care project? What has been helpful or harmful in obtaining their support?
   - What training has been provided for staff to aid in the transition to Family Care? Who conducted the training?

3. Describe the development of your IT for Family Care. Describe staff reaction to the new system?

C. Service delivery and referrals

1. Please briefly list the services provided by your county's Resource Center.
   - Are there services not provided that you see as necessary?
   - Please describe your prevention services.
2. Tell us about your current plans for the enrollment process.
3. lease 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?
4. How has open enrollment worked so far? Which populations are picking the COP program over the CMO?

II. ACCESSING THE SYSTEM

A. Outreach

1. Number of referrals since beginning of program: _____
2. Please list referrals by population:
   - Aged - Since inception:_____; current monthly average _____, expected monthly average in one year: _____
   - Under 65 w/physical disabilities - Since inception:_____; current monthly average _____, expected monthly average in one year: _____
   - MR/DD - Since inception:_____; current monthly average _____, expected monthly average in one year: _____
   - Other - Since inception:_____; current monthly average _____, expected monthly average in one year: _____
3. How effective have your marketing and outreach efforts been? What were your number of contact goals by population? Have they been met? If not, what are your plans for improvement?
4. What steps did you take in developing your marketing/outreach plan submitted to the State? Can we get a copy of your outreach plan? Describe your consultation with the State in this process.
5. Describe your plan to reach isolated populations.

6. Describe your outreach efforts to community agencies.

7. Describe your outreach plans for children coming of age to transition to Family Care.

8. Describe the development of your outreach plan to notify facilities in your area required to make referrals to the RC, such as nursing facilities and ICF-MRs. What materials do you provide them? May we see copies of the materials distributed?

9. Describe the process of collaborating with providers to develop the procedures for making and responding to referrals.

   - Please comment on provider reaction to the RC.

B. LTC Financial and Functional Screening

1. What issues arise in using the functional screen for determining eligibility? What are its strengths and weaknesses?

2. Who administers the functional screen? How are they trained?

3. Where does the screening take place? (ex. client's place of residence)

4. Please comment on the timeline for determining functional eligibility.

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

6. How have you dealt with enrollment while financial eligibility is pending?

7. What are the terms outlined in your Memorandum of Understanding (MOU) with the CMO under which a person meeting functional eligibility criteria may receive services while financial eligibility is pending? Can we get a copy of the MOU?

C. Long-Tem Care Options Counseling

1. Describe your efforts to develop a knowledge base of range of long-term care options.

2. Describe the strengths and weaknesses with the long-term care options counseling process.

3. How do you determine immediacy of need for LTC counseling?

4. Is your benefit specialist within the agency? If not how do you arrange for this service in a timely manner?

5. Describe your plan for providing benefit specialist services to people with disabilities under age 60.

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

D. 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?

III. CONTEXTUAL FACTORS

SOCIAL, ECONOMIC, AND POLITICAL FORCES THAT HAVE A BEARING ON INTERVENTION OR INFLUENCE IMPLEMENTATION

A. Quality Assurance

1. What role does the RC play in quality assurance? How could that role be enhanced?

B. Relationship with the State and Federal Govt.

1. Does current federal law restrict your programs' operations? Are there any state regulations that you find restrictive?

2. How would you characterize your county's relationship with the State when it comes to implementing Family Care?

C. Relationship with the CMO

1. Please describe the RC relationship with the CMO.

2. Do you have a plan for separation of the RC from the CMO? Has the State approved it? Can we get a copy?

IV. FUTURE OF FAMILY CARE

1. What do you consider to be the strengths and weaknesses of Family Care compared to the current COP program?

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?

V. EVALUATION OF PROGRAM AND DATA AVAILABILITY

1. Are there any plans for the County to evaluate the RC? Could we get copies of the evaluation plans?
2. Please describe the program data you maintain and the format for maintaining it. Address the following areas:
   - Eligibility determination
   - Assessments
   - Prior authorization forms
   - Claims
   - Others?
3. Are any of these data computerized? How long have the data been computerized?
4. Would it be possible to obtain a codebook for the data to determine what data you are collecting and how it is being collected?
5. Are there any other documents, reports or data that you could share with us?

Site Visit Protocol for Evaluation of Wisconsin Family Care Program

Current COP Staff

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. SYSTEM DESCRIPTION AND HISTORY

A. History of the Program

1. How long has your county had the COP program?

2. Please give a brief overview of what the COP programs are designed to accomplish and the sources of funding.

B. Program Statistics

1. Please list the number of recipients (estimate) enrolled as of April 1, 2000 in the chart below.

Pop.	COP-W	COP-R	Community Aides	Personal Care	Others (please list)
Aged					
Under 65 w/ physical disabilities					
MR-DD					
Other					

2. Do you have summary data about the COP program prior to Family Care? Are there any documents or reports you could share with us?

3. Please list the services provided below.

Pop.	COP-W	COP-R	Community Aides	Personal Care	Others (please list)
Aged					
Under 65 w/ physical disabilities					
MR-DD					
Other					

- Can beneficiaries receive services outside the home, for example, in the workplace and community?

- To what extent are services designed to return persons with disabilities to work?

- Do the programs offer adult foster care, board and care, or assisted living options to beneficiaries? If offered, what are the advantages and disadvantages of these options? How is the room and board portion accounted for?

- Do the programs offer services such as cash payments and respite care directly to informal caregivers What are the advantages and disadvantages of such services?

C. Reaction to Family Care

1. Describe how Family Care has affected the COP program.

   - To what extent have or will COP staff been incorporated into Family Care?

   - How has the COP staff reacted to the Family Care project? What has been helpful or harmful in obtaining their support?

   - What training has been provided for COP staff to provide understanding of Family Care? Who conducted the training?

II. ACCESSING THE SYSTEM

1. How did individuals access the system prior to the RC? How were referrals made prior to the RC?

2. How is eligibility for COP determined?

3. Please describe your the provider network in your county.

   - For which areas of service do you have a strong capacity?

   - What service area needs to be expanded? What is your plan to expand that capacity?

   - Has or do you anticipate that the shift to Family Care will alter the county's relationships with providers?

4. Please describe the mechanisms for managing care under COP. Do you set caseload requirements? If yes, what are they?

   - Who provides case management?

   - Who employs the case managers? Who is responsible for providing oversight?

5. How do service plans take into account the availability of informal care?

6. How is consumer-direction incorporated into the plan of care and service delivery? How does this differ for each population?

   - What are the barriers to consumer-direction in current COP program?

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

III. CONTEXTUAL FACTORS

Social, economic, and political forces that have a bearing on intervention or influence implementation

A. Cost Containment

1. To what extent do COP recipients receive services funded outside the COP-W or COP-R funding stream?

   - How do you maximize use of these services?
   - Do you think your county has done a good job of maximizing the use of non-COP-W/COP-R services? Why or why not?

2. How are benefit amounts determined relative to functional level?

3. How do you determine beneficiary cost sharing?

4. How do you set payment rates for providers? Are the payment rates adequate?

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

B. Quality Assurance

1. Is there a shortage of home care or residential care workers? If so, what effect has the shortage had on access to and quality of services?

2. Describe the quality improvement program. Does the approach differ by type of worker – individual or agency worker?

   - Training or criminal background checks for workers
   - Licensure, conditions of participation
   - Use of outcome measures
   - Complaint hotline
   - Long-term care ombudsman
   - Role of case manager

3. How do the quality assurance systems incorporate beneficiaries' views? How does the program respond to these views?

   - Consumer satisfaction surveys
   - Grievance procedures

4. How are quality of care standards enforced?

   - Suspension of payment
   - Sanctions
   - Suspension of admissions
   - Adult protective services

5. In your opinion, which standards are most effective in ensuring beneficiaries receive good quality care? How could the standards be made more effective?

C. Relationship with the State and Federal Govt.

1. Does current federal law restrict your programs' operations? Are there any state regulations that you find restrictive

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?

3. How does Family Care affect these restrictions?

IV. FUTURE OF FAMILY CARE

1. What do you consider to be the strengths and weaknesses of Family Care compared to the current COP program?

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?

V. EVALUATION OF PROGRAM AND DATA AVAILABILITY

1. Are there any plans for the County to evaluate the COP program? Could we get copies of the evaluation plans?

2. Please describe the program data you maintain and the format for maintaining it. Address the following areas:

   - Eligibility determination
   - Assessments
   - Reassessments
   - Plan of care
   - Prior authorization forms
   - Claims

3. Are any of these data computerized? How long have the data been computerized?

4. Would it be possible to obtain a codebook for the data to determine what data you are collecting and how it is being collected?

5. Are there any other documents, reports or data that you could share with us?

Site Visit Protocol for Evaluation of Wisconsin Family Care Program

LTC Council

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. HISTORY AND DEVELOPMENT

- Please provide a brief history of the development of the council.
- Please list members of the council. What are the demographics of the group?
- How often does the Council meet?
- How are the meetings run? Who facilitates?

II. ROLE OF THE COUNCIL

- Please describe the responsibilities of the council.
- 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.

III. IMPRESSIONS OF THE SYSTEM

- Describe the communication the council receives from the State and County officials regarding the changes in the LTC system.
- How well do you think Family Care has met or will meet its goals for transforming the LTC system?
- How well do you think that program has or will expand consumer choice and service quality?
- List some concerns you have with the redesign of the system.

IV. UTILIZATION OF SERVICES (ASK ONLY OF MEMBERS WHO CAN SPEAK TO THIS)

- What are the strengths and weaknesses of the program's case management system?

- How well are beneficiaries' and informal caregivers' preferences incorporated into the service plan?
- Are there services you think should be covered but are not?

V. FUTURE OF FAMILY CARE

- What do you consider to be the strengths and weaknesses of Family Care compared to the current COP program?
- 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 Disabilities
  - Individuals with complex medical needs
- What are the most innovative aspects of the long-term care system in this county?
- you could change one aspect of Family Care, what would it be and why would you change it?
- How do you believe that Family Care will evolve over time? What do you see as the Council's role.

APPENDIX D

Protocols For Follow-Up Interviews

Table of Contents

APPENDIX D

Follow-Up Interview Protocol for Evaluation of Wisconsin Family Care Program

County Staff

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. CMO AND RC RELATIONS

- Separation/governance issue
- Transfer of information between the RC and the CMO
- Timing of the development of the RC and the implementation of mandatory referrals in relation to the CMO

II. IMPLEMENTATION OF THE CMO

- What changes have you made to implement the CMO in each of the following areas:
  - Clinical practices (e.g., hiring RNs, etc.)
  - Staff training (e.g., cultural competency)
  - Business practices
  - Information technology
  - Others
- What additional changes to do you anticipate having to make and what is the timeline for implementing these changes?

III. OUTREACH

- Goals for number of contacts for the RC
  - Enrollment projection goals

- Status of Pre-admission Consultation (PAC) referrals
- Member handbook? Other educational materials?
- Unmet needs of the target population

IV. PROVIDER ISSUES:

- CMO or RC plans to monitor the extent to which providers have adequate capacity to provide an appropriate range of services
  - Access to preventative and wellness services
  - Shortages of any types of services and reason for shortages
  - Adequate choice in providers
  - Mix and geographic distribution – any under-served areas or populations
  - Specialized expertise with the target populations served
  - Culturally competent providers
  - Other access issues
- Provider relationships/ contracts process. What would you change about the process?
- Services used the most – changes since the implementation of the CMO
- Adequacy of reimbursement rates

V. ASSESSMENT AND CARE MANAGEMENT

- Strengths and weaknesses of the screening and assessment process and the newest version of the functional screen
- Caseload conversion process. Is there anything that you would have done differently now that FC is up and running?
- Care managers efforts to monitor costs under FC in comparison to the fee-for-service system; (e.g. how do capitated cost constraints affect care managers' decision? How helpful is the Resource Allocation Decision (RAD) methodology?)
- Care managers' perception of how FC has affected how they do their job.

VI. CONSUMER DIRECTION

- Status of the LTC Council. Is the County LTC council functioning according to the contract with DHFS? If not, why? Please comment on the degree that they have been involved with the program.

- Please comment on the accuracy, comprehensiveness, and timeliness of information given to consumers in Family Care.

- Please comment on consumer choice in FC. Is it expanded? Care managers perceptions?

VII. RELATIONSHIP WITH DHFS:

- Please describe the working relationship that your county has had with DHFS throughout the implementation of Family Care. What can be improved?

Follow-Up Interview Protocol for Evaluation of Wisconsin Family Care Program

Consumer and Provider Representatives

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. BACKGROUND

A. LTC Council Members

- Please comment on the development of the LTC Council.
- Please list members of the council. What are the demographics of the group?
- How often does the Council meet?
- How are the meetings run? Who facilitates?
- Please describe the responsibilities of the Council.
- 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.

B. LTC Council Not Yet Formed

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

C. Consumer and Provider Representatives

- What is your capacity as a provider? What services do you provide?
- What populations do you serve?
- Please describe your affiliation with the LTC system in this county (i.e. family member of service recipient, service recipient, etc.)

II. FAMILY CARE – SYSTEM DESCRIPTION

- Please comment on the purpose and goals of the Family Care Program.

- How well do you think Family Care has met or will meet its goals for transforming the LTC system?

- Describe the communication you receive from the State and County officials regarding the changes in the LTC system.

III. ELIGIBILITY AND ASSESSMENT

- Please comment on the eligibility and assessment in Family Care based on the following three criteria:

  a) accuracy

  b) timeliness

  c) comprehensiveness

IV. CASE MANAGEMENT AND SERVICE PLANNING

- What are the strengths and weaknesses of the program's case management system?

- How well are beneficiaries' and informal caregivers' preferences incorporated in the service plan?

- Please comment on appropriate service use under Family Care.

- What is needed for service use to become more appropriate?

- How well do service plans promote continuity in service delivery and funding?

V. SERVICES

- Please comment on choice in and access to providers in Family Care compared to the previous system.

- What is needed to expand this choice and access?

- Please comment on information provided to consumers about services based on the following three criteria:

  a) accuracy

  b) timeliness

  c) comprehensiveness

- Please comment on the access to emergency and protective services in Family Care.

- Are there services you think should be covered but are not?

- How has Family Care changed the way that your agency provides services and supports to people? (providers)

VI. CONSUMER DIRECTION

- How well do you think that Family Care has expanded consumer choice to date?
- What is needed for Family Care to continue to expand consumer choice?
- Please comment on the information that the Resource Center makes available to consumers based on the following three criteria:

  d) accuracy

  e) timeliness

  f) comprehensiveness

- Please comment on the self-directed support option.
- Please comment on your awareness of the Independent Advocacy Service.

VII. REIMBURSEMENT (PROVIDER REPRESENTATIVES)

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

VIII. QUALITY ASSURANCE

- Please comment on the strengths and weaknesses of service quality assurance in Family Care compared to the previous system.
- What improvements, if any, could be made?
- Please comment on your awareness and assessment of the effectiveness of the grievance and appeals process.

IX. CONCLUSIONS

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

- What are the most innovative aspects of the long-term care system in this county?
- If you could change one aspect of Family Care, what would it be and why would you change it?
- How do you believe that Family Care will evolve over time? What do you see as your role?

Follow-Up Interview Protocol for Evaluation of Wisconsin Family Care Program

Key Stakeholders (State Level)

County _____

Date:_____

Name(s) and #s of Respondents:_____

_____

_____

I. FAMILY CARE – SYSTEM DESCRIPTION

- Please comment on the purpose and goals of the Family Care Program.
- How well do you think Family Care has met or will meet its goals for transforming the LTC system?
- Describe the communication you receive from the State and County officials regarding the changes in the LTC system.

II. ELIGIBILITY AND ASSESSMENT

- Please comment on the eligibility and assessment in Family Care based on the following three criteria:

  g) accuracy

  h) timeliness

  i) comprehensiveness

III. CASE MANAGEMENT AND SERVICE PLANNING

- What are the strengths and weaknesses of the program's case management system?
- How well are beneficiaries' and informal caregivers' preferences incorporated in the service plan?
- Please comment on appropriate service use under Family Care.
- What is needed for service use to become more appropriate?
- How well do service plans promote continuity in service delivery and funding?

IV. SERVICES

- Please comment on choice in and access to providers in Family Care compared to the previous system.
- What is needed to expand this choice and access?
- Please comment on information provided to consumers about services based on the following three criteria:
  a) accuracy
  b) timeliness
  c) comprehensiveness
- Please comment on the access to emergency and protective services in Family Care.
- Are there services you think should be covered but are not?
- How has Family Care changed the way that your agency provides services and supports to people? (providers)
- Consumer Direction
- How well do you think that Family Care has expanded consumer choice to date?
- What is needed for Family Care to continue to expand consumer choice?
- Please comment on the information that the Resource Center makes available to consumers based on the following three criteria:
  d) accuracy
  e) timeliness
  f) comprehensiveness
- Please comment on the self-directed support option.
- Please comment on your awareness of the Independent Advocacy Service.

V. REIMBURSEMENT (PROVIDER REPRESENTATIVES)

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

VI. QUALITY ASSURANCE

- Please comment on the strengths and weaknesses of service quality assurance in Family Care compared to the previous system.
- What improvements, if any, could be made?
- Please comment on your awareness and assessment of the effectiveness of the grievance and appeals process.

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- What do you consider to be the strengths and weaknesses of Family Care compared to the previous long-term care system?
- 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
- What are the most innovative aspects of the long-term care system in this county?
- If you could change one aspect of Family Care, what would it be and why would you change it?
- How do you believe that Family Care will evolve over time? What do you see as your role?