

*Wisconsin Department of Health Services
Division of Long-Term Care*

**Managed Care and Employment
Task Force**

~ Final Report ~

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Far and away the best prize that life offers is the chance to work hard at work worth doing.

-Theodore Roosevelt

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Acronyms

ADRC	Aging and Disability Resource Center
CIP	Community Integration Program
CMS	Center for Medicaid and Medicare Services
COP.....	Community Options Program
DBS.....	Disability Benefit Specialist
DET.....	Division of Education and Training
DHS.....	Department of Health Services (formerly DHFS)
DHFS	Department of Health and Family Services
DLTC	Division of Long-Term Care
DMHSAS.....	Division of Mental Health and Substance Abuse Services
DPI.....	Department of Public Instruction
DRA	Deficit Reduction Act
DVR	Division of Vocational Rehabilitation
DWD.....	Department of Workforce Development
IEP.....	Individualized Education Program
IPE.....	Individual Plan for Employment
IRWE	Impairment-Related Work Expense
MAPP.....	Medical Assistance Purchase Plan
MCETF	Managed Care and Employment Task Force
MCO	Managed Care Organization
MCP	Member Centered Plan (Managed Care)
MIG.....	Medicaid Infrastructure Grant
OSHA.....	Occupational Safety & Health Administration
PACE/Partnership.....	Program for All-inclusive Care for the Elderly
PASS.....	Plan for Achieving Self-Support
PEONIES	Personal Experience Outcome Integrated Interview & Evaluation System
QA/QI	Quality Assurance/Quality Improvement
RAD	Resource Allocation Decision
SHRM.....	Society of Human Resource Managers
SSI.....	Supplemental Security Income
SSDI.....	Social Security Disability Insurance
VR.....	Vocational Rehabilitation
WDBN	Wisconsin Disability Benefits Network

Executive Summary

Introduction

Hopes, goals, and aspirations: these qualities define and drive all of us, including those of us with disabilities. Meaningful involvement in community life, including opportunities to contribute our talents and skills in ways that benefit our communities and enrich our lives, is often part of these aspirations. So too are financial stability and security. Employment is a primary way for working age people to contribute to their communities and one of the most satisfying and meaningful ways for people to achieve their goals.

As part of its core values, the Department of Health Services (DHS) supports community integration for people with disabilities, consumer choice in how and where long-term care services are provided, and maximizing the respect and dignity afforded people with disabilities by their fellow community members. The Department's long term care system plays a critical role in supporting individuals with disabilities in their desires to contribute to the community and in their efforts to consider, pursue, and maintain employment.

Current Challenges

Historically, in Wisconsin and across the nation, participation in employment, and particularly integrated employment, among working age adults with disabilities has been limited. Currently, most working age adults with disabilities served by the public long-term care system in Wisconsin are unemployed or employed in non-integrated settings. With unemployment come high rates of poverty that greatly restrict lifestyle choices, stability, and security. Unemployment is also associated with poorer health and greater social isolation.

Key factors that contribute to the low rates of employment in integrated settings for people with disabilities involved in the long-term care system include:

- Clients have an incomplete understanding of integrated employment opportunities and the interaction between employment and public benefits; many people with disabilities believe they risk losing publicly-funded benefits if they become employed
- Providers currently have limited capacity to provide integrated employment services; expansion of capacity will require restructuring by existing providers and support for the development of new providers
- Employers have limited experience and expertise in employing people with disabilities

Family Care Framework

Family Care, Wisconsin's managed care long-term care program, offers a promising framework for overcoming these challenges. At Family Care Aging and Disability Resource Centers (ADRCs), staff can offer full and accurate information on the interaction between employment and public benefits, as well as information on the range of employment options available under

Family Care. The Family Care Managed Care Organizations (MCOs) are responsible for developing an individualized care plan in collaboration with the individual. The care planning process is based on the person's desired outcomes, goals and aspirations. The process provides the opportunity to explore employment options and identify employment possibilities. Care plans can include a mix of employment and non-employment activities that reflect an individual's needs and preferences. Family Care includes a more comprehensive and integrated set of services, including vocational services for all populations, transportation, and personal care services in the workplace. In addition, individuals can self-direct some or all of their services in Family Care. MCOs are responsible for developing provider capacity in all service areas and have the flexibility to structure their contracts and relationships with providers in creative ways that will help expand and support integrated employment.

Because Family Care is an entitlement fully funded by the state, all individuals leaving the K-12 and vocational rehabilitation systems who meet the Family Care functional level of care can transition to coverage under Family Care, thus continuing without disruption, the employment planning and supports initiated in these other systems. Unlike the previous waiver system, the rate-setting method used in Family Care is designed to reflect actual expenditures by MCOs so that increased spending on employment-related services is factored into future rates, ensuring that efforts to expand employment services are recognized and financially supported over time. By creating a framework that eliminates many of the constraints of the system that existed prior to Family Care, the statewide expansion of Family Care provides a promising opportunity to strengthen employment outcomes for people with disabilities.

Pathways to Independence

In addition to Family Care, Wisconsin has another promising framework for strengthening employment outcomes among people with disabilities. Through 2011, Wisconsin's Medicaid Infrastructure Grant (MIG) "Pathways to Independence" can provide significant systems change resources to support building a sustainable infrastructure for increasing integrated employment outcomes for those involved in Wisconsin's long-term care system. Together, Family Care and Wisconsin's Medicaid Infrastructure Grant create an unprecedented opportunity for positive change.

The Task Force

Against this backdrop, the Managed Care and Employment Task Force (MCETF) was convened in May 2007 by Division of Long-Term Care Administrator Sinikka Santala and charged with recommending a comprehensive strategy to expand work options for adults who rely on the community-based, long-term care system. The Task Force, composed of 28 members representing a wide range of interests and expertise, analyzed the challenges and identified best practices from Wisconsin and elsewhere for overcoming these challenges. Among the best practices used consistently in other high-performing states is the existence of a state long-term care agency policy on employment. Given this, the Task Force, guided by the Department's values, the principles embodied in Family Care itself, and Family Care's existing framework and structures, crafted an overarching policy statement and a set of recommendations to support this statement. Following is the core of the policy statement that guided the Task Force and underlies the more specific recommendations:

Among employment options, integrated employment offers people with disabilities the greatest access to full community inclusion and an array of employment choices equal to those available to citizens without disabilities. Integrated employment at a competitive wage offers individuals a meaningful path toward economic security and the respect and dignity associated with employment, which is enjoyed by working citizens without disabilities. Therefore, while always respecting individual informed choice, because integrated employment provides access to the fullest range of employment choices and outcomes, and better opportunities for community integration and meaningful earnings for members, **the managed care long-term care system should support integrated employment as the preferred employment option.**

RECOMMENDATIONS

The following recommendations developed by the Task Force are intended to ensure best practices for supporting and facilitating a broad range of quality employment choices and outcomes. The recommendations are divided into two groups:

- Recommendations related to improving the managed long-term care system's infrastructure and broader community collaborations, and
- Recommendations related to improving the experiences and outcomes of individual consumers

Improving System Infrastructure and Community Collaboration

1. The Department should adopt a clear policy on employment for the managed long-term care system that will guide all system partners in a common effort to achieve common goals.
2. In support of full implementation of the policy on employment by the managed long-term care system, MCOs should establish an internal organizational culture that values work and identifies supporting members to work as a core value and organizational best practice.
3. In support of full implementation of the policy on employment by the managed long-term care system, the Department should offer to MCOs strong support, technical assistance, and financial incentives related to increasing employment among managed care members, and should ensure that certification of MCOs takes into account MCO capacity to support integrated employment.
4. In order to blend all resources available for individuals wishing to pursue employment, the Department and MCOs should strengthen coordination with critical system partners, including the school system, the vocational rehabilitation system and the "One-Stop" Job Center system.
5. In order to ensure all MCO members have a range of employment choices equal to those available to citizens without disabilities, targeted efforts should be undertaken to increase the pool of Wisconsin employers hiring qualified applicants with disabilities to fill existing or customized positions.

6. In order to enhance and ensure the best quality employment outcomes for managed care members, the Department should establish processes to monitor outcomes and stimulate continuous quality improvement.

7. In order to measure progress in relation to employment participation, the Department should work with MCOs and providers to develop data systems that effectively track employment data and to publish an annual report of employment outcomes at the MCO and system levels.

8. To facilitate the expanded provision of employment services and supports to MCO members, the Department and MCOs should undertake efforts specifically designed to evaluate accurately and improve the cost-effectiveness of employment supports and services.

Improving the Experiences and Outcomes of Individual Consumers

9. As individuals enter the long-term care system, ADRCs should provide information and assistance on opportunities to work and the range of employment opportunities that can be facilitated and supported through the long term care system.

10. The Long-Term Care Functional Screen, used to determine eligibility, is initially administered by ADRCs and updated annually by MCOs. As the first managed care interview tool that raises the topic of employment, the employment section of the screen should be revised to capture more specific and accurate information about each person's employment preferences, status, and support needs.

11. As individuals consider the possibilities around employment, benefit specialists should be available to provide accurate, timely and easy-to-understand information on the intersection of benefits eligibility and employment, and also on work incentives that allow individuals to work while maintaining eligibility for Social Security, Medicaid, and long-term care services.

12. As individuals consider employment possibilities, they should be fully informed about the Medical Assistance Purchase Plan (MAPP). To increase the use of MAPP to facilitate employment among those enrolled in or eligible for Medicaid, the state should make specific program changes that will eliminate disincentives to work that currently exist in MAPP.

13. When individuals join MCOs, they should have inter-disciplinary team staff knowledgeable about the broad range of employment options that exist, and the services available through managed care and other systems that can support individuals to pursue employment.

14. Individuals should be engaged in an assessment and care planning process that effectively addresses employment and in doing so, promotes and facilitates informed choice.

15. When managed care members need long-term care services to support their employment goals, the Department should ensure that MCOs have services in the benefit package that: are updated to reflect and advance the Department's values; encourage use of current best practices; and allow for a broad range of effective service models that can support a wide range of employment options.

16. When managed care members need long-term care services to support their employment goals, MCOs should contract with employment service providers in ways that encourage and reward positive employment outcomes.

17. In order to ensure all MCO members have a range of employment choices equal to those available to citizens without disabilities and are able to pursue their individualized employment goals, service providers should be assisted in expanding their capacity to develop and support high quality integrated employment outcomes.

Detailed presentation of all recommendations can be found in the section of this report that begins on page 22. Further detail, including rationales for each recommendation, can be found in the issue committee reports included in Appendix E.

The recommendations in this report, with the advantages created by Family Care and the resources for implementation available through Wisconsin's Medicaid Infrastructure Grant, offer the potential to significantly increase access to and participation in integrated employment by individuals with disabilities who rely on Wisconsin's long-term care system. While change is possible at any time, Wisconsin has a unique window of opportunity for change that exists right now and should not be missed.

Managed Care and Employment Task Force Final Report

Introduction

The Managed Care and Employment Task Force (MCETF) was convened in May 2007 by Division of Long-Term Care Administrator Sinikka Santala. Composed of 28 members, the Task Force represented a wide range of interested and knowledgeable consumers and family members, providers, employers, Family Care organizations, counties, advocates, and state agencies. A full list of Task Force members is in Appendix A.

The Task Force was charged with developing a blueprint for a comprehensive strategy that

- Will expand work options for adults who rely on the community-based long-term care system
- Can be implemented within the managed long-term care system being expanded throughout Wisconsin
- Will effectively integrate all resources available to support consumers' employment goals
- Will support and advance the four key values of Wisconsin's managed long-term care system: choice, access, quality, and cost-effectiveness.

Context for the Task Force

The Managed Care and Employment Task Force is an outgrowth of the core values the Department of Health Services (DHS) embraces for people with disabilities.

- DHS supports community integration and consumer choice in how and where long-term care services are provided
- DHS supports maximizing the respect and dignity afforded people with disabilities by their fellow community members
- DHS believes that all people with disabilities *can* contribute to their communities
- DHS recognizes that employment is one of the primary ways people contribute to their communities and one of the most satisfying and meaningful ways in which people spend their time

For these reasons, the long term care system plays a critical role in supporting individuals with disabilities in their desires to contribute to the community as they consider, pursue, and maintain employment.

Program Context for Task Force: Convergence of Two Major DHS Initiatives

The Managed Care and Employment Task Force was convened at this time in part because the Department is engaged in two major program initiatives focused on managed care and employment. Currently, the Department is embarked on an initiative to expand the Family Care managed long-term care program statewide. Family Care began on a pilot basis in certain counties in the year 2000. In his 2006 State of the State address, Governor Jim Doyle set 2011

as the goal for completing the statewide expansion of the successful Family Care program. Family Care is based on four core principles:

- Choice: People have better choices about where they live and the services and supports available to meet their long-term care needs
- Access: Improved access to services, resulting in the elimination of waitlists for community-based care
- Quality: Improves quality by focusing on achieving individuals' health and social outcomes
- Cost Effective: By delivering quality services at less cost than the current community waiver long-term care system, establishes a cost effective long-term care system for the future.

The second initiative is Wisconsin's Medicaid Infrastructure Grant (MIG) "Pathways to Independence." Under the federal "Ticket to Work" legislation, the Department is eligible for annual awards for integrated employment system change projects through 2011. Wisconsin can request annual funding up to 10% of the service expenditures of the Medicaid Purchase Plan. For 2008, the Department requested and was granted \$7 million in federal MIG funding. This is expected to increase in future years.

The intent of the MIG program is to achieve system change and ensure sustainability of that change by identifying gaps and weaknesses in the existing array of employment-related policies, services and supports and by developing alternative strategies and better practices that strengthen and add capacity to the rehabilitation, workforce, education, and Medicaid systems. Wisconsin's MIG is guided by a set of strategic priorities, consistent with the Department's values and the charge to the Task Force:

- Development of a system of unprecedented collaboration among all service providers, with a person-centered focus and a specific plan for a unified system that serves both employers and people with disabilities, resulting in a more productive work environment
- Increasing the extent in which employers, policymakers, insurers and people with disabilities are engaged in increasing access to long-term care and other benefits for employees
- Creation and provision of practical technical assistance and on-going supports for employers who employ and accommodate people with disabilities
- Support for the principles of universal design and the creation and use of assistive technologies to enhance independence and productivity for people with disabilities

The statewide expansion of Family Care and the Pathways Grant initiative converge to offer people with disabilities a greater range of employment choices and to provide accessible, high quality and cost effective services that support integrated employment. The Task Force builds on both initiatives to strengthen employment opportunities for people with disabilities in the managed long-term care system. There is synergy between MIG and Family Care goals, and between the MIG's strategic priorities and the Task Force's charge and activities. This, in addition to Wisconsin's ability to request and receive the nation's largest MIG grant award, provides a rare window of opportunity for stable and full funding, through 2011, of activities and initiatives designed to create sustainable systems change that can increase integrated employment outcomes for those involved in Wisconsin's long-term care system.

Work of the Task Force

To carry out its charge, the Task Force undertook the following activities:

- Learned about the Family Care managed long-term care program
- Reviewed data on current employment options and outcomes in Wisconsin's long-term care programs
- Studied evidence on the relationship between employment and health
- Studied best practices in Wisconsin and other states to promote employment opportunities for people with disabilities
- Convened seven issue committees to discuss the key topic areas of informed choice and member-centered planning, state agency contracting and funding, managed care organization strategies for contracting and purchasing, multi-agency blended services and funding, provider network development, measuring outcomes and quality, work incentives, and employer supports
- Sought input through conducting provider network surveys and making presentations to interested groups and at relevant conferences
- Analyzed and discussed program and policy options
- Conducted eight listening sessions in four areas of the state to seek public input on the draft final report.

From its inception in May 2007 through June 2008, the full Task Force held eight meetings, and the seven issue committees held over thirty meetings drawing on numerous state and national experts for input. Listening sessions were held in Appleton, Eau Claire, Madison and Milwaukee. Input from these listening sessions and submitted comments were used in finalizing this report. In addition, many of the comments received included valuable suggestions related to implementation of the policy and recommendations contained in this report and will be shared with those assigned responsibility for implementation.

Current Employment Experience of Wisconsin Long-Term Care Clients

Wisconsin has a long-standing commitment to community-based long-term care. Since the 1980s, the Community Integration (CIP) and Community Options (COP) Medicaid "waiver" programs have been in place. Administered by counties, these programs provide frail elders and adults with disabilities the opportunity to receive certain long-term care services in community settings as an alternative to residing in a nursing home. CIP and COP waivers operate in all counties except where Family Care operates.

In the last ten years, three community-based managed long-term care programs have been piloted in certain counties. The first managed long-term care program, Family Care, began operating on a pilot basis in five counties in 2000 and covers all Medicaid-funded institutional and community based long-term care services. One of the pilot sites, Milwaukee, serves only elders. The other four original pilot sites serve adults with disabilities as well as frail elders. The remaining two managed long-term care programs, PACE and Partnership, operated in seven counties as of 2006, and are fully integrated managed care programs covering all Medicaid and Medicare funded health and long-term care services. PACE serves frail elders; Partnership serves frail elders and adults with physical disabilities. Since 2007, Family Care and PACE/Partnership have been expanding to additional counties.

The following table summarizes the employment experience in 2006 for people aged 18 through 64 with developmental and physical disabilities enrolled in the Department’s community-based long-term care programs: the CIP and COP waivers, Family Care, and the Partnership program. The Task Force recognizes that people over age 64 can and do work. However, the data on employment experiences for individuals over age 64 is significantly different from the data for younger adults, due to the fact that many individuals over age 64 have made a decision to retire from employment. To avoid retirement decisions significantly influencing the analysis, the Task Force examined data for adults aged 18 to 64. The complete data is provided in Appendix B.

Employment Experience for Adults aged 18-64 in Long Term Care Programs in 2006				
	Individuals with Developmental Disabilities		Individuals with Physical Disabilities	
	% Employed	% Employed in integrated setting	% Employed	% Employed in integrated setting
Waivers	66%	18%	8%	4%
Family Care	52%	25%	8%	5%
Partnership	N/A	N/A	6%	4%

The data show that most working age individuals with disabilities currently served by the public long-term care system in Wisconsin are unemployed or employed in non-integrated settings. More specifically, the majority of individuals with developmental disabilities, 82% in the waiver programs and 75% in Family Care, are not currently engaged in integrated employment. It is noteworthy, however, that access to integrated employment for individuals with developmental disabilities is stronger under Family Care, where 25% of clients with developmental disabilities are in integrated employment positions, than under the waivers where a smaller proportion, 18% are in integrated positions.

The experience for individuals with physical disabilities differs significantly. In all three community-based long-term care programs, participation in employment and particularly integrated employment is strikingly low: less than 9% of working age individuals with physical disabilities are employed in any setting and less than 6% are employed in integrated settings.

Employment Experiences Nationally

Wisconsin’s experience mirrors the national situation. National data (from the Institute for Community Inclusion at the University of Massachusetts-Boston) indicates that national participation in mainstream employment by working age adults with disabilities is roughly half of the level of participation among working age adults without disabilities. Average wages for working people with disabilities are about half the average wages for those without disabilities. In addition, more than four times as many men with disabilities live in poverty than men without disabilities, and over three times as many women with disabilities live in poverty than women without disabilities.

Nationally, the number of persons with developmental disabilities served by the long-term care system is rising. Between 1988 and 2004, the number grew 84% from 288,000 to 530,000. During the same period, participation in integrated employment services among people with developmental disabilities also grew by 88,000, but participation in facility-based employment and non-work services grew to a greater extent, increasing by 168,000. While on average, people in individualized integrated employment work fewer hours per week, their weekly wages are 325% higher than those working in facility-based employment.

In response to the low participation in employment, particularly integrated employment, a number of federal policy and legislative measures were initiated, designed to increase employment participation among people with disabilities. These measures include the New Freedom Initiative, the Social Security Administration's work incentives, the Ticket to Work and Work Incentives Improvement Act, the Workforce Investment Act, recent amendments to the Rehabilitation Act, a new focus on school to work transition in the Individuals with Disabilities Education Act, and the Americans with Disabilities Act. With the creation of Medicaid Infrastructure Grants, the federal Center for Medicaid Services is moving to increase integrated employment participation among people with disabilities with long-term care needs.

Challenges to Employment

Factors related to clients, program design, providers, employers, and other systems contribute to the low rates of employment in integrated settings for people with disabilities involved in the long-term care system.

Clients: Incomplete understanding of integrated employment opportunities and the interaction between employment and public benefits

When initially asked about employment as part of the functional eligibility screening process used for entry into the long-term care system, a high proportion of working age individuals who are unemployed, 67% of individuals with developmental disabilities and 79% of individuals with physical disabilities, stated they were not interested in working. (See Appendix B for complete data.) Based on more in-depth surveys funded by MIG and undertaken by two Partnership sites, plus other information from practitioners experienced in the long-term care system, two key factors drive this high level of initial disinterest. First, many clients and their family members have inaccurate or incomplete information about integrated employment alternatives and the services available to support them in these settings. Second, many people with disabilities believe they risk losing publicly-funded benefits, including SSI, SSDI and access to critical health services through Medicaid, if they become employed. The availability of the Medicaid Purchase Plan (MAPP), which allows people with disabilities to be employed and retain Medicaid eligibility, suggests this perception is not accurate in all cases. Social Security offers a range of work incentives for individuals receiving SSI and SSDI, but these options have been little used. For example, in December of 2004, of the 83,813 SSI recipients in Wisconsin, only 57 were using Plans for Achieving Self-Support (PASS Plans) and only 296 were using Impairment-Related Work Expense (IRWE), two available work incentive tools. [Source: SSI Disabled Recipients Who Work report, Social Security Administration, 2004]

Program Design: Waiver programs for people with physical disabilities do not include services to support employment

While the Community Integration Program (CIP waiver) serving adults with developmental disabilities includes vocational services, the Community Options Program (COP waiver) serving frail elders and adults with physical disabilities does not include vocational support within the set of covered services. As a result, clients and case workers in waiver programs for people with physical disabilities do not have experience in identifying and supporting employment options.

System Coordination: Transition from vocational rehabilitation and K-12 systems to employment supports provided by the long-term care system is not always seamless, and in non-Family Care areas, is not guaranteed

In many areas of the state the vocational rehabilitation, school system, and long-term care systems are not fully coordinated. Because waiver funding is insufficient without Family Care, those leaving the K-12 or vocational rehabilitation systems can not in all cases transition to the long-term care system, which makes them unable to access on a permanent basis the employment-related supports identified and/or initiated through the vocational and K-12 systems.

Providers: Limited current capacity to provide integrated employment services; expansion of capacity will require existing providers to restructure and new providers to be developed.

A recent nationwide survey of community rehabilitation providers reviewed by the Task Force found that on average, just 1.7% of staff time is allocated to integrated job development activities. As part of its own fact-finding efforts, the Task Force conducted a survey of vocational and day service providers and personal assistance providers to gather information on current and future provider capacity. The Task Force also reviewed a county-by-county analysis of the current network capacity of employment service providers, completed by outside consulting firm Virchow Krause under contract with the Department. (See Appendix C for the complete survey results and Virchow Krause reports.) While current capacity of service providers to support individuals in integrated employment settings is limited, all providers responding to the Task Force survey, including those currently offering non-integrated work opportunities, expressed interest in providing more integrated employment services if demand for these services increases, as expected under Family Care. Due to their expertise in working with individuals with disabilities, existing providers are a valuable potential resource for expanding employment-related capacity in Family Care sites. Current providers will need to expand or restructure their current business models to strengthen their focus upon and capacity for supporting people with disabilities in integrated settings. In addition, new providers of integrated employment services will be needed, as will strategies for effectively supporting them.

Related Service Providers: Lack of adequate transportation and other support services for integrated employment; need for all service providers involved with the client to support their employment participation and goals.

In many areas of the state, transportation options are not readily available or are poorly coordinated with the long-term care system. In areas of the state without Family Care, long-term support funding for transportation is often unavailable. Lack of existing transportation options,

or lack of funding to support long-term care recipients in accessing the available options, was cited as a major barrier for employment for people with disabilities in the DHFS Pathways to Independence regional listening sessions and in the survey of vocational and day service providers conducted by the Task Force. Additionally, residential support providers are not always being actively engaged in supporting clients to pursue and maintain employment, and without this support, it may be difficult for clients to be successful in employment.

Employers: Limited experience and expertise in employing people with disabilities.

Due to the limited participation of people with disabilities in the workforce, employers have relatively little experience in employing people with disabilities. Also, many employers are unaware of the positive business benefits resulting from employing people with disabilities. For example, a recent Gallup poll confirmed that employing people with disabilities is likely to result in increased market share for a business, as consumers with disabilities and others interested in supporting people with disabilities, shift their purchases to that business (Siperstein, et al., 2006).

Job Development: Limited types of employment being pursued; expansion of integrated employment needs to include expansion of the range of work opportunities pursued.

Job development, particularly for people with developmental disabilities, often involves placement of individuals in a limited range of jobs (e.g. food service, cleaning). It appears that assumptions are being made about what types of jobs people are capable of doing. Work opportunities that reflect a person's true interests and aspirations may be dismissed as unrealistic or unavailable. Job developers may have inadequate time, expertise or support from funding sources to develop work opportunities that go beyond the typical jobs people with disabilities fill presently.

Family Care Framework

Family Care provides a framework for addressing and overcoming the challenges just described. ADRCs serve as the entry point into the Family Care long-term care system and are welcoming places that provide information and assistance to clients and their families. Trained staff at the ADRCs explain the interaction between employment and public benefits, as well as the range of employment options at the outset of an individual's exploration of long-term care options.

Under Family Care, MCOs are responsible for developing and delivering individualized, person-centered care. Each Family Care client (member), in collaboration with the MCO's interdisciplinary care team, develops a care plan that reflects his or her preferences and needs, and that seeks to achieve the individual's goals. This outcome-based and collaborative approach provides the opportunity to explore available employment outcomes. Care plans can be developed to include a mix of employment and non-employment activities that reflect an individual's preferences. In addition, there are no caps or limitations imposed on employment-related or other services.

Family Care includes a more comprehensive set of services that include vocational services for all populations, transportation, and personal care services in the workplace, thereby overcoming

the limitations of the service coverage under the waivers. Family Care includes a stronger focus on coordination of the services and supports a client receives so that all involved collaborate to support the outcomes the client has identified. In addition, in Family Care clients can self-direct all or some of their services, which may be a useful and effective approach to support employment goals.

MCOs are responsible for developing provider capacity in all service areas and have the flexibility to structure their contracts and relationships with providers in creative ways to stimulate capacity expansion.

Because Family Care is an entitlement fully funded by the state, all individuals leaving the K-12 and vocational rehabilitation systems who meet the Family Care functional level of care can transition to coverage under Family Care, thus providing the opportunity to continue the employment planning and supports initiated in the other systems without disruption.

Because the rate-setting methodology used in Family Care reflects, on a lagged basis, actual expenditures of the MCOs, increased spending on employment-related services by MCOs (as well as changes in other service expenditures) are factored into the future rate provided to MCOs. In this way, efforts by MCOs to expand employment services are recognized and financially supported over time.

By creating a framework that eliminates many of the constraints of the system that existed prior to Family Care, the statewide expansion of Family Care provides an opportunity to strengthen employment outcomes for people with disabilities. In that context, the Task Force sought to identify best practices that could be used within Family Care to strengthen most effectively access to and choice of employment opportunities for people with disabilities.

Findings on Best Practices from Other States and Nationally

The Task Force heard presentations by national experts on best practices in the employment of people with developmental disabilities, physical disabilities and mental illness. The Task Force also heard presentations from five states and localities—Georgia, Oklahoma, Tennessee, Washington, and Denver, Colorado—that are undertaking targeted efforts to improve employment participation and outcomes for adults with disabilities.

Currently Family Care MCOs, like counties under the waiver programs, use “fee-for-service” approaches to purchase employment-related services and supports. That is, MCOs reimburse providers for services delivered, as opposed to paying for outcomes achieved. A fee for service method rewards the least effective providers who take the most time to develop and support jobs, and penalizes the most effective producers, who are able to more efficiently develop jobs and to phase-out paid job supports for the client through effective training and development of natural supports.

In contrast, several high-performing states and localities use a reimbursement system that pays for outcomes. The following specific payment strategies were identified in the following states/localities:

- Structuring reimbursement to pay for hours worked rather than hours of service (Oklahoma)
- Providing incentives or bonus payments for specified desirable outcomes, such as longevity of the job placement (Denver, Colorado)
- Purchasing service packages on a daily basis from providers, where a mix of services can be provided in any given day and higher daily rates are paid if the mix of services includes supporting an individual in integrated employment (Tennessee)
- Providing higher payments to providers with staff who have completed outcomes-based credentialed training (Denver, Colorado)
- Developing options to pay employers and co-workers for training, on-the-job supports and transportation (Oklahoma and Washington)

Other key best practices associated with increased integrated employment outcomes in other states include:

- Existence of a clear policy on employment, which emphasizes integrated employment as the preferred outcome for individuals with disabilities and is reflected in contract expectations that include clearly defined goals
- Allocation by the state long-term care agency of resources, including staff, dedicated to employment with clear accountability at all levels
- Investment in technical assistance to support organizational change among providers
- Making employment an integral part of individual service planning processes, making integrated employment the first day/vocational option discussed with individuals, and utilizing creative strategies to facilitate informed choice
- Consistent use of evidence-based practices by service providers
- Sustained investment in competency-based training and technical assistance focused on evidence-based practices, also use of strategies that reward service providers who maintain competent staff
- Identifying integrated employment outcomes as a critical indicator of quality, developing data systems to track employment outcomes and using data to establish and measure benchmarks for improvement of outcomes over time
- Effective collaboration, including interagency agreements and joint training initiatives with the public vocational rehabilitation agency
- Development of employment-related transportation systems and creative individualized solutions for providing transportation

The Role of Employment in Contributing to Positive Outcomes for Family Care Members and the Family Care System as a Whole

Recognizing that a lack of choice negatively affects an individual's quality of life, the long-term care system is committed to ensuring that clients have meaningful choices. While employment is an outcome that has intrinsic value, the Department desires other personal outcomes for Family Care participants that can be facilitated by participation in employment. Poverty greatly restricts choices about where and with whom one lives and how one spends the day, including the types of community activities one can pursue. People living in poverty may wish to engage in activities that most people take for granted, such as eating out, going to a movie, and taking

transportation to visit friends, but lack the financial resources to do so. Employment, particularly integrated employment, can counteract poverty and enable people to have real choices about where and with whom they live, and how they spend their leisure time. Employment and the income that comes with it contribute significantly to stability in housing, nutrition and other aspects of life.

Integrated employment can also expand people's relationships and support networks, combating the negative effects of isolation and offering ongoing opportunities to meet new people and develop meaningful relationships. Integrated employment also offers a way to become involved in the community and enhance one's status as a contributing member. Employment engenders respect from others and can increase a person's sense of self-worth.

Finally, employment can contribute positively to ensuring people have and maintain the best possible health. This not only benefits individuals, it can also benefit the Family Care system by reducing long-term health care costs. Research consistently demonstrates a relationship between employment status and health for all population groups, including individuals with disabilities. The relationship is bi-directional: good health can help facilitate employment and employment can help facilitate good health. In studies that compared individuals with similar characteristics, including health conditions and type of disability, employment was found to be related to better health and unemployment related to poorer health. In addition, employment has been shown to maintain and enhance health. Conversely, unemployment has been demonstrated to contribute to poor health, which in turn contributes to higher health care costs.

With regard to mental health, supported employment has been shown to contribute to recovery from mental illness. While the Family Care managed long-term care system does not serve individuals with a primary diagnosis of mental illness, an analysis completed by DHFS staff of the Family Care population indicates that 40-60% of participants have a co-occurring mental illness which must be treated. For this reason, strategies that improve mental health are relevant and applicable in Family Care.

Overall, prioritizing support for employment is consistent with prioritizing positive health outcomes in Family Care. At this time, it appears we may be underestimating the health-related benefits associated with employment and the health-related costs of *un*employment for individuals and the long-term care system. A full discussion on the literature demonstrating the relationship between employment and health, which was reviewed by the Task Force, can be found in Appendix D.

Development of the Policy Statement on Employment

Early in its process, the Task Force recognized the need to develop a policy statement that could guide its work. At the same time, the Task Force learned that best practices used consistently in other high-performing states include adoption of a state policy on employment for people with disabilities. The Task Force developed a policy statement following here that could both guide its work and be recommended to the Department as part of an overall strategy to improve employment outcomes while building on the values and goals of the Department and the Family Care initiative.

Policy Statement on Employment

The Managed Care and Employment Task Force shares the Department's goals for Wisconsin citizens with disabilities through community inclusion, maximizing the respect and dignity afforded people with disabilities by their fellow community members, and ensuring that citizens with disabilities have access to the same set of choices and opportunities available to citizens without disabilities.

In support of these goals, the Task Force seeks to promote opportunities for persons with disabilities to be involved and contributing members of their communities. As citizens, everyone is expected to contribute to the community in some way. Employment is one of the primary ways people contribute to the community as it provides

- The opportunity to earn income, to achieve greater stability and financial security, and to use that income to enrich one's life based on one's responsibilities, interests and preferences
- The opportunity to have meaningful and enjoyable social interactions and to develop relationships and friendships
- The opportunity to pursue activities that are enjoyable, stimulating, and provide one with a sense of purpose and a feeling of self-worth
- The opportunity to ensure the best possible health by counteracting the negative mental and physical health effects of unemployment and poverty
- The opportunity to reduce reliance on public benefits
- The opportunity to contribute to the economic well being of the community and state

Despite the many benefits associated with employment, individuals with disabilities have significantly higher unemployment rates than those without disabilities, and are three times more likely to live in poverty than those without disabilities. Unemployment and poverty are associated with increased mental and physical health problems. The pursuit of employment is hindered by a Social Security system that requires proof of inability to work in order to establish and maintain eligibility for income support benefits. Difficulty in meeting the Social Security criteria raises fear of benefit loss among many beneficiaries when return to work is contemplated or pursued. The reasons for the lack of participation in employment by individuals with disabilities are complex, but it is clear that the long-term care system has a critical role to play in supporting individuals with disabilities to consider, pursue, and maintain employment.

A principle goal of Wisconsin's managed care long-term care system is to give people more and better choices about the services and supports available to meet their needs. Given this, any policy regarding employment in managed care should vigorously safeguard individual informed choice while promoting more and better choices consistent with the Department's declared policy goals for individuals with disabilities. Therefore, the Task Force recommends and supports the following employment policy statement for the managed care long-term care system:

Among employment options, integrated employment offers people with disabilities the greatest access to full community inclusion and employment choices equal to those available to citizens without disabilities. Integrated employment at a competitive wage offers individuals a meaningful path toward economic security and the respect and dignity associated with employment that is enjoyed by working citizens without disabilities. Therefore, while always

*respecting individual, informed choice, because integrated employment provides access to the fullest range of employment choices and outcomes, better opportunities for community integration, and meaningful earnings for members, **the managed care long-term care system should support integrated employment as the preferred employment option.***

In support of this policy statement, the Task Force expects that the managed care long-term care system will

- Make work and career a primary, consistent, and on-going focus
- Presume that persons who express a desire to work are able to, and not presume that people who express no interest in work are not able to
- Provide everyone with the opportunity to regularly consider integrated employment as one of the ways they can choose to spend their time as a meaningful way to contribute to their community
- Explore with each individual the option of identifying integrated employment as a desired outcome, as part of comprehensive, person-centered, outcomes-based service planning
- Regularly offer, as part of outcomes and service planning, choices that can assist individuals participating in sheltered employment at less than minimum wage the opportunity to transition to integrated employment at a competitive wage
- Provide everyone with the information and assistance needed to make an informed choice about working. To this end, the variety of options for working will be explained as part of ensuring informed choice. Those who choose to pursue work shall be provided with the information and assistance they need to make an informed choice about what kind of work they wish to pursue and the services and/or supports they need to do this
- Provide outcomes-based service planning that takes advantage of the services, supports, and resources available through comprehensive coordination with other systems and programs
- Provide support from the long-term care system to pursue and obtain integrated work at a competitive wage, with the necessary accommodations, services, supports, and assistive technology
- Invest resources and effort in the development of the long-term care system's capacity to support everyone who chooses integrated work, and in the provision of a diverse and comprehensive range of services and supports for integrated employment which use evidence-based, best-practice approaches
- Increase the number of long-term care recipients who are supported in pursuing and maintaining integrated employment at a competitive wage

For the purposes of this policy, the following definitions apply:

Integrated employment refers to working for a competitive wage in a community-based job (i.e., a job that is not based in a community rehabilitation facility or residential long-term care institution for people with disabilities). The employment must be in a work setting where, to the extent the employment typically involves interaction with others, the interaction is predominantly with co-workers or business associates who do not have disabilities or with the general public. Integrated employment includes employment located in a community business, self-employment and ownership of a micro-enterprise.

Competitive wage means a payment for work that is generally equivalent to the payment made to others performing similar work. Competitive wage does not mean commensurate wage or special minimum wage (sub-minimum wage).

As evidenced by the policy language, and in response to its charge, the Task Force is recommending that the best way to expand work options for adults who rely on the community-based long-term care system is for the system to focus on expanding integrated work options. In developing the policy, the Task Force concluded that a preference for the Department's managed long-term care system to support a range of integrated employment choices is consistent with all of the core values, as noted on page 9, that the Department embraces for people with disabilities. This policy promotes community inclusion and offers people with disabilities access to the same set of employment opportunities that are available to citizens without disabilities. As well, Task Force members agreed that the range of choices available under the umbrella of integrated employment maximizes the respect and dignity afforded to persons with disabilities by their fellow community members.

The Task Force noted that the Department clarifies its commitment to consumer choice by declaring the specific goal of ensuring that "citizens with disabilities have access to the same set of choices and opportunities available to citizens without disabilities in our state." This commitment to consumer choice clearly reinforces the Department's equally held commitment to community inclusion.

The Task Force also recognized that moving away from segregated services to a system that offers people with disabilities the same set of residential choices and opportunities available to people without disabilities is a policy goal that the Department has pursued with deep commitment. Beyond realizing cost savings and ensuring adherence to recent legal precedents, the Department has enabled thousands of individuals with disabilities, who would not have chosen to leave segregated residential services, to realize significant improvements in quality of life and personal growth.

Research and experience demonstrates that such positive outcomes can also be achieved in employment, through an equivalent policy focus that involves moving away from segregated services to a system that offers people with disabilities the same set of employment choices and opportunities that are available to people without disabilities. It is the role of policymakers to advance policies and services that are expected to improve quality of life for those affected. Offering a full range of new choices is a critical part of positive systems change that results in improved quality of life for those being served.

The Task Force recognized that the current Family Care contract already expresses an expectation that Managed Care Organizations will authorize services in ways that "take into account *anticipated* long-term social and quality of life issues...including support for the least restrictive residential setting for the member." [Family Care Contract, Page 43; emphasis added] The contract goes on to say that "the Managed Care Organization **will** provide services in the most integrated level of residential setting consistent with the desired outcomes, preferences and identified needs of a participant." [Family Care Contract, Page 43; emphasis added] The Task Force concluded that it is now a natural progression of the Department's values and policies to apply such expectations to employment (and by extension day service) settings.

RECOMMENDATIONS

Introduction

Given that the long-term care system has a critical role to play in supporting individuals with disabilities to consider, pursue and maintain employment, the recommendations of the Managed Care and Employment Task Force have one primary goal: to ensure best practices for supporting and facilitating a broad range of positive employment choices and outcomes at all levels of the managed long-term care system. The recommendations are presented here in brief; a full description can be found in Appendix E, which includes the issue committee reports.

Medicaid Infrastructure Grant funding can be used to support those recommendations that require funding. It is recognized that there are many demands on all of the entities involved in the Family Care expansion and that the timing of implementation of these recommendations will need to be considered in the context of the overall demands of the Family Care expansion initiative.

In addition to making these recommendations, the Task Force strongly supports a number of features already incorporated in the Family Care program that facilitate integrated employment including:

- The inclusion of transportation services to support employment participation, particularly in integrated settings
- The flexibility to support a mix of employment and non-employment activities during an individual's day or week so the individual does not have to choose between integrated employment (often part-time) and supports needed for other activities
- The absence of policies that create caps on the number of hours of support or expenditures permitted for integrated employment.

Recommendation Area 1:

The Department should adopt a clear policy on employment for the managed long-term care system to guide all system partners in a common effort to achieve common goals.

1-A. The Department should adopt the ***Policy on Employment*** developed by this Task Force, communicate it to ADRCs and MCOs, and use it to guide the Department's expectations and relationships with ADRCs and MCOs. This includes incorporating the policy itself, or its intent and expectations, into the Department's contracts with ADRCs and MCOs. Consistent with this, DHS, through policy, contracting, quality assurance, and performance monitoring should convey to MCOs a clear expectation that

- Work and career will be one of the primary, on-going areas of focus that MCOs will maintain as part of meeting members' holistic needs
- Integrated employment is the preferred employment option because it provides access to the fullest range of employment choices, better opportunities for community integration, and meaningful earnings for members
- MCOs are expected to fully support members in their pursuit of integrated employment at a competitive wage, and by doing so, increase the number and percentage of long-term care recipients involved in integrated employment.

1-B. The policy on employment adopted by the Department should clearly define what employment outcomes/situations are considered integrated by the Department.

1-C. The Department should expect that members be as informed as possible before deciding if they want to work and before identifying specific employment preferences regarding services and supports. Where policy and contract references are made to member choice, the Department should clarify that the expectation is *informed* choice; and provide its definition. The Department should also provide guidance on the expectations of MCOs and their teams in supporting informed choice with regard to employment.

Recommendation Area 2:

In support of full implementation of the policy on employment by the managed long-term care system, MCOs should establish an internal organizational culture that values work and identifies supporting members to work as a core value and organizational best practice.

2-A. Each MCO should develop guidelines, consistent with the policy on employment, that clearly convey its philosophy, values, and expectations concerning employment outcomes and services to MCO staff, members, families and other natural supports, providers and partners (including ADRCs).

2-B. Employment should be a target area of focus for MCO performance improvement projects in CY2009-2011.

2-C. For services in the benefit package that are typically used to support employment, DHS and individual MCOs and their providers should review their respective policies in order to address any requirements that may discourage supported employment. MCOs may also want to ask their providers to review their internal policies and rules for the same purpose. MCO teams should have a formal method for reporting individual situations in which service policies or rules interfere with the team's ability to authorize the support service a member requires.

Recommendation Area 3:

In support of full implementation of the policy on employment by the managed long-term care system, the Department should offer strong support, technical assistance, and financial incentives to MCOs in order to increase employment outcomes for managed care members, and should ensure that certification of MCOs takes into account MCO capacity to support integrated employment outcomes.

3-A. DHS/DLTC leadership should offer sustained support to MCO leadership teams as they establish an internal organizational culture that values work and identifies supporting members to work as a best practice.

3-B. The Department should provide technical assistance by providing information on current best practices that MCOs can use in implementing the recommendations of this Task Force and the contractual obligations related to employment outcomes and services.

3-C. The Department should explore whether the current capitated rate system could be refined, using an actuarially sound approach, to incorporate MCO utilization adjustments for services, including employment-related services, with less lag time.

3-D. The Department should consider implementing an employment pay for performance initiative for Family Care MCOs, contingent on sufficient resources at the Department level to develop and support the initiative. Incentive payments would be tied to the achievement of integrated employment benchmarks set by the Department.

3-E. The Department should support pilots that, under the new (Social Security) *Ticket to Work and Self Sufficiency* program and in partnership with DVR whenever possible, combine MCOs and their Provider Networks as “Employment Networks” and thus make these managed long-term care entities eligible for federal outcome payments for achieving members’ integrated employment goals.

3-F. The certification process should be used as one means to evaluate an MCO’s capacity to support the integrated employment outcomes of its members. Ideally, the certification process should ensure that

- The comprehensive assessment identifies an individual’s personal goals and needed supports for employment
- The MCO service authorization policy includes guidelines on how care management teams should apply the policy in supporting a member’s employment, and that those guidelines do not create any disincentives to support a member’s desire to pursue integrated employment
- MCOs identify a source of expertise on employment options and services that will be available to their interdisciplinary teams, provider network developer, and quality assurance manager
- MCOs have an adequate number of providers of integrated employment services (e.g. supported employment, vocational futures planning, integrated prevocational services) and those providers are able (have a solid plan) to expand their capacity to meet demand, particularly from those coming off waiting lists
- At full implementation, MCOs have at least two qualified sources of vocational futures planning services identified. (The MCOs themselves could be a source for the service, if they provide the service in-house.)
- At full implementation, MCOs have options for prevocational services that are not limited to work centers/sheltered facilities

Recommendation Area 4:

In order to blend all resources available for individuals wishing to pursue employment, the Department and MCOs should strengthen coordination with system partners, including the school system, vocational rehabilitation system, and the workforce “One-Stop” system.

4-A. Current efforts should continue to fully implement the collaborative activities related to the 2007 Interagency Agreement on youth transition (partners in the agreement are DVR, the Department of Public Instruction (DPI) and DHS/DLTC/Division of Mental Health and Substance Abuse Services (DMHSAS). The Department’s policy on employment and its commitment to having ADRCs target outreach to students in transition should be added to the existing interagency agreement on transition.

4-B. The Department, DVR, and DPI should coordinate their efforts to promote joint staff trainings specific to integrated employment for the agencies' common customers in order to blend service, funding, and high quality service delivery.

4-C. The Department, DVR and the Department of Workforce Development's Division of Education and Training (DET) should work collaboratively to develop and implement an interagency agreement (modeled after the existing interagency agreement on youth transition) for **adults** seeking integrated employment and eligible for services from these agencies. In part, the agreement should identify multiple strategies for blending funding at the state agency level to streamline the negotiations regarding specific individuals. The agreement should also specify the resources, including staff, that will be contributed by each partner.

4-D. The Department, DVR and DET should coordinate activities to provide MCO staff, DVR counselors, Disability Navigators, and DET Employer Services Teams with information, training, and/or technical assistance on their respective programs and services, and on how the various services available through DVR, DET and the managed long-term care benefit package can be coordinated to provide the short and long-term support individuals with disabilities need for integrated employment.

4-E. The Department should request that DVR and MCOs appoint liaisons to: (1) coordinate employment services and planning with their common consumers at the local level; and (2) partner with ADRCs in coordinating outreach efforts to schools, transition-age students with disabilities and their families. MCO and DVR staff should coordinate their employment services activities with "One Stop" Job Center partners and any locally coordinated employment services that exist within that Workforce Development area.

4-F. Where members are receiving services from both VR and the MCO, it is important that ongoing communication takes place between their teams in order to coordinate efforts. As part of this commitment to coordination, the teams should ensure that the managed care member-centered plan (MCP) employment outcome and the vocational rehabilitation individual plan for employment (IPE) support and service goals are consistent and coordinated. The MCO and VR teams should also ensure that there is a common understanding of the role of each agency (including where the responsibilities of each agency start and stop) in assisting the individual.

4-G. Given that the Center for Medicaid and Medicare Services requires that vocational services under the waivers (e.g. prevocational, supported employment, and vocational futures planning services) be provided only when they are not available through the vocational rehabilitation or special education systems, the Department and MCOs should collaborate to develop guidelines for teams to ensure that members who are eligible for services from the other systems are encouraged and supported by their MCO team to access and navigate those systems, and that all of the member's employment-related needs are met in a satisfactory way.

4-H. The Department should collaborate with DVR on policy guidance for DVR counselors and MCO care management teams in order to ensure DVR services to secure integrated employment continue to be available to individuals in work centers/sheltered facilities or in group employment (e.g. enclaves and work crews) and to individuals receiving day services who express an interest in competitive, integrated employment. The policy guidelines should be covered in the information, training, and technical assistance efforts.

4-I. The Department should collaborate with DVR to train CMO staff and to update DVR counselors on DVR's procedures to determine when DVR concludes services for individuals in supported employment. The DVR guidance should identify criteria to be used in determining when an individual's employment goal has been met and what amount of extended support the CMO will provide to a particular individual.

Recommendation Area 5:

In order to ensure all MCO members have a range of employment choices equal to those available to citizens without disabilities, targeted efforts should be undertaken to increase the pool of Wisconsin employers hiring qualified applicants with disabilities to fill existing or customized positions.

5-A. The Department should join with relevant state-level partners, including DWD, to provide interested employers with a single point of contact in seeking qualified applicants with disabilities. As part of these efforts, state agencies should consider whether and how this single point of contact might be created and sustained on a statewide, regional or local basis to offer customized assistance, which ideally should include (1) someone coordinating and communicating to employers the details of what and who is available from each of the different agencies and resources, and (2) someone assisting the employer to recruit candidates (consumers) as well as to support them once employed (e.g. setting up a job coach to assist with orientation to the workplace, training, etc.; identifying reasonable accommodations and sources of support available to help cover the cost, if substantial).

5-B. The Department should join with relevant state-level partners, including its state partner with primary responsibility for employment, to collaborate on raising awareness of existing state-level efforts, where necessary developing new efforts, and encouraging MCOs and local partners to

- Educate employers on the business benefits of hiring people with disabilities and the untapped labor pool represented by people with disabilities in our state. As part of these efforts, specifically, (1) engage Chambers of Commerce to ensure their member benefit includes this education, and (2) offer this education through Society of Human Resource Managers (SHRM) chapters. Consideration should also be given to the possibility of undertaking a statewide marketing initiative aimed at raising business/employer awareness of people with disabilities as a labor pool and how employing people with disabilities can help businesses capture greater market share.
- Support an initiative to encourage business leaders/owners and other employers to develop their own message about the value of employing people with disabilities
- Encourage government units, MCOs, ADRCs and service providers to expand employment opportunities within their organizations for people with disabilities
- Engage with union organizations and employers with unionized workplaces to develop strategies to remove obstacles to employment of people with disabilities in unionized workplaces. Strategies might include the development of memorandums of understanding (MOUs) to allow more flexibility for unionized businesses to hire and retain people with disabilities in customized positions.
- Engage with corporations to address corporate-wide policies that may inadvertently limit employment opportunities for individuals with disabilities.

5-C. The Department should engage with state-level partners, including the Departments of Revenue and Workforce Development, to consider the option of implementing a state work opportunity tax credit, modeled after the federal tax credit, but offering tiered credit amounts to encourage the hiring of individuals with more substantial disabilities. Higher credits should be available to employers who hire people with more significant levels of disability (e.g. category one under Division of Vocational Rehabilitation guidelines). The amount of the credit could also be tied to the hours offered to a new hire with a disability, where the larger the number of hours employed, the larger the employer's credit.

5-D. The Department should engage with state-level partners on expanding and improving publicity of state agency efforts to recognize publicly Wisconsin employers for their commitment to hiring individuals with significant disabilities and on how to encourage similar efforts at the local level.

Recommendation Area 6:

In order to enhance and ensure the best quality employment outcomes for managed care members, the Department should establish processes to monitor outcomes and stimulate continuous quality improvement.

6-A. To reflect the importance the Department places on meaningful work opportunities for managed care members, the Department should ensure that annual contracts with MCOs

- Include employment as an MCO quality indicator. (Quality indicators are listed in Appendix V of the CY 2008 contract.)
- Concerning all MCO quality indicators, establish minimum levels of performance regarding employment, particularly integrated employment, among MCO members
- List annual progress goals related to employment, and how MCO performance will be measured and evaluated
- Clearly state that quality assurance and quality improvement (QA/QI) activities conducted by the MCOs should in part address member employment outcomes
- Require MCOs to submit employment-related data specified in the contract, using standard measurements also specified, to enable DHFS to measure each MCO's performance on employment

6-B. In order to ensure consistent, high quality employment for managed care members, the Department should re-establish employment as a separate personal experience outcome used to measure and evaluate quality in the managed long-term care system. [The personal experience outcome that currently includes employment—*I do things that are important to me*—should be maintained.] Until full implementation of this recommendation, the current efforts to measure MCO performance by its progress in supporting members to achieve their personally identified employment outcomes through the PEONIES (Personal Experience Outcome Integrated Interview & Evaluation System) process should be continued.

Recommendation Area 7:

In order to effectively measure progress of employment outcomes and participation, the Department should work with MCOs and providers to develop data systems that track employment data and to publish an annual report of employment outcomes at the MCO and system levels.

7-A. For the purposes of tracking employment participation among managed care members, employment should be defined as any activity in which an individual is compensated for that activity, at least in part, through a monetary payment. This is intended to include self-employment and micro-enterprise, which typically involve selling goods an individual produces (e.g. art, crafts, jewelry, etc.) or selling services on an individual basis.

7-B. The Department should annually measure individual MCO employment performance by using the Functional Screen or other data sources and tracking the following:

- Wages earned by members who are employed
- Hours worked by members who are employed
- Number of months, in the last 12, in which each employed member worked
- Type of employment for each (from limited, pre-established list of categories)
- Number of employed members who report their employment matches their preferences and abilities
- The number and percentage of MCO members who
 - a. Have an employment outcome/goal included in their member-centered plan
 - b. Have services/supports for employment included in their individual service plans
 - c. Have, in the last 12 months, used DVR services
 - d. Are receiving prevocational services in integrated settings, of the total number and percentage receiving prevocational services
 - e. Have, in the last 12 months, partially or fully transitioned from prevocational services to integrated employment at minimum wage or higher

It is recommended that the Department begin measuring MCO and system-wide performance using these criteria and establish appropriate progress goals for MCOs and the system as a whole in relation to (1) working age members, and (2) all members. Data systems should be developed, integrated, and modified to enable collection and reporting of this data.

7-C. The Department should establish a standard unit definition for reporting services so that employment data is reported consistently by all MCOs. The Department should require that all units of service provided to members be reported, not just face-to-face units.

7-D. To accurately track trends in the usage of **prevocational services**, the provision of prevocational services should be reported using the following categories:

- 108.10: Facility-based work (sheltered workshop)
- 108.20 Community-based work (enclave or work crew)
- 108.30 Community-based training (not involving paid work)

The Department should establish clear definitions for each of these categories consistent with the definitions used for employment settings in the Functional Screen. Also, similar sub-categories should be considered for supported employment and vocational futures planning services.

7-E. A consistent approach to tracking employment outcomes and data should be used for both managed care and the self-directed services waiver.

7-F. The Department and DVR should collaborate on the development of employment data tracking systems to integrate data, reconcile different definitions used in collecting data, and allow the two agencies to jointly track outcomes and performance of common customers.

7-G. The Department should review and analyze employment-related data, and produce an annual report on system and individual MCO progress and performance with regard to performance indicators and goals established by the Department.

Recommendation Area 8:

To facilitate the expanded provision of employment services and supports to MCO members, the Department and MCOs should undertake efforts specifically designed to evaluate accurately and improve the cost-effectiveness of employment supports and services.

8-A. The Department should develop methods for evaluating at the system level the value, cost-effectiveness and cost-benefit of providing long-term support services for integrated employment, and for comparing the cost-effectiveness and cost-benefit of integrated employment with other day and employment service alternatives. While this type of analysis of the fiscal costs and benefits is informative and useful, it is important to bear in mind that integrated employment also provides many non-fiscal benefits, particularly by enhancing an individual's quality of life.

8-B. Providers should be supported in developing cost-effective models for shared job supports, which can allow access to community employment for more individuals.

Recommendation Area 9:

As individuals enter the long-term care system, ADRCs should provide information and assistance regarding opportunities to work and the full range of employment opportunities that can be supported through the long term care system.

9-A. ADRC staff who provide information and assistance or options counseling should know the range of work opportunities available to individuals with disabilities, the potential benefits associated with working, and the range of supports and services available to support work. This can be achieved through training or other mechanisms.

9-B. The K-12 school system should be knowledgeable about the range of employment options available to students when they leave school. ADRCs should collaborate with the DVR and DPI to develop a plan and identify appropriate methods for undertaking coordinated outreach to secondary school personnel, transition-age students, and parents in order to ensure that prior to establishing a student's post-secondary employment goal, those involved in transition planning know the services available from the vocational rehabilitation and long-term care systems that can support integrated employment, and how and when both systems can be accessed.

9-C. To help students with disabilities transfer from school to work, ADRCs could help the school system explore ways to bring integrated employment providers into the transition planning process prior to the IEP transition team establishing a post-secondary employment goal in order to assist students and their families in fully understanding the option of integrated employment, and how it can be supported by the long-term care system.

9-D. ADRCs should pursue practices that promote local collaboration with Job Centers, including consideration of the possible advantages of co-location.

9-E. ADRCs should provide information and assistance to individuals with disabilities who are not involved with DVR, no longer enrolled in secondary education, and who need to obtain disability documentation to access services and accommodations in pursuing post-secondary education or employment.

Recommendation Area 10:

Because the Long-Term Care Functional Screen, initially administered by ADRCs and updated annually by MCOs, is the first managed care interview tool that raises the topic of employment, the employment section of the screen should be revised to capture more specific information about each person's employment preferences, status, and support needs.

Note: For more detail regarding these recommendations, please see Appendix E for the final report of Issue Committee #1, which includes all of the recommendations related to the Long-Term Care Functional Screen.

10-A. The employment section of the Long-Term Care Functional Screen, along with the instructions and training for screeners related to this section, should be modified in ways that will ensure maximum validity and reliability for the information being collected.

10-B. Those being screened should know that their answers regarding employment interest and status will not impact their eligibility for long-term care.

10-C. If an individual indicates a lack of interest in employment or new/different/more employment, the primary reason for the lack of interest should be recorded by the screener.

Recommendation Area 11:

As individuals consider the possibilities around employment, benefit specialists should be available to provide accurate, timely and easy-to-understand information on the interaction of benefits eligibility and employment, including work incentives that allow individuals to work while maintaining eligibility for Social Security, Medicaid, and long-term care services.

11-A. Disability Benefit Specialists must have knowledge of Social Security work incentives, and how they and consumers can access Work Incentives Benefit Specialists for expert information regarding work incentives in the Social Security and Medicaid programs.

11-B. The Wisconsin Disability Benefits Network (WDBN), currently in the initial year of a four-year agreement with DHS, should carry out statewide outreach to inform those interested in the availability and value of work incentive benefits counseling.

11-C. As a pilot(s), Work Incentives Benefit Specialists should be placed in one or more ADRCs to determine if this approach improves employment outcomes for individuals in the long-term care system.

11-D. DHS should encourage other state agencies to purchase work incentive benefits counseling services only from credentialed practitioners (when credentialing is available).

Recommendation Area 12:

As individuals consider employment possibilities, they should be fully informed about the Medical Assistance Purchase Plan (MAPP). To increase the use of MAPP to facilitate employment among those enrolled in or eligible for Medicaid, the state should make specific program changes that will eliminate disincentives to work that currently exist in MAPP.

12-A. The Department should conduct public outreach to people not working or enrolled but likely to benefit from MAPP participation and employment, and to MAPP participants to ensure their understanding of MAPP and other work incentive programs.

12-B. When DHFS sends consumers notification of eligibility for the Medicaid Purchase Plan, new participants should be encouraged to seek work incentive benefits counseling; information should be provided that directs them to the nearest counseling resource.

12-C. The income limits for participants in MAPP should be raised.

12-D. The MAPP premium formula should be changed to eliminate the impact of a participant's monthly disability/retirement cash benefit payment on the monthly premium amount.

12-E. A means should be created for people participating in MAPP to retain their accumulated employment-based assets at retirement without losing Medicaid eligibility.

12-F. The "marriage penalty" for MAPP participants should be eliminated by excluding a spouse's income for purposes of MAPP eligibility determination.

12-G. Under the authority of the Deficit Reduction Act (DRA), the Department should create an array of integrated employment services for MAPP participants that may be funded through Medicaid. The clearest example is work incentive benefits counseling.

Recommendation Area 13:

When individuals join MCOs, they should have inter-disciplinary team staff knowledgeable about the broad range of employment options that exist, and the services available through managed care and other systems that can support individuals to pursue employment.

13-A. The knowledge and skills that teams need to effectively address employment with members should be included in the core competencies that are established by MCOs. MCOs should develop ways to ensure that core competencies related to employment are maintained.

13-B. MCO care managers should understand the best practices related to providing integrated employment services so they can effectively identify, arrange, coordinate and monitor the services necessary to assist members.

13-C. MCO staff should have employment expertise, including but not limited to Work Incentives Benefit Counseling, available to them either through an MCO position dedicated to employment or through other best practice models (e.g. use of peer mentors, consultants, etc.). Any Medicaid-eligible increased expenditure by an MCO for employment expertise will be reflected, with a two-year lag, in the capitation rate for that MCO.

Recommendation Area 14:

Individuals should be engaged in an assessment and care planning process that effectively addresses employment and in doing so, promotes and facilitates informed choice.

14-A. DHS currently reviews and approves each MCO's assessment process. As part of the review, DHS should ensure that this process effectively addresses employment outcome. DHS staff should be available for technical assistance and advice to MCOs, if requested.

14-B. The role of the MCO interdisciplinary team related to employment should be consistent with expectations included in the case management service definition and consistent with what is expected of teams in addressing other outcome areas; they should ensure that employment is given the same consideration as all other outcome areas.

14-C. The Department should re-establish employment as a personal experience outcome area used to guide member-centered planning in the managed long-term care system. [The personal experience outcome that currently includes employment—*I do things that are important to me*—should be maintained, but employment should be separated from this.] Until full implementation of this recommendation, the current Department efforts to integrate employment into the PEONIES interviewing process should be continued.

14-D. The choice of integrated employment should be clearly explained so that each person can make an *informed* choice about whether to pursue it. As a way of providing information to Family Care clients, MCOs should consider using integrated employment service providers as resource experts when MCO teams are assisting individuals with disabilities in considering integrated employment. MCO teams should also consider providing opportunities for individuals to visit job sites, do informational interviews with potential employers, do job shadowing, and complete work experiences if such opportunities can help facilitate informed choice.

14-E. The Department should support integrated employment service providers in the development of educational materials that explain the option of integrated employment to consumers, families, ADRC staff, MCO interdisciplinary teams, and school staff involved in transition, thereby contributing to informed choice.

14-F. The opportunity to choose to pursue employment (and for those employed, the opportunity to pursue more employment, a job change, a partial or full move to integrated employment, or career advancement) should be offered to members as part of every member-centered plan development or review meeting, which generally occurs twice a year, in order to ensure that members know that they can identify employment as a goal or area for further exploration.

14-G. When an outcome reflecting an individual member's desire to explore or pursue employment is identified in the member's plan, details regarding the particular employment goal

(type of work, hours, employer preferences, etc.) should be developed, included in the plan, and conveyed to the service provider(s) who will assist the member with achieving his or her goal.

14-H. MCOs typically use the Department's Resource Allocation Decision (RAD) method as their service authorization process. To strengthen RAD's effectiveness in employment, the Department, in collaboration with MCOs, should develop guidelines on the appropriate use of the RAD in determining the best and most cost-effective way to meet a member's employment goal. DHS could integrate these guidelines into the RAD trainings for MCOs and their teams so that the RAD's specific application to employment outcomes is fully understood. Any guidelines developed by an individual MCO for using the RAD in relation to member employment outcomes should be consistent with the guidelines developed by DHS. The guidelines should include examples of best practices and creative approaches MCOs have used in applying the RAD method to members' employment outcomes.

Recommendation Area 15:

When managed care members need long-term care services to support their employment goals, the Department should ensure that MCOs have services in the benefit package that: are updated to reflect and advance the Department's values; encourage use of current best practices; and allow for a broad range of service models that can support a wide range of employment options.

15-A. The definition of **supported employment** services in the Family Care benefit should be revised to reflect best practices, including but not limited to support of self-employment or micro-enterprise, customized job development, facilitation of natural supports in the workplace, and on-the-job training.

15-B. The definition of **vocational futures planning** services in the Family Care benefit should be revised to reflect current best practices and to increase flexibility in using the service.

15-C. The Department should update the service definition of **prevocational services** to reflect the definition and standards used in the Community Integration Program (CIP) and to further encourage best practices, including the provision of services that offer people the chance to learn skills directly related to achieving their individually identified employment goals. Prevocational services should enhance what is currently available through DVR, and should not be based on a readiness model. For prevocational service providers that offer paid work opportunities incidental to the delivery of prevocational services, the following standards should be incorporated into the service definition:

- Adopting a downtime policy
- Adopting OSHA health and safety standards
- Adopting minimum staffing ratios
- Prohibiting unpaid contract work or engaging in training that involves doing unpaid contract work

15-D. Policy governing employment services should clarify that a Family Care enrollee can be referred to DVR or to MCO-funded supported employment services without prior participation in **prevocational services**.

15-E. The Department should consider developing rigorous criteria that would apply for new admissions to **prevocational services** in work centers/sheltered workshops while honoring individual informed choice.

Recommendation Area 16:

When managed care members need long-term care services to support their employment goals, MCOs should contract with employment service providers in ways that encourage and reward positive employment outcomes.

16-A. MCOs should define a set of quality indicators for the employment outcomes and services they seek to encourage. These quality indicators should be used in contracting with employment service providers and in measuring and rewarding their performance.

16-B. MCO provider network developers should encourage approved providers of employment services to apply to become approved VR vendors. This will offer one way to ensure continuity of service for MCO members who use VR and managed care services.

16-C. MCOs should be encouraged and assisted to develop, pilot, and ultimately implement contracting and purchasing strategies that

- Pay for outcomes (e.g. member hours worked) rather than service hours, in order to reward providers for producing high quality employment outcomes
- Ensure employment services, including integrated employment services, are available to individuals of all acuity levels, and if necessary, use tiered outcome payment rates that reflect level of disability and barriers to employment for the individuals being served
- Reward providers for maintaining competent staff
- Encourage consideration of paying employers and co-workers to provide the supports an individual needs to learn and maintain an integrated job
- Ensure consumers have more choices on how they can participate in integrated employment, and to this end, consider rewarding providers when individuals receive a mix of services in a given day or week that includes integrated employment

16-D. If payment based on service hours continues, MCOs should consider a provision in their provider contracts that allows payment not only for face-to-face service delivery time, but also the non face-to-face time spent by the provider to support the client. Allowing billing for all hours of direct service, whether face-to-face or not, will ensure that hourly service rates for integrated employment are comparable to rates for other day/vocational services.

16-E. MCO provider contracting requirements should include an expectation that providers submit outcome-related data to the MCO at specified intervals (e.g. twice per year) for the individuals being served. Outcome-related data should minimally include hours worked, wages earned, and hours of support provided for the reporting period determined by the MCO.

16-F. MCOs should identify a method for monitoring employment service provider contracts, measuring overall employment service provider performance, and regularly engaging in discussions with these providers regarding their performance.

Recommendation Area 17:

In order to ensure all MCO members have a range of employment choices equal to those available to citizens without disabilities and are able to pursue their individualized employment goals, service providers should be helped to expand and improve their capacity to develop and support high quality integrated employment outcomes.

17-A. Existing providers who currently offer a mix of employment and day services, and who wish to develop or expand their organizational commitment to provide integrated employment services, should be provided support and technical assistance to: (1) engage the organization's leadership (board and management) in considering a stronger focus on integrated employment, (2) successfully blend all funding sources available to support integrated employment services, (3) identify strategies for reallocating existing organizational resources to support expanded integrated employment services, (4) rebalance their services in favor of integrated employment, and (5) develop effective models that can be adopted by other providers.

17-B. New or existing integrated employment service providers wishing to expand their service capacity should be supported to (1) implement the most promising, evidence-based practices to create and sustain integrated employment opportunities for individuals with disabilities, and (2) overcome the most difficult obstacles they identify in increasing integrated employment opportunities.

17-C. All employment service providers should be encouraged to develop partnerships with their local One-Stop Job Centers and to ensure that the individuals they serve are accessing the centers' available services.

17-D. The Department should provide clarification and guidance in industry meetings and other settings to providers of personal assistance and personal care services, explaining that under Family Care, managed care organizations are able to authorize and purchase personal assistance services for the workplace to support managed care members.

17-E. The Department should provide technical assistance to service providers who wish to begin providing personal assistance services in integrated workplaces for managed care participants. The technical assistance should include sample operational policies, financial and budgeting tools, staff recruitment and training information, etc.

17-F. Providers should have access to high-quality, affordable training that can contribute to developing and maintaining the core competencies of their staff. A statewide core training program, which can help ensure a minimum set of core competencies among provider staff, is a cost-effective way to ensure consistent access to high-quality, up-to-date training that will give Wisconsin's providers access to best practices, including evidence- and values-based practice. The training offered through this statewide program should address the training needs of agency leadership and program managers as well as direct service staff. These efforts should be coordinated with all other training efforts recommended by the Task Force to ensure a system-wide, comprehensive, and cost-effective approach to employment training.

17-G. The Department of Health and Family Services (DHS), through its Division of Long-Term Care (DLTC) and the Department of Workforce Development (DWD), and the DVR should partner on an on-going collaborative initiative to encourage its common set of providers/vendors

to maintain staff who are knowledgeable of, and able to implement, the best and most innovative practices related to the provision of employment services and supports. As part of this effort, DHS/DLTC and DWD/DVR should collaborate to develop, maintain and regularly update an evidence-based, state-wide training curriculum for supported employment service providers.

Conclusion

People with disabilities, like all people, have aspirations and goals. Meaningful involvement in community life, including the opportunity to contribute one's talents and skills in ways that benefit one's self and one's community, is often part of these aspirations and goals. So too are financial stability and security.

However, people with significant disabilities face many barriers to full community participation. For citizens with long-term care needs, Wisconsin's innovative Family Care program offers an effective means of reducing these barriers to participating in the life of the community and maintaining maximal physical and mental health.

The Managed Care and Employment Task Force was assembled to advise the Division of Long Term Care on a comprehensive strategy to strengthen employment options for members of Family Care. During its process, Task Force members learned from the experiences of other states and identified promising best practice models for expanding and improving integrated employment outcomes within a managed care environment. Utilizing this learning and the expertise of its members, the Task Force developed a comprehensive set of recommendations. Implementation can be supported with Wisconsin's Medicaid Infrastructure Grant, "Pathways to Independence."

Guided by principles embodied in Family Care itself, and by its existing framework and structures, the Task Force crafted recommendations that address seventeen issue areas. The scope of these recommendations is substantial, addressing a very complex and challenging issue. Underlying all of the recommendations is the "Policy Statement on Employment," developed by the Task Force through consensus after considerable discussion and thought. This policy statement was crafted to express, in the context of employment, the values of the Department, and in turn, Family Care.

The Task Force wishes to thank Sinikka Santala for the opportunity to come together to address the issue of employment so thoroughly and to submit the recommendations contained in this report to the Department for consideration.

"I long to accomplish great and noble tasks, but it is my chief duty to accomplish humble tasks as though they were great and noble. The world is moved along, not only by the mighty shoves of its heroes, but by the aggregate tiny pushes of each honest worker."

-Helen Keller



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All members confirmed as of 5-14-07.

Managed Care and Employment Task Force

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Managed Care and Employment Task Force:

Recent Data on the Employment and
Interest in Employment of People with
Disabilities within Family Care and
other Community-Based Programs



Wisconsin Department of Health and Family
Services/Division of Long-Term Care

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Employment Excerpt from Adult LTC Functional Screen

EMPLOYMENT: The ability to function at a job site. This question concerns the need for employment-related assistance. Since the need for help with ADLs and IADLs is captured in other sections, this question essentially covers job coach duties.

<p>A. CURRENT EMPLOYMENT STATUS & INTEREST</p>	<p><input type="checkbox"/> 1 Retired <input type="checkbox"/> 2 Not employed <input type="checkbox"/> 3 Employed full time <input type="checkbox"/> 4 Employed part-time</p>	<p>Check one of the two boxes below (required): <input type="checkbox"/> I -- Interested in new job <input type="checkbox"/> N --Not interested in new job</p>
<p>B. IF EMPLOYED, WHERE</p>	<p><input type="checkbox"/> 1 Attends pre-vocational day activity/work activity program <input type="checkbox"/> 2 Attends sheltered workshop <input type="checkbox"/> 3 Has a paid job in the community <input type="checkbox"/> 4 Works at home</p>	
<p>C. NEED FOR ASSISTANCE TO WORK (Optional for unemployed persons)</p>	<p><input type="checkbox"/> 0 Independent (with assistive devices if uses them) <input type="checkbox"/> 1 Needs help weekly or less (e.g., if problems arise) <input type="checkbox"/> 2 Needs help every day but does not need the continuous presence of another person <input type="checkbox"/> 3 Needs the continuous presence of another person</p>	

Instructions for Filling Out Employment Excerpt from Adult LTC Functional Screen

4.14 Employment

- The ability to function at a job site. This question concerns the need for employment-related assistance. Since the need for help with ADLs and IADLs is captured in other sections, this question essentially covers job coach duties.

EMPLOYMENT RATING SYSTEM

A. Current Employment Status & Interest:

- A1: Retired
- A2: Not employed
- A3: Employed full time
- A4: Employed part-time
- I: Interested in new/different job
- N: Not interested in new job

B. If Employed, Where:

- B1: Attends pre-vocational day activity/work activity program
- B2: Attends sheltered workshop
- B3: Has a paid job in the community
- B4: Works at home

C. Need for Assistance to Work:

- C0: Independent (with assistive devices if uses them)
- C1: Needs help weekly or less (e.g., if problems arise)
- C2: Needs help every day but does not need the continuous presence of another person
- C3: Needs the continuous presence of another person

What number and percentage of clients aged 18-64 in Family Care and other community-based programs are employed?

2006	Family Care		Waiver		PACE-Partnership*	
	Number	Percent	Number	Percent	Number	Percent
Employed	921	27.5%	7709	46.9%	65	5.9%
Not Employed	2425	72.5%	8719	53.1%	1035	94.1%
Total	3346		16,428		1100	

Notes:

1. "Employed" includes community employment, home-based employment, pre vocational work, and sheltered workshops.
2. *PACE-Partnership Members primarily have physical disabilities, as compared to Family Care Members and Waiver Clients some of whom also have physical disabilities, while others have developmental disabilities
3. Data includes all Family Care Members (except Milwaukee), PACE-Partnership Members, and Waiver Clients with disabilities who were 18-64
4. Family Care and PACE-Partnerships and were obtained from the Long-Term Care Functional Screen

What is the employment status of individuals by target group?

2006	Family Care				Waiver				PACE-Partnership			
	Developmental Disabilities		Physical Disabilities		Developmental Disabilities		Physical Disabilities		Developmental Disabilities		Physical Disabilities	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Employed	778	52.3%	143	7.7%	7315	65.5%	394	7.5%	65	5.9%	1035	94.1%
Not Employed	709	47.7%	1716	92.3%	3851	34.5%	4868	92.5%	1035	94.1%	1100	94.1%
Total	1487		1859		11,166		5262		1100		1100	

Note: PACE-Partnership data heavily influenced by Milwaukee Partnership data as illustrated below...

* Without Milwaukee about 7.4% PACE-Partnership Members Employed

2006	Non-Milwaukee		Milwaukee		Total	
	Number	Percent	Number	Percent	Number	Percent
Employed	62	7.4%	3	1.2%	65	5.9%
Not Employed	781	92.6%	244	98.8%	1035	94.1%
Total	843		247		1100	

Notes:

1. "Employed" includes community employment, home-based employment, pre vocational work, and sheltered workshops.
2. Data includes all Family Care Members (except Milwaukee), PACE-Partnership Members, and Waiver Clients with disabilities who were 18-64
3. Family Care and PACE-Partnership data obtained from the Long-Term Care Functional Screen
4. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses

How has the aggregate employment status changed from 2003 to 2006?

	Family Care Developmental Disabilities		Family Care Physical Disabilities		PACE-Partnership Physical Disabilities	
	Number	Percent	Number	Percent	Number	Percent
2003 Employed	651	60.7%	99	10.8%	50	9.2%
2003 Not Employed	422	39.3%	821	89.2%	493	90.8%
2003 Total	1073		920		543	
2004 Employed	704	59.6%	117	11.3%	60	9.8%
2004 Not Employed	478	40.4%	919	88.7%	551	90.2%
2004 Total	1182		1036		611	
2005 Employed	760	55.1%	133	7.2%		
2005 Not Employed	620	44.9%	1702	92.8%		
2005 Total	1380		1835			
2006 Employed	778	52.3%	143	7.7%	62	7.4%
2006 Not Employed	709	47.7%	1716	92.3%	781	92.6%
2006 Total	1487		1859		843	

Notes:

1. "Employed" includes community employment, home-based employment, pre vocational work, and sheltered workshops.
2. Data includes all Family Care Members (except Milwaukee) and PACE-Partnership Members (except Milwaukee) with disabilities who were 18-64
3. Family Care and PACE-Partnership data obtained from the Long-Term Care Functional Screen

Types of Employment for Clients in Family Care and Waivers

2006	Family Care		Waiver	
	Number	Percent of Employed	Number	Percent of Employed
PreVocational/ Sheltered Wksp	514	55.8%	6162	80.0%
Community	456	49.5%	2206	28.6%
From Home	23	2.5%	89	1.2%
Total Employed	921	13.6%	7709	13.4%
Total Clients Served	3346	0.7%	16,428	0.5%

Notes:

1. Data includes all Family Care Members (except Milwaukee) and Waiver Clients with disabilities who were 18-64
2. Family Care data obtained from the Long-Term Care Functional Screen
3. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses
4. Duplicated counts for prevocational/sheltered wksp, community, and from home: If member/client was in more than one type of employment, then the individual would be included in the counts for each type of employment he/she was in.
5. Total counts are unduplicated.

Types of Employment for People with Developmental Disabilities

2006	Family Care		Waiver	
	Number	Percent of Employed Total Clients	Number	Percent of Employed Total Clients
PreVocational/ Sheltered Wksp	478	61.4%	6009	82.2%
Community From Home	366	47.0%	2005	27.4%
Total Employed	5	0.6%	37	0.5%
Total Clients	778	0.3%	7315	0.3%
	1487		11166	

Notes:

1. Data includes all Family Care Members (except Milwaukee) and Waiver Clients with disabilities who were 18-64
2. Family Care data obtained from the Long-Term Care Functional Screen
3. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses
4. Duplicated counts for prevocational/sheltered wksp, community, and from home: If member/client was in more than one type of employment, then the individual would be included in the counts for each type of employment he/she was in.
5. Total counts are unduplicated.

Types of Employment for People with Physical Disabilities

2006 PreVocational/ Sheltered Wksp Community From Home Total Employed Total Clients	Family Care		Waiver		PACE-Partnership	
	Number	Percent of Employed Total Clients	Number	Percent of Employed Total Clients	Number	Percent of Employed Total Clients
	36	25.2%	153	38.8%	8	12.3%
	90	62.9%	201	51.0%	46	70.8%
	18	12.6%	52	13.2%	13	20.0%
	143		394		65	
	1859		5262		1100	
		1.9%		2.9%		0.7%
		4.8%		3.8%		4.2%
		1.0%		1.0%		1.2%

Notes:

1. Data includes all Family Care Members (except Milwaukee), Pace-Partnership Members, and Waiver Clients with disabilities who were 18-64
2. Family Care data obtained from the Long-Term Care Functional Screen
3. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses
4. Duplicated counts for prevocational/sheltered wksp, community, and from home: If member/client was in more than one type of employment, then the individual would be included in the counts for each type of employment he/she was in.
5. Total counts are unduplicated.

Changes in the Types of Employment for People with Disabilities from 2003 to 2006

	Family Care Developmental Disabilities			Family Care Physical Disabilities			PACE-Partnership Physical Disabilities		
	Number	Percent of Employed	Percent of Total Clients	Number	Percent of Employed	Percent of Total Clients	Number	Percent of Employed	Percent of Total Clients
PreVocational/									
2003 Sheltered Wksp	385	59.1%	35.9%	19	19.2%	2.1%	7	14.0%	1.3%
2003 Community	335	51.5%	31.2%	71	71.7%	7.7%	34	68.0%	6.3%
2003 From Home	7	1.1%	0.7%	9	9.1%	1.0%	11	22.0%	2.0%
2003 Total Employed	651			99			50		
2003 Total Clients	1073			920			543		
PreVocational/									
2004 Sheltered Wksp	413	58.7%	34.9%	28	23.9%	2.7%	7	11.7%	1.1%
2004 Community	361	51.3%	30.5%	73	62.4%	7.0%	45	75.0%	7.4%
2004 From Home	6	0.9%	0.5%	16	13.7%	1.5%	12	20.0%	2.0%
2004 Total Employed	704			117			60		
2004 Total Clients	1182			1036			611		
PreVocational/									
2005 Sheltered Wksp	460	74.2%	33.3%	33	24.8%	1.8%			
2005 Community	357	47.0%	25.9%	83	62.4%	4.5%			
2005 From Home	6	0.8%	0.4%	18	13.5%	1.0%			
2005 Total Employed	620			133					
2005 Total Clients	1380			1835					
PreVocational/									
2006 Sheltered Wksp	478	61.4%	32.1%	36	25.2%	1.9%	8	12.3%	0.7%
2006 Community	366	47.0%	24.6%	90	62.9%	4.8%	46	70.8%	4.2%
2006 From Home	5	0.6%	0.3%	18	12.6%	1.0%	13	20.0%	1.2%
2006 Total Employed	778			143			65		
2006 Total Clients	1487			1859			1100		

Notes:

1. Data includes all Family Care Members (except Milwaukee) and PACE-Partnership Members (not including Milwaukee 2003 & 2004; including Milwaukee 2006) with disabilities who were 18-64
2. Data obtained from the Long-Term Care Functional Screen
3. Duplicated counts for prevocational/sheltered wksp, community, and from home. If member/client was in more than one type of employment, then the individual would be included in the counts for each type of employment he/she was in.
4. Total counts are unduplicated.

What level of employment assistance is needed by people with developmental disabilities?

	2006		Waiver	
	Family Care Total	Percent	Total	Percent
Independent (may be with assistive devices)	34	4.4%	322	4.4%
Need help every day, no need of continuous presence of another	378	48.6%	3629	49.6%
Needs help weekly or less	179	23.0%	1505	20.6%
Needs the continuous presence of another	187	24.0%	1859	25.4%

Notes:

1. Data includes all Family Care Members (except Milwaukee) and Waiver Clients with disabilities who were 18-64
2. Family Care data obtained from the Long-Term Care Functional Screen
3. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses
4. Employment Assistance only includes services related to employment (e.g., job coaching), and does not include personal care

What level of employment assistance is needed by people with physical disabilities?

	2006		Family Care		Waiver		PACE-Partnership	
	Total	Percent	Total	Percent	Total	Percent	Total	Percent
Independent (may be with assistive devices)	71	49.7%	154	39.1%	37	56.9%		
Need help every day, no need of continuous presence of another	35	24.5%	129	32.7%	12	18.5%		
Needs help weekly or less	32	22.4%	70	17.8%	15	23.1%		
Needs the continuous presence of another	5	3.5%	41	10.4%	1	1.5%		

Notes:

1. Data includes all Family Care Members (except Milwaukee), PACE-Partnership Members, and Waiver Clients with disabilities who were 18-64
2. Family Care and PACE-Partnership data obtained from the Long-Term Care Functional Screen
3. Numbers/percentages of Waiver Clients with physical disabilities include both people with physical disabilities and people with mental health diagnoses
4. Employment Assistance only includes services related to employment (e.g., job coaching), and does not include personal care

How much funding is being utilized for employment and day services?

Services	DD (N = 1,313)		PD (N = 1,102)	
	Cost	% of All Cost	Cost	% of All Cost
ADULT FAMILY HOME	\$ 16,429,293.63	37.9%	\$ 1,511,042.08	9.3%
SUPPORTIVE HOME CARE	\$ 4,481,121.91	10.3%	\$ 3,097,482.94	19.0%
CARE MANAGEMENT	\$ 4,361,244.87	10.1%	\$ 4,274,610.57	26.2%
PRE-VOC/SHELTERED	\$ 3,413,894.38	7.9%	\$ 201,636.70	1.2%
DAY SERVICES	\$ 2,891,564.17	6.7%	\$ 81,727.01	0.5%
DAILY LIVING SKILLS	\$ 2,492,743.89	5.8%	\$ 209,328.35	1.3%
CBRF	\$ 2,084,825.34	4.8%	\$ 805,055.43	4.9%
TRANSPORTATION	\$ 1,351,762.84	3.1%	\$ 374,494.32	2.3%
RESPIRE	\$ 1,163,991.15	2.7%	\$ 123,451.70	0.8%
SUPPORTED EMPLOYMENT	\$ 1,128,804.54	2.6%	\$ 32,595.79	0.2%
NF/ICF-MR	\$ 1,113,481.71	2.6%	\$ 1,925,626.82	11.8%
HOME HEALTH	\$ 1,022,369.30	2.4%	\$ 1,556,661.07	9.5%
ADAPTIVE EQUIPMENT/DMS	\$ 639,098.16	1.5%	\$ 1,006,133.35	6.2%
COUNSELING/THERAPEUTIC	\$ 271,142.98	0.6%	\$ 411,813.01	2.5%
ADULT DAY CARE	\$ 174,667.64	0.4%	\$ 65,575.63	0.4%
FINANCIAL MANAGEMENT	\$ 90,591.35	0.2%	\$ 30,775.11	0.2%
CSP	\$ 43,654.70	0.1%	\$ 119,786.89	0.7%
HOUSING ASSISTANCE	\$ 35,262.06	0.1%	\$ 26,359.85	0.2%
ALL OTHER SERVICES	\$ 34,783.41	0.1%	\$ 24,433.20	0.1%
RECREATION/ALTERNATIVE	\$ 31,786.74	0.1%	\$ 14,876.81	0.1%
SKILLED NURSING	\$ 28,748.72	0.1%	\$ 39,108.41	0.2%
HOME DELIVERED MEALS	\$ 24,544.81	0.1%	\$ 163,982.15	1.0%
DAY TREATMENT-MEDICAL	\$ 16,371.03	0.0%	\$ 17,811.06	0.1%
CONGREGATE MEALS	\$ 4,504.32	0.0%	\$ 10,025.72	0.1%
RCAC	\$ -	0.0%	\$ 183,404.79	1.1%
Total	\$ 43,330,253.65	100.0%	\$ 16,307,798.76	100.0%

Notes:

1. Costs equal the costs of 2006 services across all Family Care counties except Milwaukee.
2. Data obtained from encounter data.

What is the average amount per member spent on employment and day services in Family Care?

Employment Services	DD		PD	
	Recipient Count	Cost	Recipient Count	Cost
PRE-VOC/SHELTERED	469	\$3,413,894.38	46	\$201,636.70
SUPPORTED EMPLOYMENT	251	\$1,128,804.54	17	\$32,595.79
DAY SERVICES	369	\$2,891,564.17	34	\$81,727.01
				PMPY
				\$4,383.4
				\$1,917.4
				\$2,403.7

Remember, **366** members with DD were reported to work in the community and **5** members with DD were reported to work from home (Slide 8). 371 – 251 = **120** people with DD who are working in the community without supports. If these additional 120 were factored into the DD supported employment PMPY, then DD supports would cost **\$3,042.60** PMPY.

Likewise, **90** members with PD were reported to work in the community and **18** members with PD were reported to work from home (Slide 9). 108 - 17 = **91** people with PD who are working in the community without supports. If these additional 108 were factored into the PD supported employment PMPY, then PD supports would cost **\$260.70** PMPY.

Notes:

1. Costs equal the 2006 costs of services across all Family Care counties except Milwaukee.
2. Data obtained from encounter data.
3. PMPY = Per member per year
4. PMPY equals cost of service per member. (Numbers of hours of service provided per member may vary. Also, the number of hours each member works may vary.)

What is the initial interest in employment when members are screened for the first time?

	Family Care Developmental Disabilities		Family Care Physical Disabilities		PACE-Partnership Physical Disabilities	
	Number	% of Group	Number	% of Group	Number	% of Group
Unemployed and Interested in New Job	106	33.5%	82	20.6%	160	18.1%
Unemployed and Not Interested in New Job	210	66.5%	317	79.4%	726	81.9%
Total Unemployed	316	41.4%	399	84.7%	886	93.2%
Total Number of Respondents*	764		471		951	
Total Number of Clients	1313		1102		1100	
Employed Full Time and Interested in New Job	27	21.1%	1	10.0%	1	10.0%
Employed Full Time and Not Interested in New Job	101	78.9%	9	90.0%	9	90.0%
Total Employed Full Time	128	16.8%	10	2.1%	10	1.1%
Total Number of Respondents*	764		471		951	
Total Number of Clients	1313		1102		1100	
Employed Part Time and Interested in New Job	59	18.4%	9	14.5%	10	18.2%
Employed Part Time and Not Interested in New Job	261	81.6%	53	85.5%	45	81.8%
Total Employed Part Time	320	41.9%	62	13.2%	55	5.8%
Total Number of Respondents*	764		471		951	
Total Number of Clients	1313		1102		1100	

Notes:

1. Data obtained from functional screen, which is an eligibility screen. The fact that it is an eligibility screen may influence responses.
2. * Total number of respondents includes Family Care members (except those in Milwaukee) who provided answers on both the earlier and later functional screen (**58.2%** of Family Care Members with DD and **47.2%** of Family Care Members with PD) and PACE-Partnership Members who provided answers on most current (2006) LTCFS (**86.5%**).
3. Definition of full time employment: 1. For people with DD, 5 days a week 2. For people with PD, 35 or more hours a week

12 months later if member was unemployed...

If member was unemployed and interested in new job...

	DD N	% of Group	PD N	% of Group
Still Unemployed and Still Interested in New Job	63	59.4%	52	63.4%
Still Unemployed But Now Not Interested in New Job	12	11.3%	20	24.4%
Achieved Employment	31	29.2%	9	11.0%
Retired	0	0.0%	1	1.2%

If member was unemployed and not interested in new job...

	DD N	% of Group	PD N	% of Group
Still Unemployed and Still Not Interested in New Job	181	86.2%	292	92.1%
Still Unemployed But Now Interested in New Job	13	6.2%	12	3.8%
Achieved Employment	14	6.7%	4	1.3%
Retired	2	1.0%	9	2.8%

Notes:

- Family Care Members Only.** (Data are also available for PACE-Partnerships, but were not requested.)
- Data obtained from functional screen, which is an eligibility screen. The fact that it is an eligibility screen may influence responses.
- * Total number of respondents includes Family Care members (except those in Milwaukee) who provided answers on both the earlier and later functional screen (**58.2%** of Family Care Members with DD and **47.2%** of Family Care Members with PD).
- Definition of full time employment: 1. For people with DD, 5 days a week 2. For people with PD, 35 or more hours a week
- Functional screen currently does not have a definition for "retired."

12 months later if member was employed full time ...

If member was employed full time and interested in a new job...

	DD N	% of Group	PD N	% of Group
Still Employed Full Time and Still Interested in a New Job	17	63.0%	0	0.0%
Still Employed Full-Time and Now Not Interested in a New Job	4	14.8%	0	0.0%
Employed Part-Time and Interested in a New Job	1	3.7%	0	0.0%
Employed Part-Time and Not Interested in a New Job	3	11.1%	0	0.0%
Unemployed and Interested in a New Job	2	7.4%	0	0.0%
Unemployed and Not Interested in a New Job	0	0.0%	1	100.0%
Retired	0	0.0%	0	0.0%

If member was employed full time and not interested in a new job...

	DD N	% of Group	PD N	% of Group
Still Employed Full-Time and Still Not Interested in a New Job	91	90.1%	5	55.6%
Still Employed Full-Time and Now Interested in a New Job	4	4.0%	0	0.0%
Employed Part-Time and Interested in a New Job	1	1.0%	1	11.1%
Employed Part-Time and Not Interested in a New Job	4	4.0%	1	11.1%
Unemployed and Interested in a New Job	0	0.0%	0	0.0%
Unemployed and not Interested in a New Job	1	1.0%	1	11.1%
Retired	0	0.0%	1	11.1%

Notes:

- Family Care Members Only.** (Data are also available for PACE-Partnerships, but were not requested.)
- Data obtained from functional screen, which is an eligibility screen. The fact that it is an eligibility screen may influence responses.
- * Total number of respondents includes Family Care members (except those in Milwaukee) who provided answers on both the earlier and later functional screen (**58.2%** of Family Care Members with DD and **47.2%** of Family Care Members with PD).
- Definition of full time employment: 1. For people with DD, 5 days a week 2. For people with PD, 35 or more hours a week
- Functional screen currently does not have a definition for "retired."

12 months later if member was employed part time ...

If member was employed part time and

interested in a new job...

	DD		PD	
	N	% of Group	N	% of Group
Still Employed Part-Time and Still Interested in a New Job	35	59.3%	4	44.4%
Still Employed Part-Time and Now Not Interested in a New Job	9	15.3%	4	44.4%
Employed Full-Time and Interested in a New Job	3	5.1%	0	0.0%
Employed Full-Time and Not Interested in a New Job	1	1.7%	0	0.0%
Unemployed and Interested in a New Job	8	13.6%	0	0.0%
Unemployed and Not Interested in a New Job	3	5.1%	1	11.1%
Retired	0	0.0%	0	0.0%

If member was employed part time and not

interested in a new job...

	DD		PD	
	N	% of Group	N	% of Group
Still Employed Part-Time and Still Not Interested in a New Job	218	83.5%	38	71.7%
Still Employed Part-Time and Now Interested in a New Job	13	5.0%	1	1.9%
Employed Full-Time and Interested in a New Job	2	0.8%	1	1.9%
Employed Full-Time and Not Interested in a New Job	7	2.7%	2	3.8%
Unemployed and Interested in a New Job	11	4.2%	4	7.5%
Unemployed and Not Interested in a New Job	8	3.1%	7	13.2%
Retired	2	0.8%	0	0.0%

Notes:

- Family Care Members Only.** (Data are also available for PACE-Partnerships, but were not requested.)
- Data obtained from functional screen, which is an eligibility screen. The fact that it is an eligibility screen may influence responses.
- * Total number of respondents includes Family Care members (except those in Milwaukee) who provided answers on both the earlier and later functional screen (**58.2%** of Family Care Members with DD and **47.2%** of Family Care Members with PD).
- Definition of full time employment: 1. For people with DD, 5 days a week 2. For people with PD, 35 or more hours a week
- Functional screen currently does not have a definition for "retired."

While interest decreases with age, there is a very high level of disinterest even among younger individuals.

Employment Status and Interest Among Members 18-64 (from the LTCFS)

	Family Care Physical Disabilities				Total %
	Age 18-30 %	Age 31-50 %	Age 51-64 %	N	
Unemployed and Interested	16	69	65	150	18.5%
Unemployed and Not Interested	27	236	398	661	81.5%
Total Unemployed	43	305	463	811	100.0%

	Family Care Developmental Disabilities				Total %
	Age 18-30 %	Age 31-50 %	Age 51-64 %	N	
Unemployed and Interested	108	68	16	192	36.0%
Unemployed and Not Interested	102	133	107	342	64.0%
Total Unemployed	210	201	123	534	100.0%

	PACE-Partnership Physical Disabilities				Total %
	Age 18-30 %	Age 31-50 %	Age 51-64 %	N	
Unemployed and Interested	32	68	61	161	18.2%
Unemployed and Not Interested	14	154	558	726	81.8%
Total Unemployed	46	222	619	887	100.0%

Notes:

1. Data obtained from functional screen, which is an eligibility screen. The fact that it is an eligibility screen may influence responses.

Managed Care and Employment Task Force
Meeting #5

Existing Provider Networks

December 4, 2007

By:

Christine Smith, Senior Manager

Dave Varana, Senior Consultant

VirchowKrause
& company

Presentation Objectives

- Summary of Medicaid Infrastructure Grant (MIG) Community Resource Mapping Project - 2007
- Contents of Report
- Provider Network Diagnostics
- Performance Measurement Barriers

Background

- Community Resource Mapping Project presents the most comprehensive picture of services provided to consumers intended to help them prepare for, find, and maintain employment.
- Significant focus on provider network
- Analysis includes all Wisconsin counties, organized into Wisconsin Council on Workforce Investment regions.

3

What is the Community Resource Mapping Project?

- 2005 statewide picture of:
 - persons with long term disabilities,
 - the services they received that helped them prepare for, find, and maintain employment, and
 - the organizations (public, private, and non-profit) that delivered these services.
 - detailed information is presented at the County, regional, and statewide level.

4

What is the Community Resource Mapping Project?

Project Parameters:

- Oversight by Waisman Center and Office of Independence and Employment (DHFS/OIE)
- Content by regions based on the Wisconsin Council on Workforce Investment initiative.
- Information is presented for agencies that provide services across county borders (multi-county consortium)

Deliverables:

- Data diagnostic tool CoRM db (Access)
- Hardcopy 11 volumes 1,200 pages bound

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Why was the Project Completed?

- To answer questions relative to providers and services available to increase employment and related supports for persons with disabilities (part of larger Pathways to Independence project)
- To date there has been no comprehensive (multi-agency) statewide effort to aggregate information on employment related services for consumers.
- Similar information exists, but centered on:
 - single state agency or program,
 - single category of disability, such as developmental disabilities.

6

What 2005 State Programs were Included?

- DHFS
 - Family Care (Five Counties);
 - Community Options Program (COP/COP-W);
 - Community Integration Programs (CIP-1A, CIP-1B, and CIP-II);
 - Brain Injury Waiver program (BIW);
 - Mental Health programs, Supported Employment program, Family Support program; and
 - Programs reported under HSRS/CORE serving persons with disabilities that were administered by county or multi-county agencies
- DWD
 - Division of Vocational Rehabilitation (DVR);
 - Workforce Investment Act/Trade Adjustment Assistance (WIA-TAA) programs; and
 - Wisconsin Works (W2)/(TANF).
- DOT
 - Specialized Transportation Assistance Program (s. 85.21 program).

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What's Not Included?

- DHFS
 - Medicaid fee-for-services program,
 - SSI Managed Care program,
 - PACE and Partnership programs, and
 - Institutional Medicaid.
- Technical Colleges and University System
- Other State and Federal Agencies
- Local Agency Program/Case Information

8

How Should This Information Be Used?

- To compare types of services provided to different categories of consumers across:
 - Local agencies
 - Providers
 - State and federal programs
- To assist in identifying best practice agencies
- Snapshot is diagnostic:
 - Does not explain obvious differences across counties and programs.

9

What Analysis is in the Report?

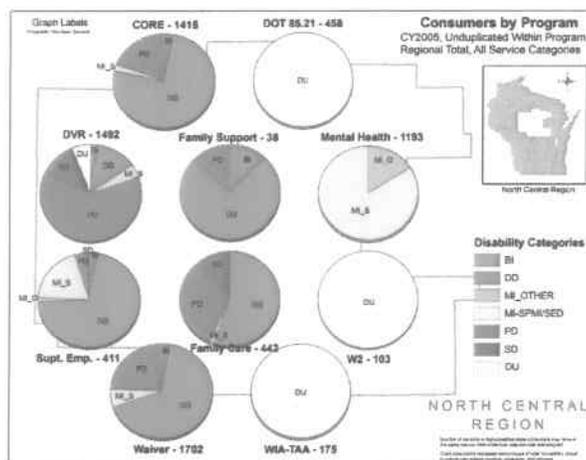
- User Guide, Statewide Analysis, Methodology, and Technical Appendices
- Seven Regional Reports:
 - Regional diagnostic
 - County-level detailed diagnostics

10

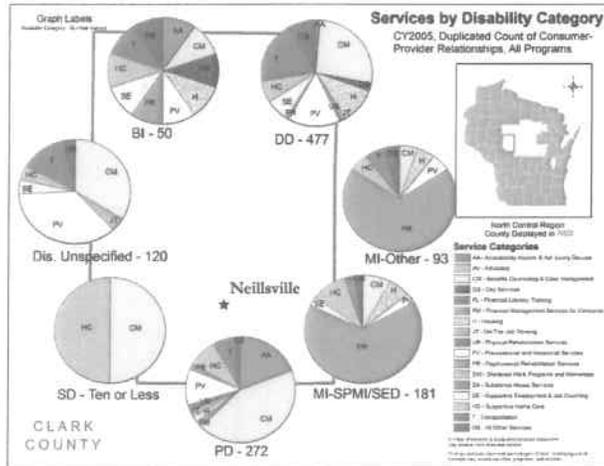
What Analysis is in the Report?

- **County Data – Narrative, Tables, and Data Visualization (Maps)**
 1. Comparison of Providers, Services, Consumers, Program & Funding to regional benchmarks
 2. Number of Consumers Receiving Services by Program and Disability Type
 3. Outlier Service Categories (ie. agency reported a service not commonly offered)
 4. Listing of Top Ten Providers in the County (or consortia territory), including services offered
 5. Expenditures
 6. Supplementary program and provider information obtained via DPI POEM
 7. Wait List Data (Some County Survey Data includes Service detail)

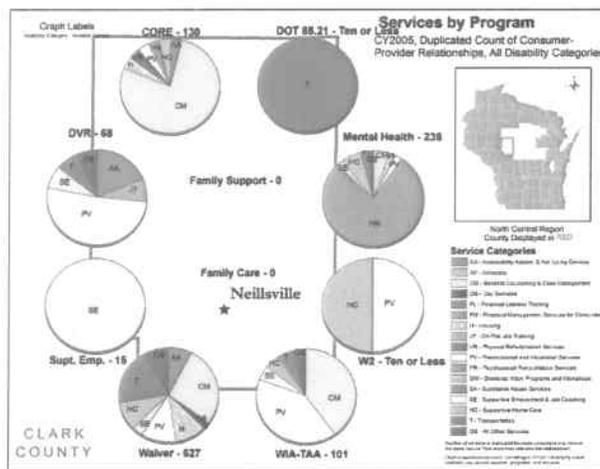
What Analysis is in the Report?



What Analysis is in the Report?



What Analysis is in the Report?



What Is Ultimate Goal?

- Expanded provider capacity
- Facilitation of integrated employment services and necessary supports
- Enhanced outcomes and improved quality
- All of the above

15

What did Mapping Tell Us?

- Provider capacity varies between counties/consortia
- Family Care Counties appear to have greater provider capacity when considered in terms of overall number of providers AND also in terms of ratio of total county population or consumer-service-relationships per 1,000 residents

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Supported Employment & Job Coaching Services Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
IRON	3	2,334	2.29
RICHLAND	7	2,801	5.55
PRICE	4	3,214	3.80
TAYLOR	5	4,010	1.85
BURNETT	3	4,187	0.24
ASHLAND	3	4,220	2.37
SAWYER	3	4,386	2.85
CALUMET	10	4,599	1.74
COLUMBIA	11	4,636	0.84
BUFFALO	2	4,728	5.01
DOOR	5	5,007	1.36
JACKSON	3	5,020	4.18
FLORENCE	1	5,295	0.19
LAFAYETTE	2	5,439	0.61
MONROE	7	5,480	0.66

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Supported Employment & Job Coaching Services Top 15 Counties – Ranked by Service per 1,000 Residents

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
RICHLAND	7	2,801	5.55
BUFFALO	2	4,728	5.01
JACKSON	3	5,020	4.18
PRICE	4	3,214	3.80
PORTAGE	5	11,680	3.39
SAWYER	3	4,386	2.85
FOND DU LAC	15	6,323	2.75
EAU CLAIRE	4	19,600	2.65
ASHLAND	3	4,220	2.37
IRON	3	2,334	2.29
LANGLADE-LINCOLN-MAH	1	93,054	2.20
LINCOLN	3	7,641	2.13
SHAWANO	3	14,138	2.07
SAUK	7	7,584	2.04
TAYLOR	5	4,010	1.85

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Personal Assistance Services

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
RICHLAND	17	1,071	6.76
PORTAGE	25	2,798	3.24
DOOR	9	3,338	1.80
ASHLAND	5	3,376	1.07
FOND DU LAC	27	3,747	1.95
BURNETT	4	4,187	1.07
SHEBOYGAN	25	4,681	0.61
BUFFALO	3	4,728	0.85
MARQUETTE	3	5,106	0.46
LA CROSSE	20	5,590	6.26
ROCK	27	5,909	2.16
WAUSHARA	4	6,304	3.09
GREEN LAKE	3	6,482	0.26
DODGE	13	6,863	0.62
PEPIN	1	7,714	0.39

Personal Assistance Services

Top 15 Counties – Ranked by Service per 1,000 Residents

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
RICHLAND	17	1,071	6.76
LA CROSSE	20	5,590	6.26
PORTAGE	25	2,798	3.24
WAUSHARA	4	6,304	3.09
ROCK	27	5,909	2.16
BAYFIELD	2	7,995	2.00
FOND DU LAC	27	3,747	1.95
DOOR	9	3,338	1.80
ADAMS	1	21,645	1.62
BURNETT	4	4,187	1.07
ASHLAND	5	3,376	1.07
LINCOLN	3	10,187	0.98
MILWAUKEE	50	18,727	0.96
BROWN	21	11,655	0.87
BUFFALO	3	4,728	0.85

Transportation Services

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
PEPIN	6	1,102	2.98
RUSK	11	1,202	1.73
RICHLAND	13	1,301	3.02
IRON	3	1,751	1.43
VERNON	15	1,969	3.89
PORTAGE	30	2,186	3.83
TAYLOR	7	2,506	1.00
WAUSHARA	9	2,522	2.46
ASHLAND	5	2,813	4.56
LA CROSSE	33	3,194	8.17
BAYFIELD	4	3,198	2.81
LAFAYETTE	4	3,263	3.19
TREMPEALEAU	7	3,515	6.08
OCONTO	9	3,896	1.39
GREEN	8	4,029	3.09

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Transportation Services

Top 15 Counties – Ranked by Service per 1,000 Residents

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
LA CROSSE	33	3,194	8.17
TREMPEALEAU	7	3,515	6.08
DANE	16	26,029	6.04
FOND DU LAC	20	4,599	4.72
ASHLAND	5	2,813	4.56
VERNON	15	1,969	3.89
MILWAUKEE	77	12,005	3.85
PORTAGE	30	2,186	3.83
SHEBOYGAN	20	5,572	3.61
CLARK	5	5,747	3.31
LAFAYETTE	4	3,263	3.19
GREEN	8	4,029	3.09
BUFFALO	1	7,092	3.03
RICHLAND	13	1,301	3.02
PEPIN	6	1,102	2.98

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Adaptive Equipment & Accessibility Modification Services

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
RICHLAND	32	552	4.56
PORTAGE	74	909	4.47
TAYLOR	12	1,432	1.80
RUSK	8	1,563	1.60
WOOD	47	1,568	1.39
LA CROSSE	69	1,575	7.97
VERNON	17	1,641	1.22
WAUSHARA	13	1,801	11.70
BARRON	23	1,902	1.47
PEPIN	3	1,929	2.07
CRAWFORD	7	1,950	1.99
WASHBURN	6	2,175	1.09
CLARK	12	2,463	0.90
LINCOLN	9	2,778	2.49
BURNETT	4	2,792	1.07

Adaptive Equipment & Accessibility Modification Services

Top 15 Counties – Ranked by Service per 1,000 Residents

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
WAUSHARA	13	1,801	11.70
LA CROSSE	69	1,575	7.97
RICHLAND	32	552	4.56
PORTAGE	74	909	4.47
LINCOLN	9	2,778	2.49
FOND DU LAC	31	3,066	2.46
SAWYER	4	2,924	2.28
PEPIN	3	1,929	2.07
CRAWFORD	7	1,950	1.99
TAYLOR	12	1,432	1.80
ADAMS	2	5,411	1.62
RUSK	8	1,563	1.60
BARRON	23	1,902	1.47
WOOD	47	1,568	1.39
MILWAUKEE	83	10,888	1.38

Job Development & Placement Services Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
CRAWFORD	6	2,926	0.68
VERNON	7	4,219	0.30
WASHBURN	4	4,351	0.40
ROCK	29	5,501	0.51
BURNETT	3	5,583	0.24
TAYLOR	3	6,683	0.45
BARRON	7	6,793	0.95
LA CROSSE	15	7,453	0.57
MARQUETTE	2	7,660	0.13
PRICE	2	8,035	0.12
CLARK	4	8,620	0.23
DUNN	5	8,624	0.83
SAUK	7	8,668	0.33
SAWYER	2	8,771	0.57
CHIPPEWA	7	8,801	0.67

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Job Development & Placement Services Top 15 Counties – Ranked by Service per 1,000 Residents

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
BARRON	7	6,793	0.95
EAU CLAIRE	9	10,889	0.92
DUNN	5	8,624	0.83
CRAWFORD	6	2,926	0.68
CHIPPEWA	7	8,801	0.67
WINNEBAGO	11	14,973	0.66
DODGE	10	8,923	0.61
DANE	33	14,197	0.59
LA CROSSE	15	7,453	0.57
SAWYER	2	8,771	0.57
FOND DU LAC	9	11,242	0.55
ROCK	29	5,501	0.51
MARATHON	8	16,754	0.50
WOOD	7	10,977	0.47
TAYLOR	3	6,683	0.45

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Prevocational & Sheltered Work Services

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
IRON	3	1,751	1.14
FLORENCE	2	1,765	20.40
PRICE	6	2,296	3.42
RICHLAND	5	3,035	3.84
RUSK	4	3,125	2.88
LAFAYETTE	4	3,263	7.48
BURNETT	4	3,350	2.75
BUFFALO	3	3,546	1.55
JACKSON	3	5,020	3.19
MARQUETTE	2	5,106	1.83
CALUMET	9	5,110	1.15
CRAWFORD	2	5,851	3.42
WAUSHARA	3	6,304	3.41
TAYLOR	2	6,683	4.14
CLARK	4	6,896	2.32

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Alternatives to Work Services

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
PEPIN	8	857	4.15
VERNON	17	1,737	1.93
LAFAYETTE	8	1,813	3.49
BURNETT	6	2,393	1.01
DUNN	17	2,395	2.48
CALUMET	18	2,421	2.72
JACKSON	7	2,510	3.09
FLORENCE	1	2,648	0.94
ASHLAND	5	2,813	3.55
TAYLOR	6	2,864	3.79
MONROE	14	2,923	1.35
PRICE	4	3,214	3.17
GREEN LAKE	5	3,241	4.11
OCONTO	11	3,247	2.85
IRON	2	3,501	1.57

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Training for Work

Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
CRAWFORD	11	1,463	2.34
BURNETT	10	1,523	1.31
WASHBURN	10	1,582	2.53
TAYLOR	11	1,671	2.00
RUSK	8	1,736	1.86
WAUSHARA	13	1,801	0.91
BARRON	22	2,067	1.77
FOREST-ONEIDA-VILAS	31	2,234	2.60
RICHLAND	7	2,276	1.37
ASHLAND-BAYFIELD-IRON	15	2,492	1.48
CHIPPEWA	23	2,567	1.88
VERNON	10	2,685	1.15
CLARK	10	3,134	0.58
SHEBOYGAN	36	3,163	1.48
PRICE	5	3,214	0.37

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Micro-Enterprise

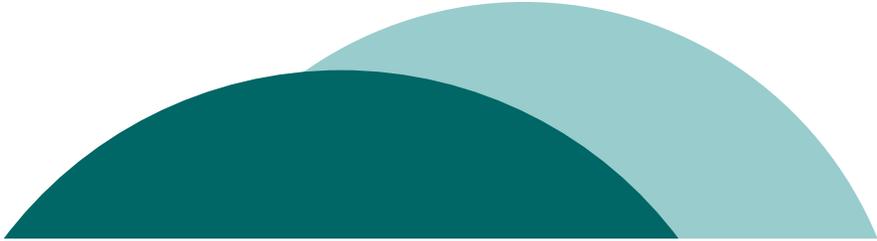
Top 15 Counties – Ranked by Residents per Provider

County/Consortia	Identified Providers	Residents per Provider	Services per 1000 Residents
TAYLOR	18	1,114	1.00
SAWYER	12	1,349	0.74
RUSK	9	1,736	0.64
BURNETT	5	2,792	0.42
SAUK	17	3,371	0.30
JEFFERSON	19	4,021	0.25
GREEN	7	5,180	0.22
MARQUETTE	2	7,660	0.13
CRAWFORD	2	8,777	0.11
JUNEAU	3	9,059	0.11
COLUMBIA	6	9,273	0.11
IOWA-LAFAYETTE	4	10,112	0.10
DANE	45	10,185	0.11
LA CROSSE	8	12,421	0.08
PORTAGE	4	13,992	0.07

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Performance Measurement Barriers

- Inability to Track Consumers Across Programs
- Data Management Variability due to Service Delivery Model Flexibility
- Reporting Requirements Vary Across Programs
- Lack of Data Standardization
- Lack of Inter-System Integration



The Relationship between Employment and Health:

A Review of the Literature Prepared
for the Managed Care
and Employment Task Force

Ellie C. Hartman, Ph.D.
University of Wisconsin-Stout Vocational
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Importance of the Employment and Health Relationship

- Poor health is generally assumed to be associated with higher health care needs, and as a result, higher health care costs.
- The long-term care system's costs are also assumed to be impacted by the health of long-term care recipients.
- Managing and controlling health care costs are critical goals for Family Care.
- If employment contributes to improving health status, efforts to increase participation in employment among the long-term care population could reduce health care costs.



The Relationship between Employment and Health

- Assumption?
 - Health influences employment
 - Poor health limits employment
 - Better health facilitates employment
 - Employment does not influence health
- Other Possibilities:
 - Employment can improve health
 - Unemployment can deteriorate health



A review of the literature on the relationship between employment and health demonstrates a consistent association between:

- Employment and better health
- Unemployment and poorer health

* Note: “Association” does not assume a cause and effect relationship, nor does it provide any information on the direction of this relationship (e.g. What comes first good health or employment?). More information on the direction of this relationship to come...

The Association between Employment and Health has been shown to exist in:

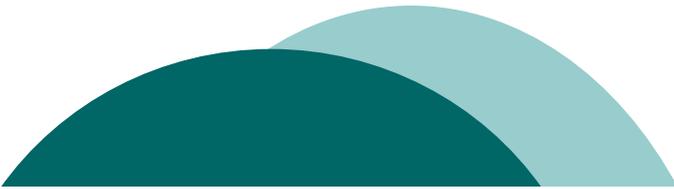
- Across all Adults
 - 20,000 British individuals (Arber, 1997)
 - 38,472 Europeans (Olsen & Dahl, 2007)
 - 8,747 Austrians (Rasky et al., 1996)
 - 15,468 Finnish employees or job seekers (Virtanen et al., 2003)
 - 270 Norwegians (Claussen et al., 1993)
- Women
 - 463 (Adelmann et al., 1990)
 - 15,500 British women (Arber et al., 1985)
 - 8,114 American women from Massachusetts (Jennings et al., 1984)
 - 2,282 Finnish women and 2,685 Swedish women (Roos et al., 2005)
 - American women (Waldron & Herold, 1986)
 - 3,301 American women (Waldron & Jacobs, 1988)
 - Wisconsin women (Passannante & Nathanson, 1985)
 - 2,865 Catalonian (Spanish) women (Artazcoz et al., 2004)
 - 719 British single mothers (Baker et al., 1999)
 - 193 British working class mothers (Parry, 1986)
 - 632 American women in Temporary Assistance for Needy Families (Chandler et al., 2004)
 - 503 current and former American welfare recipients from Michigan (Corcoran et al., 2004)
 - 288 American women from Connecticut eligible for income support (Horwitz & Kerker, 2001)
 - 148 women (Kutner, 1984)
- Younger Adults
 - 2,296 British 16 and 17 yr olds who left school (Jackson et al., 1983; Stafford et al., 1980; Warr et al., 1985)
 - 442 Australian school leavers (Winefield et al., 1991)
 - 229 Dutch 18 to 26 yr olds (Taris, 2002)
- Older Adults
 - 1,644 Americans, 60 yrs old and older (Hinterlong, 2006)
 - 1,167 British men and women between 50 and 74 years old (Warr et al., 2004)
- People with Disabilities
 - 587 Canadians with spinal chord injury (Leduc & Lepage, 2002)
 - 215 Multiple Sclerosis outpatients (Miller & Dishon, 2006)
 - 702 Australian men living with HIV/AIDS (Fogarty et al., 2007)
 - Review of studies looking at people with Schizophrenia (Marwaha & Johnson, 2004)
 - 556 Canadian people with physical disabilities (Turner & Turner, 2004)
 - 44 Australian adults with intellectual disabilities (Jiranek & Kirby, 1990)
 - 47,377 American adults (25-64) with disabilities (Okoro et al., 2007)

The Association between Employment and Health has been shown to exist in:

	Total Number of Studies	Sum of Individuals in Studies	Number of Countries Represented
Across all Adults	5	82,957	21
Women	14	35,008	9
Younger Adults	5	3,614	4
Older Adults	2	2,811	2
People with Disabilities	7	49,481	4
Total	33	173,871	24

The Association between Employment and Health and People with Disabilities

- 2007 study in the *Journal of Occupational Medicine* by Okoro et al.
- 47,377 American adults with disabilities, aged 25-64, who were living in the community
- 2001 and 2003 Behavioural Risk Factor Surveillance System, a state-based system of health surveys
- Frequent mental distress was found present in 18% of those employed and 40% of those unemployed.
- This relationship held up even when controlling for demographics and individual characteristics including age, sex, race/ethnicity, education, marital status, health risk behaviors, body mass index, health care coverage, and self-rated health



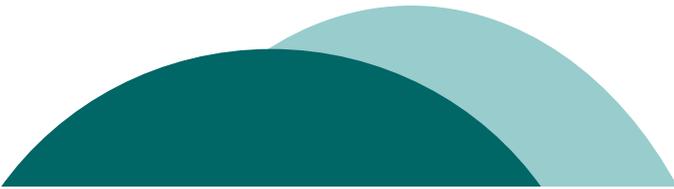
The Association between Employment and Health and People with Disabilities: Women

- 1984 study in *Women and Health* by Kutner
- 148 women with major disabling health conditions
- Those who were employed had higher perceived health status than those who were not employed



The Association between Employment and Health and People with Disabilities: Specific Disabilities

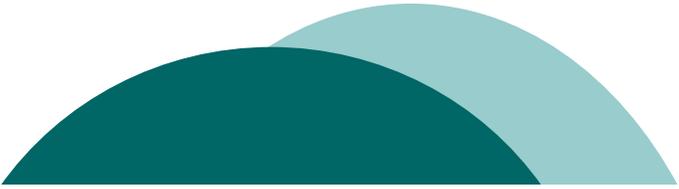
- Employed individuals reported better health-related quality of life than unemployed individuals
 - Individuals with spinal cord injuries (Leduc & Lepage, 2002)
 - Multiple Sclerosis outpatients (Miller & Dishon, 2006)
- Employed men with HIV/AIDS had higher self-reported health, lower incidence of illness than unemployed men with HIV/AIDS (Fogarty et al., 2007)
- In a 2004 literature review, Marwaha and Johnson concluded that, for individuals with Schizophrenia, work was related both to a decrease in symptoms and a higher quality of life



The Association between Employment and Health and People with Disabilities: Physical and Intellectual Disabilities

- A 2004 study (Turner & Turner) found that adults with physical disabilities who were unemployed had poorer mental health (specifically increased depression) than adults with physical disabilities who were employed.
- A 1990 study (Jiranek & Kirby) found that among young adults with and without intellectual disabilities, those who were employed had higher psychological well-being than those who were unemployed.

The relationship between
employment and better health is ...





The relationship between employment and better health is bi-directional.

There is evidence that:

- Employment contributes to better health
- Better health contributes to employment
- Unemployment contributes to worse health
- Worse health contributes to unemployment



Evidence of Health's Influence on Employment (Based on 8 Studies)

- Longitudinal evidence
 - 229 Dutch youth (Taris, 2002)
 - 238 Norwegians (Mastekaasa, 1996)
 - 270 unemployed Norwegians (Claussen et al., 1993)
- Progressive illness
 - 702 Australian men living with HIV/AIDS (Fogarty et al., 2007)
- Treatment of health
 - 3,076 American individuals with physical disabilities (Ipsen, 2006)
 - 573 American adults with Crohn's disease (Lichtenstein et al., 2004)
 - 290 American adults with major depression (Simon et al., 2000)
- Literature review
 - Women (Repetti et al., 1989)

Evidence of Health's Influence on Employment (Based on 8 Studies)

	Total Number of Studies	Sum of Individuals in Studies	Number of Countries Represented
Longitudinal	3	737	2
Progressive illness	1	702	1
Treatment of health	3	3,939	1
Literature review	1		
Total	8	5,378	4



Evidence of Health's Influence on Employment

- Longitudinal evidence
 - Dutch youth with better mental health were more likely to be employed at a later date (Taris, 2002)
 - Psychological distress predicted who was laid off four years later (Mastekaasa, 1996)
 - Fear of job loss controlled for
 - Psychiatric diagnosis decreased the chance (by 70%) of unemployed Norwegian's obtaining employment (Claussen et al., 1993)
- Progressive illness
 - HIV/AIDS
 - Longer duration with illness, less likely to be employed (Fogarty et al., 2007)



Evidence of Health's Influence on Employment

- Treatment of health
 - Exercise, greater likelihood of employment (Ipsen, 2006)
 - Clinical remission of Crohn's disease, greater likelihood of employment (Lichtenstein et al., 2004)
 - Greater clinical improvement of American adults with major depression, greater likelihood of employment (Simon et al., 2000)
- Literature review
 - Employment and women's health
 - Repetti et al. (1989) concluded that good health increases the probability that women will be employed



Evidence of Employment's Influence on Health (Based on 13 Studies)

- Statistically controlling for functional limitations
 - 556 Canadians with physical disabilities (Turner & Turner, 2004)
- Longitudinal evidence
 - 101 British men (Layton, 1986)
 - 629 unemployed British men (Warr & Jackson, 1985)
 - 1,150 British unemployed 17 year olds (Warr et al., 1985)
 - 129 unemployed Americans from Iowa (Wanberg, 1995)
 - 6,151 Australian 16-25 year olds (Graetz, 1993)
 - 60 American Veterans, 35-60 years old (Linn et al., 1985)
 - 1,427 British 16 year olds (Jackson et al., 1983)
 - 442 Australian school leavers (Winefield et al., 1991)
- Job loss not attributed to health
 - 666 British (Ferrie et al., 2001)
 - 172 Austrians (Studnicka et al., 1991)
- Treatment to increase competitive employment
 - 69 Americans with mental illness from New York (McFarlane et al., 2000)
- Meta-analysis
 - (Murphy & Athanasou, 1999)

Evidence of Employment's Influence on Health (Based on 13 Studies)

	Total Number of Studies	Sum of Individuals in Studies	Number of Countries Represented
Statistically controlling for functional limitations	1	556	1
Longitudinal	8	10,089	3
Job loss not attributed to health	2	838	2
Treatment to increase competitive employment	1	69	1
Meta-analysis	1		
Total	13	11,552	5

Evidence of Employment's Influence on Health

- Statistically controlling for functional limitations
 - People with physical disabilities compared to people without disabilities (Turner & Turner, 2004)
 - Five times more likely to be involuntarily unemployed
 - Depression greater
 - Differences not due to functional limitations
- Longitudinal evidence
 - Changes in health only observed subsequent to changes in employment
 - Job loss followed by decreases in general health (Layton, 1986; Warr & Jackson, 1985; Warr et al., 1985)
 - Reemployment followed by
 - Increases in general health (Layton, 1986; Warr & Jackson, 1985; Warr et al., 1985)
 - Increases in mental health (Wanberg, 1995)



Longitudinal Evidence of Employment's Influence on Health (continued):

Health differences measured both prior to and after changes in employment

- Employed individuals who remained employed vs. employed individuals who became unemployed
 - No health differences when both groups were employed (Graetz, 1993; Linn et al., 1985)
 - Differences in psychological distress predicted employment and health changes (Jackson et al., 1983)
 - Those who remained employed, no health changes (Graetz, 1993; Linn et al., 1985; Jackson et al., 1983)
 - Those who became unemployed, decrease in health (Graetz, 1993; Linn et al., 1985; Jackson et al., 1983)
- Unemployed individuals who remained unemployed vs. unemployed individuals who became employed
 - No health differences when both groups were unemployed (Graetz, 1993)
 - Differences in psychological distress predicted employment and health changes (Jackson et al., 1983)
 - Those who remained unemployed, no health changes (Graetz, 1993; Jackson et al., 1983)
 - Those who became employed, increase in health (Graetz, 1993; Jackson et al., 1983)

Evidence of Employment's Influence on Health (continued):

- Health differences measured both prior to and after changes in employment: Students
 - Students who became employed vs. students who became unemployed
 - No health differences when both groups students (Graetz, 1993; Winefield et al., 1985)
 - Those who became employed, increase in health (Graetz, 1993; Winefield et al., 1985)
 - Those who became unemployed, decrease in health (Graetz, 1993; Winefield et al., 1985)
- Job loss not attributed to health
 - Business closing or restructuring
 - Those who remained unemployed, poorer physical and mental health than those who gained reemployment (Ferrie et al., 2001; Studnicka et al., 1991)

Evidence of Employment's Influence on Health (continued):

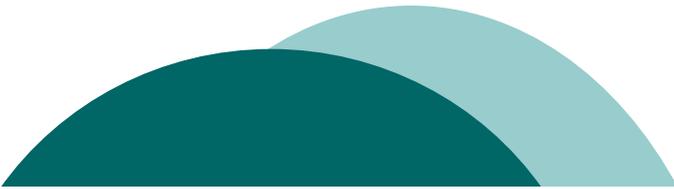
- Treatments to increase competitive employment
 - Improved mental health and decreased hospitalizations (McFarlane et al., 2000)
 - Improved health slightly better for treatment that achieved better employment outcomes (McFarlane et al., 2000)
- Meta-analysis
 - 16 longitudinal studies (Murphy & Athanasou, 1999)
 - Gaining employment increased mental well-being (effect size = .54)
 - Losing employment decreased mental well-being (effect size = .36)



Reciprocal relationship between employment and health

(Adelmann et al., 1990; Repetti et al., 1989; Waldron & Jacobs, 1988)

- Employment contributes to better health
- Better health contributes to employment
- Unemployment contributes to worse health
- Worse health contributes to unemployment



The positive effect that employment has on health appears strongest when

- The job is satisfactory
- The job is accompanied with social support
- The job contributes to or increases the individual's self-esteem



Employment and Quality of Life

- In 2005, Gardner and Carran found that 5 of the 25 Personal Outcome Measures significantly predicted the overall percentage of personal outcome attainment, accounting for 68% of the variance
 - People choose where and with whom they live
 - People are treated fairly
 - People interact with members of the community
 - People are respected
 - People choose where they work
- Employment and quality of life as measured by the Quality of Life Questionnaire within a sample of 50 Australian individuals with an intellectual disability (Eggleton et al., 1999)
 - Quality of life was greater for individuals who were employed in open/integrated/competitive employment than for individuals who were unemployed or in sheltered employment
- For 55 European adults with autism (Garcia-Villamizar et al., 2002), supported employment was related to increases in quality of life, whereas sheltered employment was not



Policy Implications

- Employment appears to be one means for ensuring that managed care members achieve the best possible health
- Increasing employment outcomes may reduce long-term care costs related to poor health and the management of poor health among managed care members
- Prioritizing employment seems consistent with a desire or need to prioritize health outcomes in managed long-term care.
- The health-related costs of unemployment, both to individuals and the long-term care system, may not be fully recognized at this time.

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #1

**Informed Choice and Integration of Full Range of
Employment Related Choices into
Member Centered Planning Process**

Final Report

March 20, 2008

Managed Care and Employment Task Force
Issue Committee #1

1. Issue Committee Charge

- Develop recommendations and guidelines for how existing Family Care policy on informed choice should be applied to employment services, supports and outcomes;
- Recommend essential components of an effective care management team which can successfully support managed care participants to choose and achieve their individually identified employment goals;
- Recommend essential components of an effective member-centered planning process that helps members make informed choices about employment goals and outcomes, and that develops effective plans for ensuring members can achieve these goals and outcomes;
- Develop recommendations and guidelines that can be used when using the Resource Allocation Decision-making process (RAD) as part of addressing employment-related needs, goals or problems;
- Develop recommendations and guidelines regarding how health and safety issues should be identified and addressed when providing services and supports for integrated employment goals.

2. List of Task Force Members Serving on Issue Committee

Paul Cook, Development Director, Community Health Partnership,
Eau Claire [Issue Committee Chair]
Lynn Carus, Consumer Representative, Milwaukee
Greg Smith, Vocation Peers Coordinator, Grassroots Empowerment Project
Laura Owens, Associate Professor, UW-Milwaukee and Director, Creative
Employment Opportunities
Jennifer Ondrejka, Executive Director, Board for Persons with Developmental
Disabilities
Jodi Hanna [Representing Monica Murphy], Disability Rights Wisconsin

3. List of Other Participants and Contributors to Issue Committee

Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Ann Sievert, Pathways to Independence, DHFS
Jenny Neugart, Pathways to Independence, DHFS
Dan Johnson, Pathways to Independence, DHFS
Staff from Portage County Managed Care Organization
Staff from La Crosse County Managed Care Organization
Staff from Fond du Lac County Managed Care Organization
Staff from Community Health Partnership Site, Eau Claire
Staff from Community Living Alliance Partnership Site, Madison
Mary Clare Carlson, People First Wisconsin
Mary Ridgely, Medicaid Infrastructure Grant Consultant

Managed Care and Employment Task Force
Issue Committee #1

Shannon Munn, Medicaid Infrastructure Grant Consultant
John Fuller, Employment Resources, Inc.
Beth Lavender, Division of Mental Health, Peer Specialist Coordinator
Deb Wisniewski, Medicaid Infrastructure Grant Consultant
Dennis Harkins, Medicaid Infrastructure Grant Consultant
Terri Lannan, Pathways to Independence, DHFS
Donna McDowell, Director of Bureau of Aging and Disability Resources
John Reiser, Director, Office on Independence and Employment
Myrt Sieger, Medicaid Infrastructure Grant Consultant
Carlene Volbrecht, Pathways Regional Coordinator, DHFS

4. Issue Committee Meetings

August 8, 2007
October 17, 2007
November 12, 2007
January 24, 2008

5. Summary of Issue Committee Process

The issue committee began by reviewing existing managed care organization approaches to assessment and member-centered planning, with a specific look at how managed care organization teams are facilitating informed choice and service planning with regard to employment. Four managed care organizations provided input: Community Health Partnership; Portage County CMO; La Crosse County CMO; and Community Living Alliance.

The committee went on to discuss the role of the Aging and Disability Resource Center (ADRC). Donna McDowell, Director of the Bureau of Aging and Disability Resources joined the discussion on the role of ADRC's in relation to employment. The committee also discussed the functional screen and how the employment information collected from the screen is used.

The committee then moved to a deeper discussion regarding what might be an appropriate role for, and expectations of, inter-disciplinary teams with regard to employment. This led to a discussion of the core competencies (knowledge and skills) that inter-disciplinary teams need to effectively address employment with members.

6. Recommendations

Note: Recommendations 1.1 to 1.14 were submitted to the full Task Force as interim recommendations and were approved by the full Task Force on February 19, 2008.

Aging and Disability Resource Centers

Recommendation 1.1: MIG should support the development and piloting of employment-specific education and training resources for ADRC staff involved in options counseling and providing information and assistance. The resources developed should be integrated into the Long-Term Care Options Counseling Toolkit for ADRC's, with the goal of effectively building the skills and knowledge necessary for ADRC staff to provide employment-specific options counseling. The resources developed should cover:

- The benefits and opportunities of employment for individuals with disabilities;
 - How individuals with varying degrees of disabilities can be successfully supported to work;
 - Basic information about work incentives so they understand that work does not automatically result in a loss of benefits or a loss of eligibility for other vital public programs, about work incentives benefits specialists (WIBS), the Vocational Rehabilitation system and the One Stops system (what each does and how to access them) so they can refer people interested in working to those resources; and
 - The range of ways individuals can pursue work, and the range of services available through Family Care and other long-term care programs that can support individuals who want to work.
- To ensure continuity, the basic content should be consistent with any education and training resources developed for managed care organization staff.

Discussion/Rationale: People with disabilities that have been through the Medicaid or Social Security disability determination processes have learned that “disability” status and “employment” do not co-exist in the administrative uses of the terms. In most instances they have given up the notion of employment and some may fear even discussing their wish to work and add income for fear of losing their hard-won benefits. Yet the fact is substantial employment is possible, based on a variety of factors such as the nature of the disability, the technologies, therapies and supports that can diminish and even eliminate work related limitations and access to Medicaid despite increased income. For many people with disabilities the first exposure they will have to the possibilities of work, and the services and supports available, will be with through their ADRC and in particular, through the options counseling that is offered by ADRC's.

Professionally crafted education and training resources that are uniformly available to all ADRC's is the cornerstone of sound and consistent practice. MIG may also be

Managed Care and Employment Task Force
Issue Committee #1

developing training around employment options and supports which is designed for managed care organization staff. System-wide training that is comprehensively designed, integrated as much as possible, and ideally built upon shared ADRC/CMO terms, concepts and values will create efficiencies of scale and consistency of policies and practices statewide.

Recommendation 1.2: Disability Benefits Specialists (DBS) should have a basic knowledge and competency level with regard to Social Security work incentives. While not expected to do full work incentives counseling, they should be expected to support the idea that people can work, once they are on benefits, and to inform individuals about the availability of work incentives counseling.

Discussion/Rationale: As discussed above, people with disability entitlements can work and many wish to do so. Yet employment has been implicitly discouraged through their experiences with the Social Security and Medicaid systems. Following a discussion about the interaction of earnings and disability eligibility rules, the encouragement and support from a DBS can provide a foundation for consumers making informed decisions about their return to work. As well, increased access to and use of work incentives counseling will likely occur if DBS's see their role as including the education of individuals about the availability of work incentives counseling, and making referrals where individuals desire such counseling.

Recommendation 1.3: Each DBS should have a relationship with a Work Incentives Benefits Specialist (WIBS) who can provide the DBS with on-going information and technical assistance related to work incentives on an as-needed basis.

Discussion and Rationale: Given the workload and fundamental nature of the DBS position and the complexities of the work incentives, the DBS should not be expected to do work incentives benefits counseling. Ideally, DBS's should receive an basic overview of work incentives not more than one year after starting in the role. WIBS, either as an informal association fostered by the statewide Wisconsin Disability Benefits Network (WDBN) or through formal arrangements such as an MOU with the WDBN or the state's array of Independent Living Centers, can provide DBS's with on-going information on work incentives and serve as a technical resource when the paid services of a WIBS is not necessary.

Recommendation 1.4: MIG should support a pilot that locates a WIBS in an ADRC. Should the pilot prove helpful in expanding access to, and use of work incentives benefits counseling, a plan for expanding to other ADRC's should be pursued.

Discussion and Rationale: Referral to community resources that meet stated needs, as well as the promotion of work as a prevention strategy, is consistent with the ADRC's overall focus and mission. Co-locating a WIBS in an ADRC would enable the ADRC to offer a one-stop service for the consumer.

Managed Care Functional Screen

Recommendation 1.5: In Section A., full-time and part-time employment should be defined consistently for all target populations. The definition of full-time employment should be 30 hours or more per week. The definition of part-time should be anything less than 30 hours per week.

Discussion/Rationale: Rather than having different definitions for the several target populations there should be uniform use of the terms.

Recommendation 1.6: For consumers working in a sheltered workshop, the screener should be asked to ascertain the typical number of hours per week spent doing paid work. This number should be used to determine full-time or part-time employment.

Discussion/Rationale: Individuals are typically not involved in paid work for all of the hours they attend a sheltered workshop. Therefore, it is important to ascertain how many hours are typically spent on paid work in order to accurately determine if a particular individual is working part-time or full-time.

Recommendation 1.7 In the interest section, the following changes should be made to better capture the questions' purpose:

I = Interested in pursuing employment, more hours, different job, or additional job.

N = Not interested in pursuing employment, more hours, different job; or additional job.

Discussion/Rationale: The purpose of this question is to determine if the individual has any interest related to pursuing or expanding his/her involvement in employment. The current screen poses the question of whether the individual is "interested in new employment". This may discourage some people who are currently employed from stating that they would like more hours or an additional job.

Recommendation 1.8: If the individual being screened is unemployed and reports not being interested in pursuing employment, the screener should be prompted to ask the primary reason and record it by checking the appropriate box in a pull-down menu or recording it in the notes section.

Discussion/Rationale: The current data from the functional screen regarding interest in employment suggests that there is a surprising number of working age individuals who report not being interested in employment. The system would benefit from having information regarding the most common reasons why individuals served by the long-term care system may express no interest in employment, changing employment, or increasing hours worked. If particular reasons are found to be very common and are considered addressable through information, education, benefits counseling or a similar approach, this could be offered by the Aging and Disability Resource Center or Managed Care Organization.

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Recommendation 1.9: The instructions should direct the screener to state that the response to the question regarding interest in pursuing employment, more hours, different job, or additional job will in no way impact the eligibility determination.

Discussion/Rationale: Consumers who deal with Social Security are used to having to prove themselves unable to work in order to establish eligibility. When these individuals are being screened for eligibility for long-term care services, they may readily assume that expressing an interest in working will count against them in terms of eligibility, unless the screener makes it clear that long-term care eligibility is will not be negatively impacted if they express a desire to work.

Recommendation 1.10: In Section B., the options for where a person is employed should be changed to the following:

Works in sheltered workshop/work center
Works in community setting in group supported employment
Works in community setting in individual employment
Works from home

Discussion/Rationale: At present, the functional screen gives four options for where a person may be employed: (1) attends pre-vocational day activity/work activity program; (2) attends sheltered workshop; (3) has a paid job in community; (4) works at home. Since this question is related to determining work setting, option (1) should not be included as these are programs, not settings. In addition, participation in a day activity program should not be counted as employment since it does not involve paid activity. Adopting the four options suggested above would allow for more accurate collection of data related to work setting and level of community integration.

Recommendation 1.11: Section C should not be optional for unemployed persons who express interest in pursuing employment. The statement saying “optional for unemployed persons” should be removed and a check box should be added for “NA – unemployed and not interested in pursuing employment.”

Discussion/Rationale: It is important to have information on the level of support an individual is likely to need if s/he expresses interest in pursuing employment. This information will also allow the Department to produce aggregate data, for all unemployed persons interested in pursuing employment, regarding the support needed to do this. In addition, because the data collected in Section C has some impact on the capitated rate setting process, it seems reasonable to have this section completed for all individuals currently employed or interested in pursuing employment.

Recommendation 1.12: The instruction manual and screener training should be revised to provide screeners with clear guidance about how to determine an individual’s need for assistance, where the individual is not currently employed but is interested in pursuing employment.

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Discussion/Rationale: Since data from the functional screen suggests that most screeners currently bypass Section C. for unemployed persons, they will likely need guidance on how to determine a consumer's need for assistance needed to work if the person is not currently employed. Determining the level of assistance needed for work will require some exploratory questioning, particularly if the person has never been employed.

Recommendation 1.13: If employment-related screen data is determined at some future point to be a cost driver, Section C. data, which is used in calculating capitated rates, should reflect the different degrees of assistance needed to work, when this data is used in determining capitated rates.

Discussion/Rationale: Determining capitated rates in a way that takes account of the level of need for assistance people have in relation to employment, can help ensure that differential needs for assistance, and the differential service costs that are likely to be associated with this, is considered in determining capitated rates.

Recommendation 1.14: The instruction manual section related to employment should be revised and the revisions should be incorporated into screener training.

Discussion/Rationale: Currently, the instruction manual for the functional screen does not provide detailed instructions for completion of the employment section of the functional screen. The manual addresses employment in Section 4.4 (Page 4-8) but that section merely cuts and pastes the employment section of the functional screen into the instruction manual. In order to ensure that the employment section of the functional screen is completed correctly and consistently, more guidance should be provided to screeners in this section of the instruction manual and in screener training.

Managed Care Organization Inter-Disciplinary Team

Recommendation 1.15 The role of the MCO inter-disciplinary team (the “Team”) related to employment should be consistent with expectations included in the case management service definition and consistent with what is expected of Teams in addressing other outcome areas; and should ensure that employment is given the same consideration as all other outcome areas. This would ensure that all Teams have a common understanding that their role in relation to employment includes the following:

- Identifies the participant’s preferred employment outcomes
- Identifies and authorizes the services needed to achieve those outcomes
- Monitors the delivery of services to support employment outcomes
- Monitors progress in achieving identified employment outcomes.
- Assists members to identify and access other services and supports for employment which are available outside of the managed care organization.

Discussion/Rationale: Among the managed care organizations that exist, there are a variety of viewpoints about the role of the Team in relation to addressing member employment goals and outcomes. Partnership sites have had a strong focus on health because they manage acute as well as long-term care. As well, they have only recently seen employment services added to their benefit package. These managed care programs are just beginning to grapple with employment and integrating that into the overall focus of their Teams. Family Care sites are also grappling with how far the role of the Team is expected to go in relation to employment, particularly given the presence of the Division of Vocational Rehabilitation. There is overall agreement that the Department should be careful to neither expect too much nor too little from Teams when it comes to employment. At one end of the spectrum, there is a need to avoid situations where Teams are not raising the subject of employment with members. At the other end of the spectrum, there is a need to avoid situations where Teams are expected to do job development and other time consuming activities that are typically done by service or support providers. It will be extremely valuable for the Department to clarify expectations regarding the role of the Team, and care managers in particular, with regard to identifying and addressing the employment outcomes of individual members. This committee agreed that employment should be given equal consideration with all other outcome areas, and employment should be recognized as one of the core outcome areas, along with health, living arrangement, etc. The committee agreed that helping people achieve employment should have the same value and status as helping people achieve other outcomes. Clearly defining the role in the contract would be one way to convey expectations regarding employment to the MCO’s. The role needs to honor the importance of offering a full range of choices around employment and providing flexible services to support each member’s individual employment goal.

Recommendation 1.16 The knowledge and skills Teams need to effectively and thoroughly address employment with members should be included in the core competencies for Teams, which are established by MCO’s. Given the role described in

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Recommendation 1.15, it is recommended that the follow skills and knowledge areas be included in the core competencies:

Core knowledge for member-centered teams should include:

- (1) Understanding of benefits of working; knowledge of common misconceptions associated with working and why these are misconceptions for many individuals; familiarity with and understanding of values articulated by Task Force.
- (2) Understanding of variety of options for pursuing work, and ability to explain the different options to the member in a way that promotes informed choice.
- (3) Understanding of the variety of services and funding available through the managed care organization and through other entities (e.g. VR and One Stops; Ticket to Work; benefits counseling; etc.) to support: exploring opportunities for employment; pursuing employment; maintaining employment; pursuing career change or advancement; and overcoming no-interest barriers.
- (4) What VR can provide and how application process for VR services should work, particularly what the team's role and responsibilities are in helping people apply to VR and what the team's role and responsibilities are if a person is denied VR services or is placed on an extended waiting list by VR.
- (5) Understanding of paths to employment that don't involve services and how to engage member's allies and wider community in assisting member to pursue, obtain and maintain employment.
- (6) Understanding of how to create ISP's which offer temporary "**in the meantime**" services to fill a person's days while the member is being assisted to find community employment (so members are not discouraged from pursuing community employment because they can't start in community employment right away).
- (7) Understanding of how to create ISP's which offer services to support community employment and other "**wrap-around**" services to fill the person's time if the person is only working part-time in the community (so members are not discouraged from pursuing part-time community employment because they will not have services for the hours when they are not working).
- (8) Understanding of how non-work services in managed care benefits package can be used to support work (e.g. personal care services can be used to provide support in the workplace; transportation services can be used to get someone to and from a job; adaptive aids can be provided to support employment), preparation for work (volunteering, mobility training), and the exploration of possibilities regarding work (e.g. job shadowing, career exploration activities) to further facilitate informed choice.

Core skills for member-centered teams should include:

- (1) Getting the dialogue going with members and strategies for how to maintain a dialogue over time about employment.
- (2) Using effective follow-up strategies if member states that s/he is not interested in employment. [It is recommended that guidelines and sample strategies be developed which can assist Teams in identifying the reasons for a

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member's lack of interest in employment and determining both whether and how to address a member's lack of interest in employment.]

(3) Using person-centered approaches to facilitate informed choice and planning around employment; strategies for starting with the person and enabling the person to lead the Team to the desired outcome and the services necessary to support the outcome.

(4) Presenting options in ways that ensure the member can understand and compare the options, and develop clear preferences. For individuals with cognitive disabilities, this should involve using strategies like: simple, everyday language; offering the opportunity to directly observe and/or experience the different options on a trial basis; providing written materials which are written at a third-grade reading level and which utilize pictures to convey meaning; and using videos to convey information on the work options available.

(5) Using the MCO's service authorization policy for employment in a way that respects each member's unique employment preferences and takes account of the scope and purpose of each of the service available in the member benefit package.

(6) Using effective strategies in talking with parents/guardians, dealing with situations where the parent/guardian and member are expressing different preferences around the question of employment, and encouraging both parties to value and make an informed choice.

Discussion/Rationale: MCO's are already required to establish and ensure core competencies for their Teams. This recommendation builds on existing practice by asking MCO's to ensure that the established core competencies specifically address the knowledge and skills areas that Teams need to effectively address employment with members.

Recommendation 1.17 Methods for ensuring that core competencies around employment are maintained by Teams should be developed and implemented by MCO's. Where this involves training, the efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost-effective approach to training around employment results. MIG resources could be made available to support MCO's in implementing this recommendation.

Discussion/Rationale: By establishing core competencies for their Teams, MCO's also make a commitment to ensure that such competencies are consistently maintained by their Teams. Developing methods to ensure Teams acquire and maintain these core competencies over time will require investment on the part of each MCO. MIG resources could be made available to support MCO's to develop and pilot strategies which ensure that Teams establish and maintain employment-related core competencies, and to design plans for long-term sustainability of the strategies found to be effective.

Recommendation 1.18 MCO staff should have employment expertise, including but not limited to work incentives benefits counseling and integrated employment expertise, available to them either through an MCO position dedicated to

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employment or through some other arrangement (e.g. use of consultants). MIG resources should be made available to pilot different methods for making the employment expertise available in order to determine the most effective and sustainable model to recommend to all MCO's.

Discussion and Rationale: MCO staffs have many responsibilities in relation to assisting members to achieve their personally identified outcomes. It is unreasonable to expect that MCO teams in particular can be experts on helping members achieve employment outcomes. Some MCO's have already made other forms of specific expertise available to teams on an as-needed basis (e.g. pharmacy expertise; home modifications expertise). Consistent with this approach, MCO teams will be much more effective at assisting members with employment goals if they can access employment expertise on an as-needed basis. MCO's should be free to decide how they make this employment expertise available. MIG supporting the piloting of this should help MCO's see the value and encourage MCO's to determine how to provide this expertise on a long-term basis.

Comprehensive Assessment, Member-Centered Planning and Individual Service Planning Processes

Recommendation 1.19 The Department should adopt and articulate the expectation that members be as informed as possible before deciding if they want to work and before identifying specific employment outcomes and preferences regarding services/supports that can best help them achieve those outcomes. Where policy and contract references are made to member choice, the Department should clarify that the expectation is *informed* choice; and provide a definition of informed choice. The concept of informed choice should be distinguished from the concept of informed consent, which relates specifically to health-care decisions.

Discussion/Rationale: A commitment to consumer choice is a critical cornerstone for an effective, high quality long-term care system. Yet choice can mean many things and choices can be presented and considered in many ways. Almost without exception, where choice is emphasized as a core value, it is informed choice that is intended. However, without explicitly stating a goal of informed choice, and defining what does and does not constitute informed choice, a focus on consumer choice may not result in consumers being assisted to make truly informed choices. Choices can be inadvertently limited, only partially explained or inaccurately explained, or presented in ways that an individual cannot fully understand and consequently cannot develop specific preferences which would typically guide informed choice-making. In order to support and facilitate truly informed choice, adequate information about the variety of options needs to be provided, including access to sufficient personal experience as is necessary for the person to develop preferences. Information must be provided in a manner that reflects the person's ability to understand and communicate. Additionally, the person should have access to unbiased, nonjudgmental advice and support to assist the person to analyze the information, including consideration of positive and negative consequences. Where the

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choices of a guardian and ward may differ, the extent to which the inter-disciplinary team is required by law to adopt the choice of the guardian as that of the ward should be clearly defined. It is critically important for the Department to link the value of consumer choice to an expectation of informed choice, and to provide guidelines regarding what does and does not constitute informed choice. This is particularly critical when it comes to promoting choice with regard to employment.

Recommendation 1.20 The Department should provide guidance on the expectations of MCO's and their Teams in relation to facilitating and supporting informed choice with regard to employment.

Discussion/Rationale: In order to ensure that all MCO members know that integrated employment is something that the managed long-term care system will help them pursue, the system must first ensure that everything possible is being done to promote informed choice around employment – both on the question of whether to work and whether to pursue integrated work opportunities. While it's important to assume that each member knows what is important to him/her, we should not assume that each member comes to the managed care organization fully aware of all of their options. Care managers and teams need to make sure that members are aware of all of their options, and that members truly understand those options and how they compare to each other. Access to work incentives benefits counseling is one critical part of ensuring informed choice, given that so many people assume that working causes loss of eligibility for both Social Security benefits and long-term care services. Identifying the essential elements necessary to ensure informed choice will be a critical precursor to members being asked to make choices about the employment outcomes they wish to pursue and achieve.

Recommendation 1.21 The opportunity to choose to pursue employment (and for those employed, the opportunity to pursue more employment, job change, a partial or full move to integrated employment, or career advancement) should be offered to members as part of every member-centered plan development or review meeting, which generally occur twice a year, in order to ensure that members are routinely consistently informed that they can identify employment as a goal or area for further exploration.

Discussion/Rationale: Evidence suggests that too often, employment (particularly the option to pursue integrated, individualized employment) is being inadequately addressed in member centered planning. Consistently asking about employment is critical, as interest and individual circumstances are likely to change over time. Where employment is being consistently addressed by Teams, this appears to be due to the fact that employment is a distinct outcome area addressed in the MCO's member-centered planning processes and documents, and Teams are expected to raise the subject of employment at every planning and review meeting. One MCO has created an employment sub-plan to the member-centered plan, which guides Teams in routinely addressing employment as part of outcomes planning and reviews. [See Appendix for La Crosse CMO's employment sub-plan.]

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Recommendation 1.22 DHFS currently reviews and approves each MCO's assessment process. As part of the assessment process review, DHFS should ensure that the assessment process thoroughly and effectively addresses the outcome area of employment. DHFS staff should be available to offer technical assistance and advice to individual MCO's, if an MCO requests this.

Discussion/Rationale: DHFS maintains responsibility for approving the assessment process and service authorization process of each MCO. DHFS can use this role to ensure that each MCO's approach to comprehensive assessment and member-centered planning adequately addresses employment and does so in a way that does not overlook or discourage integrated employment, and that does not adopt a readiness approach to identifying needs and outcomes related to employment.

Recommendation 1.23 Where members are receiving services from both VR and the MCO, it is important that effective and on-going communication takes place between the VR team and the MCO Team in order to coordinate efforts. As part of this commitment to coordination, the MCO Team and the VR team should ensure that the managed care member-centered plan (MCP) employment outcome and the vocational rehabilitation individual plan for employment (IPE) goal are consistent, so that supports and services committed by the two entities are coordinated in support of a common goal. The MCO Team and the VR team should also ensure that there is a common understanding of the role and responsibilities of each agency (including where the responsibilities of each agency start and stop) in relation to assisting the individual to achieve his/her personally identified employment outcome.

Discussion/Rationale: Blending and coordinating services and funding available through VR and managed care can greatly enhance the likelihood that consumers can achieve their integrated employment outcomes. On-going communication and coordination is essential, as is agreement between the agencies with regard to the specific employment goal/outcome they are assisting the individual to achieve, and the specific roles and responsibilities each agency is assuming in the individual's overall employment plan.

Recommendation 1.24 In collaboration with MCOs, DHFS should develop guidelines on the role and appropriate use of the Resource Allocation Decision (RAD) Method in relation to determining the most effective and cost-effective way to meet a member's employment goal/outcome. DHFS could integrate these guidelines into the RAD trainings being provided by DHFS to MCO's and their Teams so that the RAD's specific application to employment outcomes is fully understood by all MCO Teams. Any guidelines developed by an individual MCO, for using the RAD in relation to member employment outcomes, should be consistent with the guidelines developed by DHFS, and should include examples of best practices and creative approaches MCO's have used in applying the RAD method to members' employment outcomes.

Discussion/Rationale: The RAD is the most common service authorization policy used by MCO's. The goal of the RAD is to enable MCO Teams to identify the most

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effective and cost-effective method for meeting a member's identified outcome. Cost-effectiveness is defined as "effectively achieving a desired outcome at a reasonable cost and effort." Yet creators of the RAD acknowledge that there is a danger that it will be used to create cost savings for MCO's by legitimizing the referral of members to the cheapest services which may not represent the most effective method for meeting the member's identified outcome. MCO Teams need specific guidance on using the RAD in relation to member employment outcomes. Existing training does not adequately address this. With regard to employment outcomes there is a concern that an individualized employment outcome identified by a member will be translated into a referral to a prevocational program in a sheltered workshop/work center because this referral may offer the cheapest and most readily available service, or because its historically been assumed that individuals belonging to certain disability groups typically work in these settings. Significant guidance for Teams is needed to ensure that employment outcomes are not confused with employment services (e.g. I want to work in a sheltered workshop), and that people are asked about *what kind* of work they want to do. Once the kind of work a person wants to do is established, then the Team can look at the various places where people can do that kind of work, and the various ways the person can be supported to pursue and maintain that kind of work. The new guidelines developed could include case examples and would clearly explain how the RAD is intended to be used in conjunction with other assessment and planning tools.

7. Recommendations Falling Outside of Issue Committee Charge

Recommendation 1.25 DHFS should convey to MCO's the following policy expectations in order to best ensure that all of the above recommendations are successful.

- (1) Each MCO should develop and adopt a set of employment services guidelines. [Sample from La Crosse MCO is attached as part of the Appendix.]
- (2) The MCO and local VR office should each consider appointing a staff person as liaison to the other so that coordination is maximized between the MCO and VR, where the agencies are serving the same individuals. These liaisons would support MCO teams and VR counselors who are serving individuals receiving both MCO and VR services.
- (3) MCO provider network developers should encourage approved providers of employment services to apply to become approved VR vendors. This will offer one way to ensure continuity of service for MCO members who will utilize both VR and managed care services.
- (4) For services in the benefit package which are typically used to support employment, DHFS and individual MCO's should review their respective policy requirements and rules in order to identify/address any requirements or rules that may inadvertently discourage or restrict the use of these services to support employment. MCO's may also want to ask their providers to review their internal policies and rules for the same purpose. MCO Teams should have a formal mechanism by which they can report individual situations where service policies or rules interfere with the Team's ability to authorize the service to support a member's employment outcome.

8. Recommendations to be brought to the Full Task Force for Final Decision

Note: Recommendation 1.26 is similar to a draft recommendation debated in Issue Committee #6. Since consensus could not be reached regarding whether to bring the recommendation forward to the full Task Force, Issue Committee #6 plans to bring the draft recommendation to the full Task Force for a discussion and final decision. Given that Recommendation 1.26 is concerned with the same issue, this recommendation should be considered and discussed by the full Task Force when the draft recommendation from Issue Committee #6 is also considered and discussed.

Recommendation 1.26 A distinct personal experience outcome focused on employment should be restored for the purposes of member-centered planning and the personal outcomes identification which is an integral part of this planning.

Discussion/Rationale: The personal experience outcome areas are used to guide the member-centered planning process at MCO's. At present, managed care has twelve specific personal experience outcome areas. Some members might have more than one desired outcome in a particular area while others may have no desired outcomes in that area. Consistent with a commitment to individual choice, the presence of a particular outcome area does not lead to a requirement that a member have an identified outcome in that area. However, the presence of an individual outcome area does ensure that the area will be discussed as part of the outcomes identification interview. At this time, employment is not a specific outcome in the list of personal experience outcomes being used in managed care. It appears the change was made in late 2006. Employment is now one example of an outcome that would fall under the "I do things that are important to me" personal experience outcome area. Prior to this, employment was addressed as a distinct outcome area in an earlier list of personal experience outcomes adopted by the Department for managed care and the Community Options Program (COP), "People achieve their employment objectives" was the identified outcome that addressed employment. As well, in the Community Integration program (CIP), "I am working as much as I want in a job that I like" was the identified outcome that specifically addressed employment.

As mentioned earlier in this paper, the committee agreed that employment should be given equal consideration with all other outcome areas, and in order to ensure this, employment needs to be recognized as one of the core outcome areas, along with health, living arrangement, etc. The committee agreed that helping people identify and achieve employment outcomes should have the same value and status as helping people achieve the other outcomes identified in the current list of twelve personal experience outcomes. One of the greatest challenges to enabling more individuals to access the opportunity to work is that employment is often overlooked or dismissed as impossible, impractical or ill-advised during the planning process. The committee agreed that there is a need to lift up the importance of employment so that employment is given equal value, treatment and consideration.

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9. Appendices

Appendix A: La Crosse CMO Member-Centered Plan Employment Sub-Plan

Appendix B: La Crosse CMO Employment Service Guidelines

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #2

**State Agency Contracting/Funding Strategies and
Service Definitions that can Support and Facilitate
Member Employment Outcomes in Managed Long-Term Care**

Final Report

March 20, 2008

Managed Care and Employment Task Force
Issue Committee #2

1. Issue Committee Charge

- Review state contracts with MCO's and make recommendations for how contracting process and contracts themselves can be used to strengthen MCO accountability for employment outcomes;
- Review basis for current capitated rates, and recommend possible "pay for performance" strategies that may be necessary to encourage both planning and delivery of services/supports to help members achieve their employment goals (with particular emphasis on integrated employment goals);
- Review of existing waiver service definitions, used in Managed Care, that are related to employment;
- Determine whether services available include those necessary to facilitate and support employment outcomes;
- Recommend new services, or changes to existing service definitions (that may be necessary to pursue when waiver is renewed with federal government) to ensure a sufficient array of services and supports for employment, particularly integrated employment, are available through Managed Care;
- Recommend specific changes to service definitions (that may be necessary to pursue when waiver is renewed with CMS) to eliminate disincentives to helping members achieve their employment goals, with particular attention to integrated employment goals.

2. List of Task Force Members Serving on Issue Committee

Fredi Bove, Deputy Administrator, Division of Long-Term Care [Committee Chair]
Dan Bier, Waisman Center
Mary Krueger, Winnebago County
Jodi Hanna (representing Monica Murphy), Disability Rights Wisconsin

3. List of Other Participants and Contributors to Issue Committee

Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Molly Michels, Pathways to Independence, DHFS
Dan Johnson, Pathways to Independence, DHFS
Mike Linak, Developmental Disabilities Section, DHFS
Tammy Hofmeister, Developmental Disabilities Section, DHFS
Steve Stanek, Board for Persons with Developmental Disabilities
Larry Debbert, Fond Du Lac Managed Care Organization
John Reiser, Office for Independence and Employment, DHFS

Managed Care Section consultants to Issue Committee:

Monica Deignan
Tom Lawless
Peter Baugher

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4. Issue Committee Meetings

August 16, 2007

October 25, 2007

November 20, 2007

February 21, 2008

(A sub-committee on service definitions was also formed and met twice.)

5. Summary of Issue Committee Process

This committee began its work by reviewing the 2007 Department contract with Family Care managed care organizations. The committee consulted Department contract experts and considered how the contract language could be strengthened to support employment outcomes for Managed Care members. From these discussions, a short list of contract language recommendations was developed to update contract language to reflect current approaches to employment.

The committee discussed service definitions, and convened a small sub-committee to review and make recommendations regarding improvements or additions to the existing service definitions in the Family Care member benefit package that would facilitate improved employment outcomes. The service definitions sub-committee met twice and produced recommendations related to three existing service definitions designed to support employment among Family Care members.

The committee explored Performance Improvement Plans (PIP's) and heard a presentation about the first PIP being undertaken which has a specific focus on employment. The committee spent time exploring Pay for Performance (P4P), getting expert Departmental input from Department fiscal staff, Tom Lawless, and discussing what would need to be done to enable the Department to do a Pay for Performance initiative around integrated employment. The committee also discussed capitated rates, and the formula used to determine the rates. Tom Lawless provided the overview and participated in a discussion to identify what rate-related recommendations may be needed to ensure that the funding for employment services, and particularly integrated employment services, is adequate enough so as not to create any disincentive for a managed care organization to support more members to pursue employment, particularly integrated employment. The committee went on to discuss the MCO certification process and the components used to certify new MCO's prior to the start of operations, and to annual re-certify existing MCO's. The committee focused on certification requirements related to the adequacy of provider networks.

6. Recommendations

Recommendation 2.1 The Committee recommends that the Department adopt the Policy on Employment developed by this Task Force and incorporate the Policy itself, or the intent and expectations of the Policy into the Department's contract with MCO's. In

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addition, the contract should be updated to ensure it reflects current practices regarding employment, such as, for example, the inclusion of self-employment and micro-enterprise as employment options.

Discussion/Rationale: The committee agreed that it is important for MCO's to know and understand the values and mission behind Family Care in order to implement the contractual obligations correctly. If the Department adopts the Policy on Employment developed by the Task Force, the values underlying the Policy should be reflected in any contract language that specifically addresses employment. Attachment 1 includes specific contract language changes recommended to update the contract to reflect current practices and approaches regarding employment.

Recommendation 2.2 The Committee recommends that MCO's develop guidelines on employment, consistent with DHFS's policy on employment, that articulates and conveys the MCO's philosophy, values and expectations, with regard to employment outcomes and employment services, to MCO staff, members, families and other natural supports, providers and partners (including ADRC's).

Discussion and Rationale: Managed care organizations are contracted entities responsible for administering the managed long-term care system on behalf of the Department. The development of guidelines by each MCO will assist in operationalizing the values and policies of the Department. The guidelines will serve as evidence of how each MCO is implementing the Department's policies related to employment.

[Note: Similar to Recommendation 3.3]

Recommendation 2.3 The Department should gather together and provide to MCO's with the most current examples of best practices which MCO's can draw on in implementing the recommendations of this Task Force and contractual obligations related to employment outcomes and services. Medicaid Infrastructure Grant resources could also be used to provide technical assistance and/or training to MCO's who request expert assistance to implement best practices in their organizations and with their provider networks.

Discussion and Rationale: MCO's will be most effective in carrying out the recommendations of this Task Force and in meeting their contractual obligations related to employment outcomes and services if they have access to information on the best and most progressive practices that have been shown to produce positive results. The availability of technical assistance and/or training for MCO's will further assist MCO's to effectively implement best practices.

Recommendation 2.4 The Committee recommends that the Department explore whether the current capitated rate methodology could be refined, using an actuarially sound approach, to incorporate MCO utilization adjustments with less lag time.

Discussion/Rationale: The current capitation rate methodology incorporates MCO utilization adjustments with a two-year lag. This lag may serve as a disincentive for

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managed care organizations to expand investment in services to support members in integrated employment. The Federal Medicaid program requires that managed care capitation rate methodology be actuarially sound. The Department could explore whether there is an actuarially sound approach that would shorten the lag time in which an MCO's utilization adjustments are reflected in the capitation rate.

Recommendation 2.5 The Department should consider implementing an employment pay for performance initiative. Medicaid Infrastructure Grant (MIG) funding could be utilized to support the Department to develop the theoretical framework for an employment Pay for Performance initiative, including identification of causal paths, effective interventions and measures of success. Incentive payments would be tied to members achieving integrated employment outcomes.

Discussion/Rationale: Pay for Performance initiatives are designed to promote health outcomes and long-term cost-effectiveness. Important to the success of these initiatives is the work of identifying and substantiating the interventions that will promote long-term health and cost-effectiveness outcomes. MIG is an appropriate funding source to tap to support this preliminary work. Like the Alzheimer's Pay for Performance initiative, which benefited from previous work by the Alzheimer's Society with MCO's, the current Pathways/MIG employment work with MCO's lays a foundation for an employment-focused Pay for Performance initiative.

Recommendation 2.6 The Committee recommends that employment be a target area of focus for MCO performance improvement projects in CY2009-2011.

Discussion/Rationale: Up to this point, DHFS has identified areas of focus for MCO performance improvement projects. Consistent with this practice, DHFS could identify employment as a target area that MCO's could address in the annual Performance Improvement projects. Encouraging MCO's to pursue performance improvement project focused on employment while the Department holds the Medicaid Infrastructure Grant (CY2009-2011) will allow the Department to offer substantial technical assistance to MCO's that opt to focus their performance improvement project. The availability of this technical assistance should strengthen project outcomes.

Recommendation 2.7 The certification process can be used as one means to evaluate an MCO's capacity to support the integrated employment outcomes of its members. Potential areas of evaluation that could be addressed in the certification process are:

- Ensuring that the MCO has adequately addressed how it will operationalize the Department's policy on employment, and has demonstrated it has sufficient capacity to do so. [The policy statement on employment should ideally be included in the information packet sent to MCO's in order to help them prepare for certification.]
- Ensuring that the comprehensive assessment includes identification of an individual's personal outcomes for employment and assessment of support needs related to pursuing the individual's identified employment outcome.

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- Ensuring the MCO’s service authorization policy is accompanied by guidelines for how care management teams should use/apply the service authorization policy in relation to supporting a member’s employment outcomes, and that those guidelines do not create any disincentive to support a member’s desire to pursue integrated employment.
- Ensuring that the core competencies identified for MCO staff reflect the values and expectations in the Department’s policy on employment.
- Ensure MCO’s identify a source of expertise in the areas of employment options and services that will be available to their inter-disciplinary teams, provider network developer and quality assurance manager.
- Ensuring that MCO’s have an adequate number of providers of integrated employment services (e.g. supported employment; vocational futures planning) and those providers have adequate ability (and a solid plan) to expand capacity to meet demand, particularly from those coming off of waiting lists.
- Ensuring that MCO’s have at least two qualified sources for vocational futures planning services identified, prior to elimination of waiting lists. The MCO’s themselves could be a source for the service, if they provide the service in-house.
- Ensuring that the MCO’s options for prevocational services and providers are not limited to work centers/sheltered workshops, prior to elimination of waiting lists.

Discussion/Rationale: Prior to contracting with a new MCO, or with one that is going to be serving a new service area, the Department conducts a certification and pre-contracting review to determine the MCO will be able to meet certain basic requirements. The Family Care statute contains certification requirements related to adequate availability of providers, expertise in determining and meeting the needs of covered target populations, and adequate and competent staffing to perform all the functions of the MCO. As part of the certification process the Department can seek to ensure that MCOs have adequate provider capacity in their networks to address the employment-related outcomes of members, particularly integrated employment outcomes.

Recommendation 2.8 The Committee recommends that the Department update the service definition for prevocational services to reflect the definition and standards used in the Community Integration Program and to reflect best practices, including the provision of services that: offer people the chance to learn skills directly related to helping them succeed in achieving their individually identified employment goals; complement and enhance what is currently available through DVR; and are not based on a readiness model. In addition, the following standards, for prevocational service providers that provide paid work opportunities incidental to the delivery of prevocational services, should be incorporated into the service definition:

- Adopting a downtime policy:
Where people are involved in prevocational services that involve paid work activities, if there are periods in which no paid work is available for prevocational service recipients, despite the good faith efforts of the provider to secure

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such work, the provider shall ensure that each service recipient participates in training activities which are age appropriate, work related, and consistent with both the definition of prevocational services and the individual's ISP. Such activities include, but are not limited to:

1. discovery and career exploration
 2. resume development including portfolios and video resumes;
 3. job interview training and practice;
 4. job safety training;
 5. work place social skills training (employee etiquette – basics of maintaining good relationships with co-workers and supervisors, etc.);
 6. self-advocacy training
 7. community orientation, navigation and travel training
- Adopting OSHA health and safety standards
 - Adopting minimum staffing ratios
 - Doing unpaid contract work, or engaging in training that involves doing unpaid contract work, should not be undertaken.

Discussion/Rationale: It appears that prevocational services may not be achieving their intended purpose, which is to prepare people for community employment. Very few individuals move from prevocational services to regular employment, even on a part-time basis. In many cases, prevocational services are not a precursor to employment, but are the end in themselves. The current service definition is based on a readiness model which disability policy long ago abandoned. Wisconsin could better ensure that the intent of providing prevocational services is fully realized if the service definition is modernized to reflect best practices which strengthen the focus on preparing people for community employment. There is a need to invest system resources in supporting new models of prevocational services which can better achieve the intent of prevocational services. Research indicated that the best practices outlined above are being used with good results in other states. Adopting these practices in Wisconsin will strengthen the quality of prevocational services for those individuals who choose to use prevocational services.

Recommendation 2.9 The Department should consider developing rigorous criteria that would apply for new admissions and entrants to prevocational services in work centers/sheltered workshops, while honoring individual informed choice.

Discussion/Rationale: Currently, the predominant model for providing prevocational services is the work center/sheltered workshop model. As mentioned in the discussion section of Recommendation 2.8 above, the intent of prevocational services is to prepare people for community employment. Yet very few individuals move from prevocational services in work centers/sheltered workshops to regular employment, even on a part-time basis. In many cases, prevocational services offered in these settings are not a precursor to community employment, but are the end in themselves. The first employment

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placement/experience for an individual is important, as it may be the setting the individual stays in permanently, or may shape the individual's long-term expectations.

As a tool for enhancing the effectiveness of prevocational services and promoting community inclusion over an individual's lifetime, the Department could consider whether it is feasible and appropriate to set rigorous criteria for new admissions and entrants to prevocational services in work centers/sheltered workshops, including students transitioning out of the school system and individuals coming off waitlists. This approach or other strategies would narrow the flow of new entrants into work centers/sheltered workshops. An effective practice used in other states is to target concentrated attention on developing integrated employment options for new entrants into the long-term care system, particularly students aging out of school.

Recommendation 2.10 Policy governing employment services should clarify that a Family Care enrollee can be referred to DVR or to MCO-funded supported employment services without prior participation in prevocational services.

Discussion/Rationale: Prevocational services are not a prerequisite for pursuing integrated employment.

Recommendation 2.11 In order to accurately track trends in the usage of prevocational services, the provision of prevocational services should be reported using the following categories:

108.10: Facility-based work (sheltered workshop)

108.20 Community-based group work (enclave or work crew)

108.30 Community-based training (not involving paid work)*

The Department should establish clear definitions for each of these categories and they should be consistent with the definitions used for employment settings in the Functional Screen. The Department should also establish a standard service unit definition to ensure that service delivery data is being reported consistently by MCOs.

*Note: This type of prevocational services is generally not available at this time but could be made available in the future. To maximize choice, efforts should be made to develop a range of prevocational service options, including community-based prevocational training which provides an alternative to work crews/enclaves and sheltered workshops. The community-based prevocational training option would ideally offer opportunities to receive services that can assist individuals to better qualify for the community employment opportunities they will be pursuing and that are not available (or not likely to be paid for) through VR, or through other existing services that can be purchased by managed care organizations (e.g. supported employment; vocational future planning). . Examples of this training might include training in the following areas: interviewing and applying for jobs; developing and maintaining good relationships with co-workers and supervisors; participating in technical college courses designed to prepare people for entry level community jobs; and resume-building experiences (including volunteer experiences) which can help people better qualify for the community jobs they will seek.

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Discussion/Rationale: Consistent data definitions will enable reliable system-wide data to be compiled and analyzed and utilized for quality improvement and program development purposes.

Recommendation 2.12 The definition of supported employment services in the Family Care benefit should be revised to reflect best practices, including but not limited to support of self-employment or micro-enterprise, customized job development, facilitation of natural supports in the workplace, and on-the-job training. Attachment 2 provides specific suggestions regarding the supported employment definition.

Discussion/Rationale: The current definition of supported employment services does not incorporate current and best practices.

Recommendation 2.13 The definition of vocational futures planning services in the Family Care benefit should be revised to reflect current and best practices, including: Career exploration, asset-based personal employment assessment and employment goal identification; benefits analysis and assistance with accessing and maintaining work incentives; person-centered employment planning and creation of a job development plan; assistive technology screening and assessment; job seeking support or support for development of self-employment or micro-enterprise opportunities; and on-going support on an as-needed basis to maintain employment once it is achieved. Attachment 3 provides specific suggestions regarding the vocational futures planning services definition.

Discussion/Rationale: The current definition of vocational futures planning services does not incorporate current and best practices.

Recommendation 2.14 Given that the Center for Medicaid Services requires that vocational services under the waivers (e.g. prevocational services; supported employment services; and vocational futures planning services) be provided only when they are not otherwise available through the vocational rehabilitation or special education systems, MCO's should develop guidelines for teams to ensure that members who are eligible for resources and services from the other systems are encouraged and properly supported by their MCO team to access and navigate those systems, and that all of the member's employment-related needs are being met in a way that is satisfactory to the individual member.

Discussion and Rationale: The vocational rehabilitation system and (for transition-age individuals) the special education system have key roles to play in supporting individuals who are served by the long-term care system to pursue and obtain employment. Both the vocational rehabilitation and special education systems have resources and services to contribute to supporting individual employment outcomes and services, which can complement the resources that the long-term care system has available. MCO's are responsible for ensuring that they act as good stewards for the resources they are given and this includes accessing resources available from other sources which can be combined with MCO resources to assist members with their employment goals. As part

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of the stewardship role, MCO's need to support individual members to access the resources and services available to them outside the MCO. Guidelines for MCO teams could help ensure that the support the MCO team provides to members will result in those members having a positive and satisfactory experience with the other systems being accessed.

7. Recommendations Falling Outside of Issue Committee Charge

None were identified by this committee.

8. List of Attachments

1. Specific Contract Language Changes for Consideration
2. Specific Suggestions for Changes to the Supported Employment Service Definition.
3. Specific Suggestions for Changes to the Vocational Futures Planning Service Definition.

9. Appendices

- Appendix A: MCO Contract, Page 1-41 and Appendix X (Service Definitions)
- Appendix B: Relevant excerpts from Chapter 4 of MA Waivers Manual
- Appendix C: DDES Numbered Memo #99-1

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Attachment 1
Specific Contract Language Changes for consideration

Contract area: Section III. CMO Functions: Services CY 2007 Contract	Suggested change
Part III: CMO Functions: Services Paragraph 5 (Top of Page 16)	Revise this section to reflect the fact that members can receive services in the long-term care benefit package outside of their residential setting, including in the places where they work.
Part III.A.15.b Services During Periods of Temporary Absence (Page 23)	In bullet one, add the examples in parentheses <i>training or job-related reasons</i> to address possibility of receiving services related to employment outside the service area.
B.1. Member Participation (Page 31)	Language should be added here or in another appropriate place that states “ <i>members shall receive clear explanations of the full range of employment and career options available, including the option to pursue integrated employment, self-employment or micro-enterprise development.</i> ”
B.3. Interdisciplinary Team Composition – Paragraph 1 (Page 34)	Add language to clarify how the team could include other members, and specifically address how and when it would be appropriate to involve a member’s employer.
B.3. Interdisciplinary Team Composition - Paragraph 2 (Page 34)	Revise to read: The service coordinator and nurse shall have knowledge of community alternatives, <i>including but not limited to residential and vocational alternatives</i> , for the target populations served by the CMO, and <i>knowledge of the full range of long-term care resources available to support members to live, work and recreate in their communities.</i>
B.6.b.xi. Assessment Format (Page 36)	Revise to read: Education, vocational activities, <i>employment status, employment preferences and goals.</i>
B.8 ISP and MCP Development Paragraph 2 (Page 37)	Add: ”Where necessary to facilitate informed choice-making, particularly in relation to vocational options, members with cognitive disabilities shall be offered the opportunity to directly observe and/or experience the different

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	options on a trial basis, and shall be provided with an overview, using language that can be easily understood, of the supports and services available to assist members to pursue the various options available to them.”
B.9.b Providing, Arranging and Coordinating Services (Page 41)	After this section add a new section with this language: “The coordination of services includes ensuring that vocational rehabilitation services are involved appropriately and in accordance with member preferences specific to pursuing and obtaining employment. The CMO shall ensure coordination of internally available services with services available from the Division of Vocational Rehabilitation in order to effectively support members’ employment goals. The CMO will arrange for employment related services not covered in the benefit package and assist members to obtain these services. The CMO will document the services being provided to the member by the Division of Vocational Rehabilitation and the name of the member’s DVR counselor. To maximize coordination, the DVR counselor will be invited to the member’s ISP/MCP development and review meetings, unless the member objects. Within 30 calendar days of the identification of an employment outcome in the member’s MCP, the CMO will obtain the member’s informed consent to receive and share appropriate information with DVR and the CMO will provide member education with regard to the effective use of DVR services.”
B.9.c Arranging for Services Not Covered in Benefit Package (Page 41)	Revise first sentence to read: The CMO will arrange for services not covered in the benefit package, including vocational rehabilitation services , and instruct members on how to obtain these services, including identification of transportation services and how they are provided by the CMO.
Appendix X: Service Definitions for Services in Family Care Benefit Package	Even though CMS groups employment services under the broader “habilitation” category, when the Department publishes listings of the services available in the Family Care benefit package, the Department should create a separate umbrella category for employment services to give the services designed to support employment more visibility.

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Attachment 2
Supported Employment Service Definition Suggested Changes

1. With regard to the current Family Care service definition, the following should be clarified within the definition or through policy:
 - A. Competitive employment should be defined as a payment for work that is generally equivalent to the payment made to others performing similar work. Competitive wage does not include commensurate wage or special minimum wage (sub-minimum wage).
 - B. Integrated work setting should be defined as a community-based setting (i.e., not a community rehabilitation facility or residential long-term care institution for people with disabilities) where the individual has significant interaction with co-workers who do not have disabilities or with the general public. Integrated work settings include those where the individual is involved in self-employment or micro-enterprise.
 - C. Service is not limited to any particular disability group or age group.
 - D. Supported employment services can be used for the supported work options described in Numbered Member #99-1 and for the support of self-employment or micro-enterprises involving no more than 5 individuals with disabilities co-operating and co-owning the micro-enterprise. Supported employment can also support home-based employment, self-employment or micro-enterprise, unless the home is classified as a residential institution (e.g. nursing home; ICF-MR).
2. Consideration should be given to establishing a new service in the Family Care benefit package specifically designed to support self-employment and micro-enterprise, with provider standards appropriate for this work.
3. The service definition language should encourage and reflect contemporary best practices. The second sentence should be revised to reflect emphasis upon use of: discovery; person-centered employment planning; resume-building activities; customized job development; assistance with development of micro-enterprise; on-the-job training; systematic instruction; facilitation of natural supports; transportation services; and support for career advancement. Service standards should be developed which detail expectations regarding the provision of each of these service elements.
4. The service definition could note that an individual's work-related transportation costs can be paid for as part of this service. The service can also be paid for through the specialized transportation service category.
5. The criteria for making the determination that services are not available through DVR should be specified. It is recommended that these criteria mirror those used in the Community Integration Program (CIP) waiver definition, which states that the service can be provided after an individual applies to DVR for the service and is: (1) denied; (2) put on a waiting list; or (3) served and then has his/her case closed.

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6. Supported employment can be provided by any “legally responsible person” including a “relative or guardian.” (Individual providers must currently meet standards established in the MA Waivers Manual for supportive home care.) Encouraging individual providers (including relatives and co-workers) will expand the range of options people have for receiving supported employment services (including transportation) and may contribute significantly to maximizing the cost-effectiveness of the service. In order to encourage the use of individuals across all aspects of supported employment services, the “Provider Type” relating to individual providers should not be limited to “on-the-job support.” Individuals who meet the provider standards established for individual providers should be able to provide any aspect of supported employment services – not just on-the-job support. The Department may want to give consideration to establishing more appropriate standards for individual providers of supported employment services than those established for individuals providing supportive home care services.

7. When providers and managed care organizations are reporting services delivered under the supported employment service category, it will be helpful to sub-divide the category in ways that allow tracking of specific types of service being provided under the banner of supported employment. The Department should adjust the Encounter reporting system to allow for a disaggregated breakdown of the services being delivered under this service category.

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Attachment 3
Vocational Futures Planning Service Definition Suggested Changes

1. The name of the service should be changed to avoid giving the impression that this service can only fund the Vocational Futures Planning model created by Employment Resources, Inc. A more simple and direct generic name should be chosen. This will ensure that every managed care organization can identify local qualified providers for the service, and that the service is used with maximum flexibility to serve any managed care member who would benefit from the service.

2. The service definition should clarify that:
 - The service is a team-based comprehensive employment service, which may or may not be consumer-directed, that supports service recipients to obtain, maintain or advance in integrated employment, self-employment or micro-enterprise opportunities.
 - The service is not limited to any particular disability group or age group.
 - Is intended to provide vocational supports to individuals who do not require supported employment services (individuals who do not need intensive on-going support, including job coaching, to maintain integrated employment). However, short-term on-the-job supports are and should continue to be included in this service. For individuals who require supported employment, the services included in the vocational futures planning service are available through SPC 615 – supported employment.
 - Is intended to supplement, not substitute for, services available from the Wisconsin Department of Vocational Rehabilitation. This means service can be provided when an individual applies to DVR for the service and is then: (1) denied; (2) put on a waiting list; or (3) served and then has his/her case closed.

3. The core services to be provided should reflect contemporary best practices and should be amended as follows:
 - Career exploration, strengths-based personal employment assessment and employment goal identification;
 - Benefits analysis and assistance with accessing and maintaining work incentives;
 - Person-centered employment planning and creation of a job development plan, including identification of strategies to overcome any barriers identified in relation to the individual's employment goal.
 - Assistive technology screening and assessment;
 - Job seeking support or support for development of self-employment or micro-enterprise opportunities;
 - Coordination of the team involved in delivering the service, with support to the consumer to actively participate and to lead the team to the extent the consumer wishes to do so;

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- On-going support, including on-the-job support, provided on an as-needed basis to maintain employment once it is achieved.
4. While the service is a team-based approach, team members may change over time as the consumer moves through the process. The core team members shall at minimum include an Employment Specialist, a Benefits Counselor and the consumer. In addition, an Assistive Technology Consultant must be identified to consult with the team on an as-needed basis. It should be clarified that the service delivered by the team shall be coordinated by the Employment Specialist. The agency providing the service may sub-contract responsibility for providing particular pieces of the service (e.g. benefits counseling or assistive technology consultation) to qualified sub-contractors.
5. Minimum provider qualifications for the Employment Specialist and the Benefits Counselor should not include completion of advanced degrees but should focus on adequate vocational experience with the types of consumers to be served and evidence of adequate vocational training or expertise related to the particular role being assumed.

DHFS/DLTC Managed Care and Employment Task Force

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Managed Care Organization Strategies for:

- ❖ Purchasing Employment-Related Services and Supports;**
- ❖ Expanding Range of Employment Options;**
- ❖ Maximizing Cost-Effectiveness**

Final Report

March 20, 2008

Managed Care and Employment Task Force
Issue Committee #3

1. Issue Committee Charge

PART A:

- Review MCO contracts with provider organizations and recommend how contracting process and contract themselves can be used to strengthen provider accountability for employment outcomes;
- Review of existing purchasing strategies, including identification of -
(a) Provider disincentives to provide the full continuum of employment services, given current purchasing strategies;
(b) Provider incentives to provide services other than those that emphasize integration and employment services, given current purchasing strategies;
- Review of purchasing strategies used successfully in Wisconsin or other states to encourage providers to provide the full continuum of employment services, with a particular attention to integrated employment;
- Recommendation of specific purchasing strategies that MCO's can use in order to encourage providers to provide a full continuum of employment services, including strategies that could be used within the Self-Directed Supports option.

PART B:

- Review of strategies used successfully in Wisconsin or other states to maximize cost-effectiveness of employment services and supports (particularly integrated employment services and supports);
- Recommendation of specific strategies for maximizing cost-effectiveness of employment services and supports (with particular attention to integrated employment services and supports);
- Discussion and recommendation of specific strategies to overcome provider disincentives to fade paid support over time, particularly with regard to integrated employment;
- Consideration and possible recommendation of new policies or policy changes that will permit and encourage paying co-workers, employers and other non-traditional sources for employment-related supports.

2. List of Task Force Members Serving on Issue Committee

Diana Birnbaum, Supervisor, La Crosse Care Management Organization [Chair]
Terri Couwenhoven, Parent, Ozaukee County
Doug Hunt, Employment Programs Specialist, Dane County Human Services
Paul Rice, Director, Community Industries Corporation, Stevens Point

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3. List of Other Participants and Contributors to Issue Committee

Jackie Wenkman, Medicaid Infrastructure Grant Director, DHFS
Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Deb Rathernel, Provider Network Developer, Fond Du Lac Care Management Organization
Nancy Schmidt, Provider Network Developer, La Crosse Care Management Organization
Rick Hall, Project Coordinator, Division of Vocational Rehabilitation, DWD
Mike Przblinski, Community Integration Specialist, DHFS
Amy Thompson, Employment Policy Analyst, Pathways, DHFS
Alice Dolan, Employment Specialist, Fond Du Lac Care Management Organization
Glenn Olsen, Division of Education and Training, DWD

Guest Experts:

Stephen Block, PhD, Executive Director, Denver Options Managed Care Organization, Denver, Colorado
Regina Chace, Employment Programs Supervisor, Oklahoma Developmental Disabilities Services Division, Oklahoma Department of Human Services

4. Issue Committee Meetings

July 26, 2007
October 11, 2007
October 31, 2007 [Special session with Stephen Block and Regina Chace]
November 15, 2007
January 17, 2008

5. Summary of Issue Committee Process

The issue committee began by reviewing the contracting and purchasing strategies currently being used by three managed care organizations: La Crosse; Fond Du Lac; and Portage. Overall, it was learned that managed care organizations, like counties operating under the old waiver system, use fee-for-service approaches to purchasing employment related services and supports. In other words, they reimburse for services delivered, as opposed to paying for the outcomes produced by the services. The committee found that paying for outcomes is the purchasing method typically used in states that are considered high-performing in the area of employment, particularly integrated employment. In some cases, it appears that Wisconsin's reimbursement policies inadvertently discourage the use of best practice approaches by integrated employment providers. The committee discussed the challenges of ensuring their contracting and purchasing strategies reward providers for producing positive integrated

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employment outcomes in an effective and efficient manner. The committee also discussed the challenges associated with using a fee-for-service approach while also trying to encourage providers to fade on-going supports where appropriate. From there, the committee sought more information on outcomes-based contracting as a method to encourage better outcomes and reward providers for producing positive employment outcomes.

In subsequent meetings, the issue committee learned about outcomes-based contracting strategies being used by: (1) the Oklahoma developmental disabilities system; (2) the Denver, Colorado managed care organization for people with developmental disabilities; and (3) the Wisconsin Division of Vocational Rehabilitation. The issue committee also learned about how self-directed support contracting and funding works in Dane County's developmental disabilities services system. What became most clear from these discussions is that, with regard to employment, paying for services rather than outcomes creates a system that rewards the least effective providers and penalizes the most effective providers. With a fee-for-service approach, the more efficiently a provider delivers an outcome (e.g. develops a job), the less reimbursement the provider receives, while a provider who takes longer to deliver the same outcome receives a higher reimbursement. This is particularly true with regard to long-term job coaching. Providers who effectively train supported employees, and engage natural supports to assist, are able to fade paid supports over time. However, with a fee-for-service system, the desired fading results in a loss of income for the provider, while providers who don't effectively fade supports maintain their income over time.

The committee spent considerable time reviewing the strategy of reimbursing providers based on the number of hours a consumer works, which appears to encourage the provider to both maximize the hours of employment available to an individual, and minimize the individual's need for paid support. In addition to paying for outcomes rather than services, the committee also learned about the benefits of using incentive or bonus payments with providers in order to encourage the best possible performance. The committee also learned about the benefits of paying higher rates to providers with staff who've successfully completed and passed a program of training prescribed by the managed care organization.

The committee found the following strategies particularly promising for use here in Wisconsin: (1) structuring reimbursement to pay for outcomes (e.g. hours worked), rather than hours of service [a model used in Oklahoma]; (2) using "Pay for Performance" approaches with providers that involve incentive or bonus payments for providers who produce specific desirable outcomes [a model used in Denver, Colorado]; and (3) purchasing service packages on a daily basis from providers, where a mix of services can be provided in any given day and higher daily rates can be paid if the mix of services includes supporting an individual in integrated employment [a model used in Tennessee]. Wisconsin's managed care

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organizations negotiate contracts with providers and those contracts can include different payment methodologies and performance incentives such as those described.

The committee also spent time discussing the issue of cost-effectiveness, and how to maximize the extent to which providers can deliver integrated employment services and supports in a more cost-effective manner. It was agreed that the cost effectiveness of integrated employment services is under-estimated. If cost is analyzed in relation to outcomes rather than in relation to hours of service, this will: (1) help us more accurately assess cost-effectiveness; (2) ensure the system appropriately credits supported employment providers for successful fading; and (3) achieve a more accurate comparison of cost-effectiveness between supported employment and its alternatives. In addition to improving the way we measure cost-effectiveness, the committee also looked at how managed care organizations and providers could nonetheless improve the cost-effectiveness of supported employment services. The committee discussed the possibility of establishing different payment rates for the different phases of service: job development; initial training; coaching; stabilization and long-term stabilization. Overall, learning from other states and Wisconsin DVR demonstrated that contracting and payment systems which encourage providers to produce more positive employment outcomes involve some complexity, are subject to regular reviews and adjustments, and are always developed in collaboration with providers. As part of its discussions on improving cost-effectiveness, the committee also explored the option of managed care organizations contracting directly with employers and co-workers for training and on-going coaching support. The committee began identifying examples of this approach that have developed in other parts of the country (e.g. Oklahoma, Washington).

6. Recommendations

Recommendation 3.1 MCO's should develop and implement a plan to foster and sustain an internal organizational culture that values work and identifies supporting members to work as a core value and organizational best practice. MIG resources and technical assistance should be made available to MCO's for this purpose.

Discussion and Rationale: In order for MCO's to be most effective in contracting with their providers to produce and support high quality employment outcomes for members, the MCO will need to lead by example and demonstrate prioritization of employment as a critical outcome that the MCO is committed to assisting its members to achieve. This involves developing and sustaining an internal organizational culture that values work and identifies supporting members to work as a core value.

Recommendation 3.2 DHFS/DLTC leadership should offer strong and sustained support to MCO leadership teams as they work to establish an internal organizational

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culture that values work and identifies supporting members to work as a core value and organizational best practice.

Discussion and Rationale: Through its background research, the committee learned that high performing states have at least one individual in a leadership position in the state agency that is a champion with regard to employment. The on-going support this individual provides to intermediary organizations (e.g. counties and managed care organizations) has been shown to be critical for maximizing success and maintaining the necessary focus on employment in these intermediary organizations.

Recommendation 3.3 Each MCO should develop a method to clearly articulate and convey their philosophy, values and expectations, with regard to employment outcomes and employment services, to MCO staff, members, families and other natural supports, providers and partners (including ADRC's). Each MCO's philosophy, values and expectations should be consistent with those held by DHFS. It is recommended that MCO's consider articulating their philosophy, values and expectations in the form of a written policy or set of guidelines as well as including these in requests for proposals sent to providers. [An example of one MCO's employment service guidelines is attached to this report as Appendix A] MIG resources and technical assistance should be made available to MCO's for this purpose, and Pathway staff should facilitate collaboration among MCO's if such collaboration is desired.

Discussion and Rationale: In the absence of a written statement regarding the MCO's intentions and expectations in relation to supporting and facilitating member employment, it may be difficult to develop shared understanding and support among all stakeholders for the direction the MCO is intending to go in relation to employment. Shared understanding will be necessary for the MCO to fully realize its intentions and expectations with regard to employment and the employment services it makes available to members.

Recommendation 3.4 MCO's should define and articulate a set of quality indicators with regard to the employment outcomes and services that the MCO wishes to encourage. These quality indicators should be used in contracting with employment service providers, and in measuring and rewarding the performance of these providers. [A sample set of employment outcome quality indicators developed by this issue committee is attached to this report as Appendix B.]

Discussion and Rationale: A framework that describes quality indicators for employment outcomes and services can help contracted providers clearly understand the expectations the MCO has in relation to the services they provide. Providers will deliver higher quality services when MCO expectations regarding those services and the outcomes produced are clearly articulated.

Recommendation 3.5 MCO's should ensure that employment services, including integrated employment services, are available to individuals of all acuity levels. One

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strategy to ensure access to these services is tiered rates that reflect level of disability and barriers to employment for the individuals being served.

Discussion and Rationale: In order to make integrated employment services available to individuals, regardless of acuity level, MCO's will need to ensure that there are no disincentives for integrated employment service providers to serve individuals with higher levels of acuity. Generally, the disincentives to serve these individuals are financial ones. Tiered rates, based on acuity, can be an effective strategy to ensure providers are not discouraged from serving these individuals.

Recommendation 3.6 MCO's should be encouraged and assisted to develop, pilot and ultimately implement contracting and purchasing strategies that involve paying for outcomes and rewarding providers for producing the high quality employment outcomes expected by the MCO. The committee recommends that MIG funds be used to support MCO's to develop and pilot purchasing strategies based on paying for outcomes. [The committee particularly recommends use of the approach developed by Denver Options, Inc. (a managed long-term care organization serving people with disabilities in Denver, Colorado). In this approach, a working group, including provider and MCO representatives, worked together to establish new approaches to purchasing and to review/adjust these over time, based on the outcomes generated and provider feedback.]

Discussion and Rationale: Continuing the practice of paying for hours of service (in some cases, face-to face service only) inadvertently rewards less effective providers and penalizes the most effective providers. This approach also discourages the use of best practices by providers, particularly in the area of integrated/supported employment. It is critical that contracting and purchasing strategies be developed which encourage and reward providers that deliver high quality employment outcomes in an effective and efficient manner. Most critically, contracting and purchasing strategies, which offer clear incentives for providers to develop or expand their role in providing high quality integrated employment services, must be developed in order to ensure that the system has the capacity to truly offer the choice of integrated employment. [Based on its research, the issue committee created a set of important considerations for MCO's developing outcome-driven contracting and purchasing strategies. These considerations are attached to this report as Appendix C.]

Recommendation 3.7 MCO's should be encouraged and assisted to develop, pilot and ultimately implement contracting and purchasing strategies that ensure that consumers have more choices around how they can access and participate in integrated employment, including the possibility of receiving a mix of services in a given day or week that includes integrated employment.

Discussion and Rationale: Integrated employment opportunities are often part-time. Many individuals who opt for day services or sheltered employment do so because they are provided with a full week of activities where the supports they need are consistently available. In order to encourage more individuals to participate in integrated employment, the system must ensure that people can receive other services during the

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hours they are not working in integrated employment. State policy allows for this mix of services under the waivers and managed care. However, there is a need to ensure that this is fully operationalized in all counties and managed care regions, so that individuals wishing to participate in integrated employment are not left without the services and supports they need during times when they are not working in integrated employment.

Recommendation 3.8 MCO's should develop a contracting and purchasing strategy that rewards providers for maintaining highly competent and expert staff.

Discussion and Rationale: A high level of expertise and competence among provider organization staff is necessary to ensure that high quality integrated employment outcomes can be delivered in an efficient, cost-effective manner. Expertise and competence is assured in a number of ways: enabling staff to keep abreast of the best and most innovative practices in their areas of work; creating incentives to avoid turnover of staff, particularly experienced staff; honing staff recruitment strategies in order to identify key characteristics that indicated expertise and competence. Therefore, MCO's should develop and offer particular incentives for provider organizations to maintain staff that can produce high quality employment outcomes for members. As one example, financial incentives, including the Denver Options' strategy of paying higher rates to providers whose staff have attended and passed a prescribed course of training, can contribute to effectiveness and decrease turnover. And consequently, the higher rates are likely to pay for themselves in the form of reduced services necessary to achieve the member's desired outcomes and reduced recruitment and training costs associated with staff turnover.

Recommendation 3.9 The Department of Health and Family Services (DHFS), through its Division of Long-Term Care (DLTC) and the Department of Workforce Development (DWD), through its Division of Vocational Rehabilitation (DVR) should partner on an on-going collaborative initiative to encourage its common set of providers/vendors to maintain staff who are knowledgeable of, and able to implement, the best and most innovative practices related to the provision of employment services and supports.

Discussion and Rationale: DVR and DLTC have an interest in having high quality providers of integrated employment services and supports. There are many providers who are approved providers for both DVR and DLTC (through its managed care organization and county provider networks). Given this, it makes sense that DVR and DLTC collaborate on efforts that will encourage the utilization of best practice approaches among providers, rather than carry out these activities in isolation from each other. The collaboration also allows both agencies to coordinate their values and deliver a consistent message about values and goals to their provider networks.

Recommendation 3.10 As part of implementing Recommendation 3.9, DHFS/DLTC and DWD/DVR should collaborate to develop, maintain and regularly update a well-researched, evidence-based, state-wide training curriculum for supported employment service providers. Establishing certification (modeled after something like the Denver Options Job Developer Certification) where the focus is not on hours of

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training received but on demonstrating knowledge and competence as a result of training, is recommended for consideration. It is further recommended that the training include significant content related to values/philosophy, as well as practice methods. MIG funding should be made available to support the development of this curriculum and the development of a viable long-term plan for maintaining it. These efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: It is difficult for individual providers to provide their relatively small staff teams with on-going training related to values and best practices. The curriculum would ensure statewide access to a consistent training resource that would help provider staff develop and maintain core competencies, and learn/integrate the most cutting edge best practices that exist in the field. Certification would further enhance the effectiveness of the training by requiring that individual staff must pass (not just attend) the training in order to receive the Certification. A standardized statewide curriculum would ensure consistent content is available to all staff in the state.

Recommendation 3.11 MCO care managers should be provided with basic training on the best practices related to integrated employment service provision so they can effectively identify, arrange, coordinate and monitor the services necessary to assist members to achieve their integrated employment goals. MIG resources should be available to underwrite the cost of developing and delivering employment-related training for care managers. These efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: MCO care managers and inter-disciplinary teams are responsible for assisting members to choose qualified providers and monitoring the quality of the services delivered by providers. In order that MCO care managers are able to accurately assess the quality and effectiveness of the services provided, and provide constructive feedback to providers in this regard, it is important that care managers have a basic knowledge of best practices in integrated employment service provision. With this knowledge they will better understand what should be expected from providers, and they will be better able to address poor outcomes for members.

Recommendation 3.12 MCO staff should have employment expertise available to them, either through an MCO position dedicated to employment or through some other arrangement (e.g. use of consultants). MIG resources should be made available to pilot different methods for making the employment expertise available in order to determine the most effective and sustainable model to recommend to all MCO's. If MCO's are required through contract or certification to have employment expertise available to their staff, this expectation should be figured into the development of the actuarially sound capitation rate.

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Discussion and Rationale: MCO staffs have many responsibilities in relation to assisting members to achieve their personally identified outcomes. It is unreasonable to expect that MCO teams in particular can be experts on helping members achieve employment outcomes. Some MCO's have already made other forms of specific expertise available to teams on an as-needed basis (e.g. pharmacy expertise; home modifications expertise). Consistent with this approach, MCO teams will be much more effective at assisting members with employment goals if they can access employment expertise on an as-needed basis. MCO's should be free to decide how they make this employment expertise available. MIG supporting the piloting of this should help MCO's see the value and encourage MCO's to determine how to provide this expertise on a long-term basis.

Recommendation 3.13 DHFS should seek interested MCO's and support, through MIG, the development and evaluation of one or more pilot initiatives in which MCO's utilize employers and co-workers to provide the paid supports an individual needs to learn and maintain an integrated job.

Discussion and Rationale: Expanding the range of providers of integrated employment supports and developing support models that maximize cost-effectiveness are critical efforts that can help expand the ability of MCO's to provide integrated employment services to a greater number of members. Utilizing employers and co-workers as providers of on-the-job training and job coaching is an innovative and cost-effective model that has shown promise elsewhere and should be developed and piloted here.

Recommendation 3.14 MCO's should identify a method for monitoring provider contracts, measuring overall provider performance, and regularly engaging in discussions with providers regarding their performance.

Discussion and Rationale: The root of determining provider performance should be individual member outcomes. Inter-disciplinary teams are responsible for monitoring individual member outcomes. However, no one inter-disciplinary team will be monitoring outcomes for all of the individuals served by a particular provider. Therefore, it is also important for the MCO to undertake more global monitoring of individual provider performance by working with teams to pull together and evaluate provider performance information for all members served by that provider. It is important that the MCO identify a method for doing this work and feeding back the results to providers on a regular basis, in order to encourage continuous quality improvement among providers.

Recommendation 3.15 MCO provider contracting requirements should include an expectation that providers submit outcome-related data to the MCO at pre-determined intervals (e.g. twice per year) for the individuals that each provider is serving. Outcome-related data should minimally include hours worked, wages earned and hours of support provided by the provider for the reporting period determined by the MCO.

Discussion and Rationale: Performance-based contracts cannot be effectively monitored and will not be effective in producing the desired outcomes if data on outcomes is not

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routinely collected from providers and used in performance evaluation. In order that outcome data collected by individual MCO's can also be used as part of state-level tracking of employment outcomes, DHFS and MCO's will need to work collaboratively to agree on the specific data to be collected for performance evaluation and monitoring. Ensuring common definitions and reporting methods are being used across MCO's will be critical. The committee found that at present, MCO's are not using service definitions consistently and are defining units of service in a variety of ways. Ideally, data should be collected from providers by one source (e.g. MCO) and then rolled up with other MCO provider network data for statewide analysis by DHFS. The committee recognizes that some service definitions may need sub-categories in order to better track service provision and set rates for the types of services being provided. Tracking of data on hours worked and wages earned will also be helpful for MCO's wishing to access Ticket to Work resources to support members in integrated employment. Apart from the outcome data recommended for collection here, it is recognized that MCO teams and the Department's quality reviewers will retain responsibility for determining whether each member's individually identified employment outcome (as articulated in his/her member-centered plan) is being met.

Recommendation 3.16 DHFS, through policy, contracting, quality assurance and performance monitoring, should convey to MCO's a clear expectation that:

- Work and career will be one of the primary, on-going and consistent areas of focus that MCO's will maintain as part of meeting members' holistic needs.
- Integrated employment is the preferred employment option because it provides access to the fullest range of employment outcomes and choices, and better opportunities for community integration and meaningful earnings for members.
- MCO's are expected to regularly offer and fully support members to pursue integrated employment and by doing so, increase both the number and percentage of long-term care recipients who are supported to pursue and maintain integrated employment at a competitive wage.

Discussion and Rationale: If MCO's adopt work and career as a primary focus, this attention to employment will better ensure that a broad range of high quality employment options will be developed and made available, thus enhancing an MCO's ability to support Family Care's goal of offering more and better choices to members. If MCO's adopt work and career as a primary focus, this will also better ensure that teams give sufficient attention to employment options in the comprehensive assessment and member-centered planning processes. In order to improve MCO employment outcomes, senior leadership of the MCO's need to hear from DHFS that increasing and improving participation in employment is a priority. DHFS needs to adopt and share a clear policy on employment that MCO's can use as a guide for determining what is expected. The importance of supporting positive employment outcomes among members needs to be reinforced by DHFS in a number of ways. Many stakeholders concur that contract language is critical, as is making MCO performance related to employment a key component of quality and performance monitoring activities carried out by DHFS. MCO performance in the area of employment will be greatly enhanced if the senior leadership

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in the MCO understand and support the focus on employment, and the need to develop an organizational culture that values work.

Recommendation 3.17 DHFS should develop a method for accurately evaluating, at a systemic level, the cost-effectiveness of providing long-term support services for integrated employment, and comparing the cost-effectiveness of integrated employment with other day and employment service alternatives. MIG funding should be made available to contract with a qualified research expert who can design and test a valid and reliable cost-effectiveness methodology.

Discussion and Rationale: Creating a cost-effective long-term care system is a key goal of Family Care. Existing methods for determining, from a public policy perspective, the cost-effectiveness of integrated employment services provided by the long-term care system are limited. Views about the cost-effectiveness of integrated employment services are often based on the cost per hour of service compared to the cost per hour of service for the alternatives. This perspective has dampened enthusiasm in the system for investing more substantially in services to support integrated employment. It is important that the Department develops a sound method for evaluating and comparing the cost-effectiveness of integrated employment services and the alternatives. This method should tie investment in the services to the outcomes produced for the individuals being served which support the public policy goals the Department has in relation to employment. Having an effective approach to measure and evaluate the cost-effectiveness of integrated employment services, for the long-term support system, is critical for demonstrating the link between expanding integrated employment and meeting the goal of system-level cost-effectiveness established by Family Care.

8. Conclusion

Overall, the committee supports the Department of Health and Family Services using Medicaid Infrastructure Grant (MIG) funds to encourage MCO's to pilot or fully implement these recommendations. The committee also supports the use of Pathways to Independence staff and MIG consultants to facilitate collaboration among MCO's that are interested in working on similar things.

9. Appendices

- Appendix A: La Crosse MCO Employment Service Guideline
- Appendix B: Employment Outcome Quality Indicators
- Appendix C: Recommendations to be Considered/Followed in Developing Outcome-Driven Contracting and Purchasing Strategies

APPENDIX A

La Crosse MCO Employment Service Guidelines Draft Date: October 22, 2007

Overview:

Employment programs are in a state of constant change. While change is difficult, changes in employment support can result in improved quality, increased options for people with disabilities, and a major vehicle for inclusion into regular community life. Employment offers all people, with or without disabilities, access to other community citizens, a path out of poverty, and independence from service systems.

The experiences of people with disabilities across the country have demonstrated certain lessons. We have learned that:

- People can, with competent support, learn to do complex tasks.
- Acquiring a skill is not a prerequisite to obtaining and keeping a job in the community
- People perform better when the skills they need are learned on the job
- Employment contractors have found success in finding employers who are interested in having diversity in their workplace

Therefore the La Crosse county CMO has adopted the following Employment Services philosophy and Guidelines.

All members have the right to integrated community jobs:

- The CMO believes that everyone has the potential to work and values integrated competitive employment.
- All individuals, regardless of the challenge of their disability, should be afforded the opportunity to pursue integrated, competitive employment.
- The CMO is committed to providing employment services which complete the transition from separate and segregated services to supporting people in regular jobs that facilitate the achievement of, or progress towards, a competitive wage.
- Supports to pursue and maintain gainful employment in integrated settings in the community shall be the primary service option for working age adults with disabilities who want to work.

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Measures of Success:

- Increased numbers of members in the CMO will achieve their individual employment outcome for integrated competitive employment.
- Increased numbers of members in the CMO will earn at least minimum wage
- There will be a decline in the numbers of persons and length of participation in long-term segregated employment and training.

Preferred Types of Employment Supported by the CMO

1. **Individual integrated employment** at prevailing wage in business or industry at an occupation of the member's choice with natural supports and hired directly by the employer is the first preferred employment outcome. If prevailing wage is not available, then employment at minimum wage with or without paid supports. . If a member cannot secure enough desired work hours through a single job of the service recipient's choice, then **2 part time jobs** or a job that is not the member's first preference may need to be sought.
2. **Individual integrated employment** in a member operated **micro-enterprise** which produces a competitive income with natural supports is considered an alternative first preferred employment outcome. If the micro-business does not produce a competitive income, then income comparable to minimum wage earnings with or without paid supports is the next preferred option.
3. If a fully integrated placement is currently unavailable, employment of the member's choice in a **group (enclave) in a business or industry, at minimum wage or better** may be considered as the next option.
4. If there are no paid jobs to be found at minimum wage or better, **temporary** participation in a **group (enclave) in a business or industry at subminimum wage** may be considered as the next option.
5. If no individual or group community job at minimum wage or subminimum wage is available, then temporary participation in **real work in a center-based setting** may be considered as the last option.

Employment Services Plan:

At each Member Centered Plan review, the team will discuss with each member of working age (18 – 62) his or her interest and goals in relation to employment.

If the member is not interested in work, the reason will be discussed and noted. The team will provide information to the member regarding access to benefits counseling.

If the member is interested in work or uncertain the team will:

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- Discuss the member's interest areas and goals
- Encourage the use of the Job Center (789-5637) located at 402 N 8th St., La Crosse
- Encourage application to DVR (785-9500) located at 333 Buchner Place wing B, La Crosse. DVR should be the primary funding source for Assessment, Job Development and initial Coaching. (DVR typically contracts out with vendors to provide the needed services)
- Encourage natural supports and self-directed supports whenever possible.
- Encourage consultation with a benefits counselor.
- Discuss individual integrated competitive employment of the member's choice as the preferred goal, and other segregated, group, or subminimum wage employment as the exception.

If the member is currently working in an integrated community setting the team will discuss level of satisfaction and collect data on wages, hours worked, place of employment, etc.

If member is currently working in segregated site, including group community and facility based, team will discuss options to pursue community integrated competitive employment and will collect data on actual wages and hours of employment.

The Employment Services Review Committee will review data gathered from Employment Services data base to monitor progress towards goals of increasing wages and integrated employment outcomes for members, as well as for purpose of providing technical assistance to teams.

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DVR Services and Processes

- The team will consider DVR Services before CMO funding is considered for **any** employment services (including Micro-business, supported employment, and non funded DVR services such as sheltered, pre-vocational, enclave, and any other type of employment which does not meet the definition of supported employment.) If the team does not believe the member is a candidate for DVR services, the team should consult with the Employment Coordinator. The team may also consult with a DVR counselor before referral to DVR is made.
- Obtain a release of information for communication between DVR and CMO.
- The preference is for the member to apply for DVR services independently. The CMO social worker or other support person may assist the member if needed. DVR should be informed that the member is in the CMO and given the CMO team names.
- DVR services may include: Assessment, Direct Job Placement, Work Experience and/or Supported Employment
- For further information regarding DVR, **refer to Overview of DVR Services**

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Ineligible for DVR Services

- Consult with the Employment Coordinator / Employment Services Review Committee
- Individuals determined eligible for SSI or SSDI are presumed eligible for DVR services provided the individual intends to achieve an employment outcome.
- DVR counselor may not have accurate or complete information regarding the member's needs.

Eligible for DVR – Funding available

- DVR counselor or Case Assistant will notify the member and CMO team.
- DVR counselor will meet with member and begin “**Individual Plan for Employment**” (IPE) process. It is recommended that the CMO Social Worker also attend the first meeting.
- Member will choose the employment vendor.
- DVR counselor will write an authorization or purchase order for services.
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- DVR Individualized Plan for Employment (IPE)
- DVR IPE is written, with a copy to be provided to member, CMO team and vendor
- DVR IPE may include
 - Member's employment preferences
 - Services to be provided
 - Who will provide the services
 - Who is paying for the services and method of payment

Job Development

- DVR funds Job Development for Supported Employment or Direct Placement.
- Vendor intake meeting with DVR and member should occur within 30 days of referral. CMO staff are also invited and encouraged to attend.
- Vendor writes an Employment Service Plan and submits to DVR and CMO.
- CMO team attached DVR IPE and Vendor Employment Plan to Member Centered Plan.
- DVR pays vendor a flat fee (\$1200 Direct Placement track or \$1400 in Supported Employment track) when a job is secured for the member.
- In the Supported Employment track, DVR pays the vendor a flat monthly amount for Job Coaching for 6 months. (Currently \$700 per month in 2007) Vendor is also paid an incentive (\$1200) if the member is transitioned to Long Term Support (CMO) upon completion of 6 months job coaching support.
- In the Placement Track, DVR may pay the vendor an hourly job coaching rate (\$40) and a Job Retention incentive (\$1400) after 90 calendar days of success along with other closure criteria.
- After 2 to 3 months, if no job is found the DVR counselor will call a meeting with the member and the vendor. The CMO social worker should also participate.

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Job Development– No job after 2-3 months

- Meeting to be held with: Member, CMO team, DVR counselor, Vendor
- Additional 3 months of development may be authorized
- Discuss what will be different in job development these 3 months and update IPE with copy to CMO team.
- Consider change in vendor
- No job found after additional 3 months of job development, Job development ends.
- Consult with Employment Coordinator/ Employment Services Review Committee

Job Development – Job found

- Review the Employment Services Plan and DVR IPE (Individual Plan for Employment)
 - If job offer does not match the Employment Services Plan (or IPE), consider as no job has been found and clarify team's intent to support or not support job offer. If team does not support job offer, CMO will not fund agency coaching when DVR funding ends. Notify DVR counselor ASAP.
 - Continue if job offer matches the Employment Services Plan (or IPE).
- Initial Coaching costs usually funded by DVR for 3 to 6 months and may continue up to 18 months at the rate of \$700 per month regardless of hours of coaching required or hours member is employed. CMO funding will begin (with prior approval from CMO team) when DVR funding ends due to stabilization of employment.
- CMO team coordinates
 - Transportation
 - Residential supports as needed
- Set date to review supports in 3 months

Ongoing Monitoring

- Review supports and Employment Services Plan (and IPE) every 3 months for the first 18 months, every 6 months thereafter.
- Face to face meeting or via phone Include:
 - Member
 - CMO team
 - DVR counselor (prior to DVR closure)
 - Vendor
- Encourage natural supports
- Continually ask questions regarding your members support needs (see reference)
- Review/update plan to transition from DVR to CMO funding
- Set date for next review (3 or 6 months as appropriate)

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Transition of Funding from DVR to CMO

- Decision made jointly between DVR counselor and CMO team
- DVR counselor continues to follow member for 3 months after transition to CMO funding.
- Job coaching payments will be made according CMO provider rates.

Member loses their job

- Refer to DVR for Job Development
- Consult with Employment Coordinator/ Employment Services Review Committee if DVR funding unavailable

Member is not eligible for or funding is not available from DVR

CMO may fund various Employment Services when DVR funding is not available.

- **Assessment**
 - Must meet DVR specifications for requirements
 - \$650 payable upon completion of assessment report and staffing
 - To be completed within 60 days
- **Job Development for Supported Employment (Individual integrated community job at competitive wage with continued job coaching required):**
 - Must have Employment Plan completed
 - Follow DVR process of review meetings with member and vendor
 - Job should be found in 3 months.
 - \$1400 payable after 2 weeks of successful employment
- **Job Coaching for Supported Employment (Individual integrated community job at competitive wage with continued job coaching required):**
 - CMO regularly funds long term job coaching for supported employment after DVR funds job development and initial job coaching for 6 months.
 - Currently paid at hourly rate of \$27.76 in 2007
- **Placement (individual integrated community job at competitive wage with no continued job coaching required):**
 - Job Development Direct Placement - \$900 payable after hire and 2 weeks of successful employment
 - Job Development Direct Placement: \$900 payable after 90 days of successful employment
- **Group Community (Integrated employment at minimum wage or better with ongoing job coaching)**

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- CMO does not fund development of these sites
- 2008 rates to be announced (See Employment Services coordinator)
- **Segregated Group** (Community employment at subminimum wage, enclave)
 - CMO does not fund development of these sites.
 - Referral to Segregated Group requires an **exception**, (See Employment Services Coordinator)
 - 2008 rates to be announced
- **Facility Based (Sheltered workshops, Prevocational sites, segregated, piece rate and subminimum wage)**
 - Referral to Facility Based requires an **exception**, (See Employment Services Coordinator)

Micro-business: In process of development. TBA

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An exception to the CMO Employment Services Guideline which requires supports to pursue and maintain gainful employment in integrated settings in the community to be the primary service option for working age adults with disabilities who want to work may be made in consultation with the Employment Services Coordinator when the member:

- is currently working in a segregated setting or
- has been referred for community employment and is waiting for a community job or no community employment is available or
- has been assessed and it is determined with the team that the member does not desire community employment, or is not motivated to pursue community employment,

and the team in consultation with the Employment Services Coordinator agree an exception is appropriate.

XIX. References

- Overview of DVR Services
- DVR counselor list
- Sample DVR Individual Plan for Employment
- Employment Vendor list

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APPENDIX B

Employment Outcome Quality Indicators

1. INDIVIDUAL CHOICE IS OFFERED:

Consistent with the person's strengths, capacities and preferences, employment options are identified, offered and secured.

2. COMMUNITY INTEGRATION OCCURS:

At the workplace the number of people with significant disabilities is similar in proportion to the number of people with significant disabilities in the general population.

Employment by a community business, through self-employment or as owner of a micro-enterprise is preferred. A community business is a business whose primary source of income is not disability services funding.

3. FINANCIAL BENEFIT OCCURS:

Employment income creates net increase in person's total monthly income, taking account of unearned and earned sources, as well the financial value of participation in means-tested subsidy program.

Compensation at minimum wage or higher and weekly hours of 20 or more is preferred.

4. APPROPRIATE SUPPORT IS AVAILABLE:

Effective strategies including customization/carving in job development; accommodations and adaptations; assistive technology; and natural supports are utilized as appropriate.

Time between creation of the employment plan and first day at work is 6 months or less.

After an initial, time-limited period of training, the person is able to achieve a substantial level of independence (working without paid supports 50% or more of the time unless higher levels of support are required by a protective services order, or there are health &

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safety issues not specific to the work situation which justify higher levels of on-going support).

Retention occurs with no unplanned gaps in employment, and support for job change and advancement is possible.

5. CONSUMER CONFIRMS HIS/HER EMPLOYMENT OUTCOME MET

The person indicates that his/her employment outcome has been met and she/he is satisfied with the supports and services being provided.

APPENDIX C

Considerations for Developing Effective, Outcome-Driven
Contracting and Purchasing Strategies:

1. Changes will be developed and implemented in full consultation with providers.
2. The new payment system will not result in a provider that is producing the desired outcomes experiencing a net loss in revenue as a result of producing these desired outcomes.
3. The MCO may be interested in exploring utilization of a strategy that involves converting individual service needs to a dollar amount and then paying that as an outcome payment to the provider, so long as the person maintains the same level of integrated employment and the same level of earnings, and the individual reports satisfaction with the service. Sub-capitations could also be considered, with tiered capitation levels based on level of disability. Units of service can still be collected from providers for Encounter reporting and for identifying fading where this is occurring. If a new referral can be made to the provider at a particular point, the outcome payment for an existing consumer (who has had support faded) can be adjusted down to match the individual's reduced service needs, while also ensuring that the provider does not experience a cut in overall revenue.
4. In order to avoid continued high rates of turnover among integrated employment providers, it is suggested that MCO's develop outcome payments by starting with determining the cost of providing a competitive wage and competitive benefit package for provider staff, and use this as a starting point for developing payment rates for the provider organizations that employ those staff.
5. MCO's may want to consider establishing bonus payments for providers (separate from outcome payments) if: (1) the employment outcomes achieved meet certain quality criteria established by the MCO; (2) the individuals being served experience no unplanned gaps in employment during the contract period; and (3) individuals are assisted to advance in their careers.

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6. Increased service should always be possible on an interim basis if an individual experiences a need for increased support at some point. This will further encourage providers to fade without financial penalty.
7. MCO's may want to consider the benefits of establishing different outcome payment amounts for the different phases of support which occur over time.

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Issue Committee #4

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #4

**Multi-Agency Blended
Services and Funding Strategies**

Final Report

March 20, 2008

Managed Care and Employment Task Force
Issue Committee #4

1. Issue Committee Charge

- Develop a comprehensive list of services and programs available to support employment for individuals with disabilities, including the source and eligibility requirements for each of the services and programs identified;
- Develop comprehensive list of funding sources available to support employment goals of individuals with disabilities, including who administers each funding source and how each funding source can be used;
- Develop descriptions of how various services, programs and funding sources can be used consecutively or concurrently to support employment for individuals with disabilities;
- Make recommendations for ways to ensure that Managed Care Organization staff know and understand how to help members access the various non-MCO services, programs and funding sources that are available;
- Make recommendations for policy or rule changes that would increase the ability to blend or braid the various funding sources in order to support people who need long-term support to maintain employment, and people who want to move into integrated employment from non-work or segregated employment programs;
- Make recommendations regarding the need for and content of a collaborative agreement between DHFS/DDES and DWD/DVR&DWS.

2. List of Task Force Members Serving on Issue Committee

Manuel Lugo, Deputy Administrator, Division of Vocational Rehabilitation,
Department of Workforce Development [Chair]

Steve Gilles, Transition Consultant, Department of Public Instruction

Gary Denis, Acting Director, Bureau of Workforce Programs, Division of
Employment and Training, Department of Workforce Development

Tom Heffron, Education Director, Disability Services & Financial Aid,
Wisconsin Technical College System

Monica Murphy, Supervising Attorney, Disability Rights Wisconsin

Todd Breaker, Aging and Disability Resource Center Services Director,
Marathon County

Laura Owens, Associate Professor, UW-Milwaukee & Executive Director,
Creative Employment Opportunities, Inc.

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3. List of Other Participants and Contributors to Issue Committee

Cayte Anderson, Office for Independence and Employment, DHFS
Lisa Mills, Medicaid Infrastructure Grant, DHFS
Glenn Olsen, Division of Education and Training, DWD
Myrt Sieger, Medicaid Infrastructure Grant Consultant/TBI Training Specialist
Dan Johnson, Coordinator of Resources for Physical Disability at DHFS
Mary Ridgely, Medicaid Infrastructure Grant Consultant, Benefits Specialist
Amy Thomson, Pathways to Independence
Susan Bohn, Pathways to Independence Regional Coordinator
Cheryl Lofton, DHFS Bureau of Mental Health and Substance Abuse Services
Dennis Liphart, Pathways to Independence Regional Coordinator
John Jolley, Pathways to Independence Regional Coordinator
Bob Gervey, UW-Madison Departments of Rehabilitation Psychology and
Special Education

Guest Contributors:

Sharon Ryan, DHFS Office of Family Care Expansion
Dan O'Brien, Social Security Administration

4. Issue Committee Meetings

August 15, 2007

October 25, 2007

November 19, 2007 [Joint meeting with Issue Committee #7]

January 29, 2008

5. Summary of Issue Committee Process

The first meeting on August 15th was dedicated to learning about the assorted employment services and supports available to individuals with disabilities in Wisconsin. Committee members representing specific state programs shared information about the services and supports available through their respective programs as well as the funding mechanisms/sources involved. At the second meeting on October 25th, the existing Interagency Agreement between the Division of Vocational Rehabilitation, the Department of Public Instruction, and the Department of Health and Family Services was reviewed, discussed and determined to be a good model to embrace for future collaboration. Additionally, Sharon Ryan (Office of Family Care Expansion) provided an informative overview of the Family Care model and Managed Care expansion efforts currently underway in Wisconsin. Dan O'Brien (Social Security Administration-Baltimore) joined Issue Committees Four and Seven for a third meeting on November 19th as a guest presenter on the new Ticket to Work Regulations. The committees discussed how the Ticket may be better integrated into the employment service package for individuals utilizing long-term supports. The fourth and final meeting held on

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January 29th was spent reviewing the draft recommendations developed by the committee and gathering additional input and suggestions which were subsequently integrated into this report. Overall, committee members representing the partner agencies agree that a collaborative approach, which emphasizes on-going coordination, mutual investment, and a commitment to cost-sharing, will create the potential for improved outcomes for individuals who need short and long-term supports to pursue and maintain employment.

6. Recommendations

Note: Several, if not all of these recommendations involve collaborations and commitments between the Division of Long Term Care and other agency partners. In most cases, individuals able to make commitments on behalf of the other agency partners, served on this committee and endorsed the recommendations. Additionally, the committee acknowledges that some of the recommendations may have a fiscal impact on the Division of Long-Term Care which has yet to be analyzed. The committee recommends that the Division consider utilizing Medicaid Infrastructure Grant (MIG) funds, while they remain available, to address the recommendations with a fiscal impact.

Recommendation 4.1 Aging and Disability Resource Center's (ADRC) should collaborate with the Department of Workforce Development's Division of Vocational Rehabilitation (DVR) to develop a plan and identify appropriate methods for doing coordinated outreach to secondary school personnel, transition-age students and parents. Students targeted should not be limited to students being served by Special Education under the Individuals with Disabilities Employment Act (IDEA); but should also include students who have Section 504 plans. Outreach should ensure that those involved in transition planning know, early in the process, the services available from the vocational rehabilitation and long-term care systems to support integrated employment, and how, as well as when, both systems' services can be accessed.

Discussion and Rationale:

For students with disabilities who require supports to find and maintain work, access to vocational rehabilitation and long-term care services is critical. Long-term care services are particularly critical for sustaining employment opportunities developed and initially supported by the school and vocational rehabilitation systems. Coordinating outreach efforts with DVR will ensure that all school system stakeholders are provided with a clear, consistent message about the roles that DVR and the managed long-term care system play in assisting graduating students to secure and maintain employment.

IEP meetings are the venue for identifying each student's post-secondary employment goal. New IDEA performance standards now require employment (school to work transition) to be a key feature in transition planning. All transition IEP's (from age 14) are now required to include an identified post-secondary employment goal. It is critical that IEP teams have accurate and complete information about the range of employment options that can be supported by the long-term care system. Without such information, IEP teams may establish post-secondary employment goals based on incorrect assumptions about what types of employment the long-term care system will and will not

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support. Because referrals to the adult long-term care system cannot be done until a student is near graduation (age 17 ½) and by this time, the student is likely to have already identified a post-secondary employment goal, ADRC personnel are the appropriate resource personnel to convey information about options and services that are available through the long-term care system, including employment options, to the IEP team at the time they are identifying the post-secondary employment goal. While on-going involvement by ADRC staff is not necessary, ADRC's should provide introductory information when transition planning begins (age 14) and then reconnect with the student's IEP team when the student reaches age 17 ½ to provide options counseling and eligibility screening for long-term care. Engaging with IEP teams in this very limited but targeted way will ensure ADRC's can effectively coordinate efforts with the school system and DVR. As well, it will enable ADRC's to better ensure that timely screening for, and enrollment in, long-term care is arranged for eligible students; and as a result, the long-term care services necessary to support post-secondary employment outcomes are available at the appropriate time.

Recommendation 4.2 ADRC's should provide information and assistance to individuals with disabilities, not involved with DVR and no longer enrolled in secondary education, who need to obtain disability documentation to access ADA-related services and accommodations in pursuing post-secondary education or employment. Assistance should include help in identifying appropriate professionals or agencies that can provide the documentation, and help in identifying sources of funding to pay for the documentation, including, but not limited to, SSA work incentives and Ticket to Work.

Discussion and Rationale: Often, individuals with disabilities who would like to pursue post-secondary education or employment need proof of disability in order to request accommodations and disability-related services to support them in these pursuits. If individuals have left secondary education, the schools no longer maintain documentation of disability. If individuals are working with DVR, this agency would assist the individual with obtaining disability documentation. However, if an individual is no longer enrolled in secondary education and is not working with DVR, the individual is likely to face challenges and costs related to obtaining the necessary disability documentation. Offering assistance to this small group seems to fall well within the role and mission of ADRC's.

Recommendation 4.3 DHFS should encourage ADRC's to use practices that will strengthen local collaboration and coordination with Job Centers, including consideration of the possible advantages of co-location.

Discussion and Rationale: Both ADRC's and Job Centers serve people with disabilities. On the subject of employment, coordinated integration of information and services could provide individuals with disabilities with more comprehensive assistance, which is likely to improve employment outcomes and expedite progress on employment goals. Co-location of resources helpful to people with disabilities can also significantly improve access and utilization.

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Recommendation 4.4 The Department of Health and Family Services (DHFS) Division of Long-Term Care (DLTC) and the Department of Workforce Development (DWD) Division of Vocational Rehabilitation (DVR) and Division of Employment and Training (DET) should collaborate and coordinate activities to provide managed care organization (MCO) staff, DVR counselors, and Disability Navigators and DET Employer Services Teams with information, training and/or technical assistance on their respective programs and services, and how the various services available through DVR, DET and through the managed long-term care benefit package can be effectively blended to provide the short and long-term support individuals with disabilities need in order to obtain and maintain integrated employment. If necessary, MIG funds should be contributed to underwrite this effort, which should include a framework for on-going, coordinated opportunities for staff to re-access, refresh and implement the knowledge and skills acquired through this effort. Where training is pursued, the efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: DVR and DET are critical partners for MCO's seeking to assist members to achieve their integrated employment goals. At the same time, MCO's are critical partners for DVR and DET in their efforts to successfully enable individuals with significant disabilities to achieve integrated employment. In order for DVR and MCO's to approve services for individuals with disabilities who need long-term support to maintain employment, it is critical that both staff understand how their respective programs can together provide the comprehensive package of support services each individual needs to obtain and then maintain integrated employment. In particular, the shift to Family Care creates a very different reality for individuals with disabilities who are interested in integrated employment but who need long-term support to sustain that employment. The elimination of waiting lists for Family Care services, the provision of actuarially-grounded levels of funding for services, and the fact that people with physical disabilities (in addition to people with developmental disabilities) will now have access to long-term support services for employment, are all changes that are coming about as a result of Family Care. It is critical that DVR and DET understand the role that Family Care can play, and Family Care staff understands the role that DVR and DET can play, in supporting individuals with disabilities who wish to work but who need long-term support to do so. This will contribute to maximizing Family Care members' access to DVR and DET services, particularly DVR-funded supported employment services.

Recommendation 4.5 DHFS should fully support the collaborative implementation activities related to the existing Interagency Agreement on transition (partners in the agreement are DVR, the Department of Public Instruction (DPI) and DHFS/DLTC/Division of Mental Health and Substance Abuse Services), dated July 5, 2007. All partners should identify sufficient resources to carry out the Agreement. If necessary, DHFS could utilize Medicaid Infrastructure Grant (MIG) funds for this purpose. Where this involves training, the efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide,

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comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: The completion of the Inter-Agency Agreement on Transition represents a significant step toward effective and on-going multi-agency collaboration that is necessary to ensure the best possible integrated employment outcomes for individuals transitioning to adulthood and entering the long-term care system. Full implementation of the Agreement is the next step, and DHFS, like all partners, should play an active and on-going role in implementation activities. Appropriate resources allocated by all partners will ensure steady progress on successful implementation.

Recommendation 4.6 Integral to the successful implementation of Recommendation 4.5, DLTC, DVR and the Department of Public Instruction (DPI) should work together and coordinate efforts to promote and advance the development and implementation of joint staff trainings specific to integrated employment for the agencies' common customers in order to maximize collaboration, the blending of service and funding, and high quality service delivery to customers common to the involved agencies. If necessary, MIG funds should be made available to underwrite DLTC's participation and its portion of the project costs. These training efforts should be coordinated with all other training efforts recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: Providing information to staff employed by the various partner agencies in joint training events will promote a better understanding among staff of how to coordinate and integrate employment services and resources across systems. It will encourage greater collaboration, which will result in more person-centered service delivery and coordination, ultimately contributing to better outcomes for mutual customers.

Recommendation 4.7 DHFS's commitment to implementing Recommendation 4.1 should be added to the existing Interagency Agreement on transition dated July 5, 2007. Partners in the agreement are DVR, the Department of Public Instruction (DPI) and DHFS/DLTC/Division of Mental Health and Substance Abuse Services.

Discussion and Rationale: To maximize the likelihood of success, to ensure close inter-agency collaboration, and to coordinate the implementation of Recommendation 4.1 with all other inter-agency efforts, DHFS should add the implementation of this recommendation to its list of commitments in the existing Interagency Agreement on transition.

Recommendation 4.8 DHFS/DLTC and Department of Workforce Development (DWD)/DVR and DET should work collaboratively to develop and implement an interagency agreement, modeled after the existing interagency agreement on youth transition, for **adults** seeking integrated employment and eligible for services from these agencies. In part, the agreement should identify multiple strategies for blending funding

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which can be authorized at the state agency level to streamline the negotiations that must go on around specific individuals. The agreement should also specify the resources, including staff resources, which will be contributed by each partner in support of coordinated implementation of the agreement. If necessary, MIG funds should be made available to help underwrite the administrative costs of developing this interagency agreement, and subsequently implementing the DHFS commitments made in the agreement.

Discussion and Rationale: The existing Interagency Agreement for youth with disabilities in transition serves as a solid, agreed upon model in moving forward with developing a similar interagency agreement for adults with disabilities who have employment goals. Development and implementation of such an agreement can be promoted statewide and encourage buy-in and collaboration at the local level.

Recommendation 4.9 DLTC should request that DVR and the Managed Care Organizations (MCO's) consider appointing liaisons to directly collaborate, to coordinate employment services and planning with their common consumers at the local level, and in relation to transition age individuals, to jointly approach and partner with ADRC's in coordinating outreach efforts to schools, school students with disabilities and their families. The MCO's and DVR staff should coordinate their employment services activities with Job Center partners (includes DVR) and any local coordinated employment services mechanisms that exist within that Workforce Development area.

Discussion and Rationale: DVR has appointed liaisons to each high school in the state and the results have been favorable from DVR's perspective. Liaisons appointed to managed care organizations, and vice-versa, could produce similar results, and could ensure that there is active and effective collaboration between DVR, the Job Centers, and the long-term care system with regard to consumers receiving services from both entities.

Recommendation 4.10 DLTC should collaborate with DVR to support policy guidance, for DVR counselors and MCO care management teams, which ensures that DVR services to secure integrated employment continue to be available to individuals working in work centers/sheltered facilities or in group employment (e.g. enclaves and work crews) and to individuals receiving day services who express an interest in competitive, integrated employment. The policy guidance should make it clear that working in work centers/sheltered facilities, participating in group employment such as enclaves and work crews, or participating in day services can be done as an "in the meantime" activity/service funded by MCO resources while DVR is delivering services to assist a person to obtain integrated employment. As well, if individuals achieve integrated employment that is not full-time, working in work centers/sheltered facilities, participating in group employment such as enclaves and work crews, or participating in day services can be done as "wrap-around" activities/services for individuals who want or need these activities/services when they are not working in their integrated job. The content of the policy guidance developed should be covered in the information, training and technical assistance efforts outlined in Recommendation 4.4.

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Discussion and Rationale: Specific policy guidelines may help DVR counselors and MCO care managers better understand how long-term support services for options other than integrated, competitive employment and DVR services can be provided in a complementary manner to support individuals with disabilities who wish to work at least part-time in integrated employment.

Recommendation 4.11 DLTC should collaborate with DVR to train CMO staff, and to refresh the knowledge of DVR counselors, on DVR's established procedural guidance for counselors with regard to determining when DVR concludes services for individuals receiving supported employment services through DVR. The DVR guidance should identify criteria DVR counselors should use to determine when an individual's employment goal has been met, and guidelines counselors should use in determining the amount of extended support that the CMO will provide to a particular individual.

Discussion and Rationale: For individuals receiving supported employment services through DVR, the agency has the ability, under federal regulation, to offer extended support for up to eighteen months post placement in integrated employment (or longer in special situations). Currently, there is written procedural guidance available to counselors, which provides specific guidance regarding approval of extended support and when to close supported employment cases. The long-term care system picks up supports after DVR extended support is concluded. Current procedural guidance dictates that the length of time a consumer in supported employment is provided with extended support from DVR should be individually determined and should be based on the length of time necessary for the consumer to reach the target level of independence (e.g. working with 50% on-the-job supports) identified in the Individual Plan for Employment. It will be beneficial to consumers and the two cooperating systems if CMO staff and DVR counselors are both knowledgeable of DVR's policy and guidelines for the purposes of determining the amount of extended support that will be offered to individual consumers. While DVR has established policy, CMOs should also be encouraged by DLTC to develop blended funding procedures and agreements that are acceptable to DVR, the CMO and the common customer receiving long term employment supports.

Recommendation 4.12 The DLTC and DVR should collaborate on the development of employment data tracking systems which can integrate data, reconcile different definitions used in collecting data, and allow the two agencies to jointly track outcomes and performance in relation to common customers.

Discussion and Rationale: As part of the close collaboration and coordination that many of the preceding recommendations describe, it will be highly beneficial for DLTC and DVR to jointly develop systems to monitor outcomes and quality for the two agencies' shared customer base. As early as possible, DLTC and DVR should begin working together to ensure the data produced by each agency can be integrated and cross-referenced. This will involve reaching agreement on defining what each agency will track and how it will be tracked, as well as developing methods to identify and track common customers. The collaborative efforts will help both agencies move toward evidenced-based evaluation.

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7. Recommendations Falling Outside of Issue Committee Charge

None were identified by the Issue Committee.

8. Appendices

Appendix A. Inter-Agency Agreement on Transition dated July 5, 2007.

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #5

**Provider Network Development:
Provider Strategies for Evolving Programs and
Reallocating Resources in Response to Consumer Choice**

Final Report

March 20, 2008

Managed Care and Employment Task Force
Issue Committee #1

1. Issue Committee Charge

- Review and evaluate existing provider network capacity to provide employment services and supports, with particular attention to integrated employment services and supports;
- Identify existing incentives or disincentives for providers to increase their capacity to provide integrated employment services and supports;
- Determine willingness among existing providers of non-integrated employment and non-work services to engage in organizational transformation in order to offer, or increase their ability to offer, integrated employment services and supports;
- Recommend policy, funding and practice-based strategies that can encourage and support providers to expand their ability to provide services and supports for individuals who desire to be more involved in their communities, including involvement through integrated employment.

2. List of Task Force Members Serving on Issue Committee

John Bloor, NEW Curative, Green Bay [Issue Committee Chair]
Stacy Wigfield, Reach, Inc., Eau Claire
Jalaine Streng, Developmental Disabilities Program Manager, Langlade County
JorJan Borlin, Wisconsin Council on Physical Disabilities, Consumer
Mavis Vermaak, New Horizons North, Ashland

3. List of Other Participants and Contributors to Issue Committee

Rebecca Hildebrandt, Rehabilitation for Wisconsin, Inc.
Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Patricia Fabian, The Threshold
Marie Mace, Curative Care Network
Barb Roland, Eisenhower Center, Milwaukee
Jean Rumachik, Wisconsin Personal Services Association (WPSA)
Steve Reilinger, Reliant Rehabilitation Durable Medical Equipment Provider
Amy Thompson, Pathways to Independence, DHFS
Darci Vickman, Regional Coordinator, Pathways to Independence, DHFS
Kim Nelson, Community Integration Specialist, DHFS
Allison Lourash, Regional Coordinator, Pathways to Independence, DHFS
John Reiser, Office for Independence and Employment, DHFS
Tammy Liddicoat, Employment Resources, Inc.
Christine Smith, David Varana, Robin Lisowski, Virchow Krause

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4. Issue Committee Meetings

August 21, 2007
October 19, 2007
November 29, 2007
January 24, 2008

5. Summary of Issue Committee Process & Results of Provider Surveys

The issue committee engaged in a thorough discussion of the challenges to integrated employment facing both providers and consumers. The committee was in agreement that integrated employment participation is so low at present because individuals are not being referred by the long-term care system for these services, and referrals from DVR fluctuate. It is not really possible to determine if the current pattern of referrals is a result of consumer choice, cost-containment measures by the counties and managed care organizations, or some other factor. Vocational providers expressed concerns that planning always deals with residential arrangements first, and then if there is any money leftover, this is made available for day or vocational services.

The committee also considered the question of whether there is reason to conclude that the existing provider network is sufficient to meet increased demand for integrated employment services, including new demand from those currently on waiting lists and those coming out of the public school system. The committee heard a presentation from Virchow Krause and also conducted a survey of vocational and day providers. The vocational and day survey yielded responses from 77 providers who together are serving people in 71 of Wisconsin's 72 counties. All expressed interest in providing more integrated employment services if the referrals and funding necessary to do so is made available. A survey of personal care providers and a presentation to over 80 attendees at the Wisconsin Personal Services Association annual conference revealed that personal assistance service (PAS) providers are very willing to provide PA services in the workplace, but this would be a new area of business for them and they would need to develop a business plan and cost model, staffing plan, etc. to do this successfully. They reported serving many people who are not working at least in part because they cannot get personal assistance services in workplaces, including work centers/sheltered workshops. Except for some rural areas, the committee concludes there are a sufficient number of providers available to provide integrated employment services, if those services are requested.

The survey of vocational and day providers also showed that among existing providers 30% are providing community-based prevocational services, while 80% are providing supported employment services. Numbers served in supported employment ranged from 1 to 65 per provider. 66% of the providers that

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responded say the mission of their organization supports integrated, paid employment, in a job an individual chooses and likes, as the most desirable outcome for the people they serve.

Nearly 92% of respondents either somewhat agree or strongly agree that the biggest barrier to expanding integrated employment in Wisconsin for people who need long-term support is the uncertainty that sufficient long-term support funding will be available on a long-term basis. Providers noted that when budget cuts were made in the past under the waiver programs, integrated employment services were often the most likely to be cut. 57% agreed or strongly agreed that if they are able to fade supports for someone in integrated employment, they have no guarantee that the funding lost through fading will continue to be available to them so they can use it to serve a new consumer.

While many of the providers do not believe they can deliver integrated employment services at a lower cost per service hour, 69% believe the services would not cost so much if providers were more effective at identifying and recruiting natural supports. 61% believe the services would not cost so much if providers could create more customized or carved jobs that better fit a person's existing skills and abilities, and 54% believe the services would not cost so much if providers were more effective at training people to do their jobs.

In addition, 61% of the vocational and day providers surveyed believe there are real, not just perceived, benefits-related barriers to people with disabilities working in integrated employment. 85% surveyed agreed or strongly agreed that the lack of available, affordable and accessible transportation is the biggest barrier to more people with disabilities obtaining integrated employment.

The committee members noted there are few examples of individuals being able to spend part-time in integrated employment and part-time in sheltered employment under the waiver programs. Because these part-time arrangements are possible under Family Care, expansion of Family Care should encourage more individuals to try integrated employment and transition from full-time participation in sheltered employment. The most common reasons that surveyed providers cited for not being able to support more of their consumers to participate part-time in integrated employment and part-time in other activities were: funding; transportation; and inadequate staffing. Some providers reported that county policies under the waivers appear to not permit people to receive a mix of prevocational and supported employment services so individuals must choose one or the other.

40% of providers currently serving people in non-work and sheltered work programs believe that **less than 25%** of the individuals served in these programs have the capacity to work at some level in integrated employment, if appropriate supports, a willing employer and the right job match are available. Just under 30% of providers currently serving people in non-work and sheltered work

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programs believe that **more than 75%** of the individuals served in these programs have the capacity to work at some level in integrated employment, if appropriate supports, a willing employer and the right job match are available. In terms of consumer interest, 42% of providers currently serving people in non-work and sheltered work programs believe that **less than 25%** of the individuals served in these programs would want to explore the option of working at some level in integrated employment, if adequate DVR and long-term support funding were available. In contrast, only 19% of providers currently serving people in non-work and sheltered work programs believe that **more than 75%** of the individuals served in these programs would want to explore the option of working at some level in integrated employment, if adequate DVR and long-term support funding were available. However, 76% of providers disagreed that with the statement there are only so many people with disabilities who actually want paid, integrated employment and they are working with most all of them already.

Vocational and day providers listed many ideas they would pursue if DVR and long-term support funding were available to support people currently in non-work and sheltered work programs to pursue integrated employment. Some of the responses included:

- Educate individuals, parents and guardians on the benefits of integrated employment;
- Increase staff time and resources devoted to integrated employment;
- Provide vocational counseling, career exploration, job shadowing, work experience, job clubs, tours of companies;
- Do more job development;
- Train staff to work more effectively with businesses.

Vocational and day providers were also asked to identify the training, technical assistance and organizational development needs they would have if they were asked to dramatically expand their integrated employment services. A summary of the responses follows:

- **Assurances from funding sources that there would be sufficient referrals to make the organizational shift worthwhile;**
- Training for job developers and job coaches;
- Training on best practices for organization's management
- Funding to underwrite organizational development and change activities;
- Assistance with developing buy-in from board of directors and families;
- Ability to add additional professionally qualified staff;
- Help with developing job sites in very rural areas and self-employment opportunities;
- Increased funding to provide on-going supervision and mentoring to staff;
- Expansion of the agency's transportation system;
- Training on accessing and using assistive technologies & work incentives;
- Resources for staff expansion/recruitment.

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The committee also conducted a survey of residential providers which yielded 32 responses from residential service providers who together serve individuals in 58 counties. 13 of the 32 respondents serve some consumers with physical disabilities, 22 of the 32 respondents serve some consumers with developmental disabilities and 14 of the 32 respondents serve some consumers with mental illness. 78% of the providers reported serving less than 100 individuals who are employed, and of those providers, 63% reported serving less than 20 individuals who are employed. When asked where the individuals they serve are employed, 70% of those employed were reported to be employed in work centers/sheltered facilities. Most providers reported that they are able to provide early morning personal care to individuals who need to get to work between 7-9am, although a 7am start is much harder to accommodate. Getting staff to start very early and then only work for a couple of hours is most difficult, and the suggestion was made that higher rates should be paid for services provided early in the morning, late at night or for relatively short stints.

Very few residential providers surveyed are able to provide staff to drive a consumer to work in a vehicle owned by the consumer, but 50% are able to do this in a vehicle owned by the staff person, if funding is available to cover the staff person's time and mileage. Sometimes however, staff matched with consumers who work may not have drivers licenses. 40-50% of providers reported an ability to provide personal care and assistance with meals at a consumer's workplace if funding is available for this service, although doing this for someone who works second or third shifts is more difficult than for someone working first shift. Only 30% of providers said they could provide staff to travel out of town with a consumer who needs to go on a business trip. Only 40% of residential providers reported offering training to their staff specific to providing residential services to consumers who work; but none said they would not be interested in providing this training to their staff who work with consumers who are employed, if a training curriculum were available.

When asked about the biggest challenges residential providers face in helping consumers get ready so they can get to work on time, they reported: finding and retaining quality staff for this time of the day (mornings), particularly if many consumers need staff at the same time of day; varying work hours and staff not being made aware of changes in work hours; and lack of transportation. When asked about the biggest challenges residential providers face if more of their consumers began working in community jobs, they reported: finding and retaining quality staff for this time of the day (mornings), particularly if many consumers need staff at the same time of day; providing staff coverage at home if consumers come and go at different times or have different days off and can't be alone at home; having to develop good working relationships with every employer rather than with a day program or work center provider; and lack of transportation once the consumer is ready to leave his/her home, particularly if

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each consumer needs to go to a different employment site, but everyone needs to arrive at their employment site at or around the same time.

In terms of policy changes needed, residential providers again mentioned funding to provide supports when people are not working, if they can't be left alone at home and funding to pay staff more who provide early morning services, late night services, or services that involve very short-shifts. In addition, they also mentioned: support from state agencies to encourage individuals to work; and changing policy that appears to prevent consumers from receiving mixed services in a given day.

In addition to the surveys conducted, the committee reviewed feedback from presentations done by Fredi Bove and Lisa Mills to: RFW (Community Rehabilitation Providers); APSE 2007 State Conference (Wisconsin Association of Supported Employment Providers); and WPSA 2007 State Conference (Wisconsin Association of Personal Care Providers). As well, the committee reviewed the results of a Wisconsin APSE member training survey. All of these items can be found in the appendix to this report.

6. Recommendations

Note: Recommendations 5.1 to 5.5 were submitted to the full Task Force as interim recommendations and were approved by the full Task Force on February 19, 2008.

Increase and Stabilize Referrals to Providers for Integrated Employment Services

Recommendation 5.1 Medicaid Infrastructure Grant (MIG) funds should be made available for interested integrated employment service providers to collaborate on the development of an outreach and educational campaign, including at a minimum a short educational film about the option of integrated employment. This film should be used to educate consumers, families, ADRC staff, MCO inter-disciplinary teams, and school staff involved in transition.

Discussion and Rationale: Providers continue to report that they receive a low number of referrals for integrated employment, in comparison to the number of referrals they receive for day and prevocational services. Increasing and sustaining referrals for integrated employment will significantly improve a provider's ability to offer increased integrated employment services that are both high quality and cost-effective. In order to increase referrals for integrated employment services, providers believe that the choice of integrated employment needs to be more clearly and consistently explained and illustrated for those involved in determining whether individuals identify integrated employment goals. Because so few people who receive long-term care services are involved in integrated employment, providers are concerned that individuals and families, and professionals who assist individuals and families in considering integrated employment, may lack a full understanding of how integrated employment services really

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work, including: what people can do while job development is going on; how people are supported when they are not working; how people can pursue micro-enterprise or self-employment; how transportation is ensured for individuals working in the community; what happens if a person loses or chooses to leave a community job; how the safety of the individual worker is addressed; how benefits issues are monitored on an on-going basis; etc. A collaborative of providers could effectively create a public outreach and education campaign, including a film that addresses the lack of knowledge and the misconceptions/myths related to integrated employment, which may in part be responsible for the low number of referrals.

Identify and Leverage Resources Available for Integrated Employment Services:

Recommendation 5.2 Existing providers who currently offer a mix of employment and day services, including integrated employment services, and who wish to expand their capacity to provide integrated employment services should have access to the information, training, and on-going technical assistance necessary to increase their ability to deliver high-quality, integrated employment services to more individuals. This should include a focus on assisting providers to: (1) successfully leverage and blend or braid all funding sources available to support integrated employment services; and (2) identify strategies for reallocating existing organizational resources to support expanded integrated employment services. Medicaid Infrastructure Grant (MIG) resources should be made available to providers that wish to: (1) engage the organization's leadership (board and management) in considering a shift in focus to integrated employment; and (2) use the above two approaches to rebalance the services they offer in favor of integrated employment, and to develop effective models for doing this which can be replicated by other providers.

Discussion and Rationale: The issue committee found, through outreach and surveys, that the availability of adequate and consistent funding for integrated employment is the biggest challenge that providers say prevent them from expanding integrated employment services. Typically, providers look to the Division of Vocational Rehabilitation and the long-term care system to provide funding for integrated employment services. Providers would benefit from new opportunities to learn about the full range of funding sources for integrated employment that they can pursue, and to receive on-going technical assistance from peers who have had particular success in leveraging/blending multiple funding sources to offer integrated employment services to more individuals who need long-term support to maintain integrated employment. In addition, providers would benefit from opportunities to receive technical assistance from providers who've found effective ways to reallocate existing organizational resources to support the successful expansion of integrated employment services, and to make integrated employment services the primary service offered by the organization.

Address Particularly Difficult Obstacles to Expanding Integrated Employment

Recommendation 5.3 New and existing integrated employment service providers wishing to develop, improve or expand their capacity to provide these services should be

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given the support and resources necessary to: (1) implement the most promising, evidence-based practices being used to create and sustain integrated employment opportunities for individuals with disabilities, and (2) overcome the most difficult obstacles they identify in relation to increasing integrated employment opportunities. Medicaid Infrastructure Grant (MIG) resources should be made available, through an RFP process, to support promising pilot initiatives by new and existing providers who wish to expand integrated employment services through adoption of best practice strategies for job development, job coaching, and addressing specific yet common obstacles to expansion of integrated employment services.

Discussion and Rationale: In rural areas, and during times of economic slow down, advertised positions are sought by larger numbers of qualified applicants. Increased competition for fewer jobs creates significant challenges for individuals with disabilities seeking integrated employment. New and existing providers need support and resources to pursue the most promising strategies being used today to creating integrated employment opportunities for individuals with disabilities. Among these are customized employment, self-employment, micro-enterprise, and approaching business leaders with the latest facts regarding the business case for hiring people with disabilities. As well, providers would benefit from targeted assistance related to securing employment opportunities in unionized workplaces.

Facilitate and Support Personal Assistance Services Providers to Expand Services into Integrated Workplaces

Recommendation 5.4 The Department should provide clarification and guidance in industry meetings and other settings to providers of personal assistance and personal care services that under Family Care managed care organizations are able to authorize and purchase personal assistance services provided in the workplace, in order to support managed care members to pursue and maintain employment.

Discussion and Rationale: Personal assistance providers are restricted under the Medicaid fee for service system by state regulation from providing MAPC-funded personal care in the workplace. This is not the case in Family Care, as managed care organizations are able to authorize and purchase personal assistance services wherever such services are needed. However, personal assistance providers may still believe they are not able to provide personal assistance services in the work place. Official guidance from the Department to managed care organizations and personal assistance providers would help clarify the more flexible policy under Family Care.

Recommendation 5.5 The Committee recommends that the Department consider developing a toolkit for personal assistance service providers who wish to begin providing personal assistance services in integrated workplaces for managed care participants. The toolkit should include sample operational policies, financial and budgeting tools, staff recruitment and training information, etc.

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Discussion and Rationale: Few WPSA providers have extensive experience providing personal assistance in the workplace. WPSA providers will need assistance with developing business, financial and staffing plans to include this type of personal assistance service in their service package. Wisconsin's Medicaid Infrastructure Grant (MIG) could provide resources to develop a viable model that WPSA members can then use to branch out into providing workplace personal assistance services for managed care participants.

Recommendation 5.6 The Department should clearly define what employment outcomes/situations are considered as integrated by the Department. This will help provide a consistent message to providers and others.

Discussion and Rationale: Providers are concerned that they are not getting a consistent message about integrated employment from the Department, its managed care organizations and counties. Providers would like a consistent message, both in terms of definition and policy, with regard to integrated employment. Providers would like clarification about what employment situations are considered integrated. Providers may employ people with disabilities directly, hire individuals without disabilities as part of their workforce, and/or employ non-disabled staff. There needs to be clarification about whether these situations are considered integrated or not. Providers are also not clear about whether home-based employment is considered integrated employment by the Department.

Recommendation 5.7 The K-12 school system should be knowledgeable about the range of employment options available to students when they turn 18. As a means of assisting the transition of students with disabilities from school to work, the school system could explore ways to bring integrated employment providers into the transition planning process prior to the IEP transition team establishing a post-secondary employment goal, to help students and their families fully understand the option of integrated employment, and how it can be supported by the long-term care system. If transition from school to integrated employment is desired, it is critical that providers are authorized by an available funding source to begin serving students well in advance of graduation, so that integrated employment planning and job development can be completed prior to graduation.

Discussion and Rationale: In addition to information provided to transition planning teams by ADRC's, providers can be utilized to accurately explain the option of integrated employment, and how it is supported by the managed care system, to transition planning teams. Involvement of providers would need to be undertaken in ways that meet confidentiality requirements. It is essential however, that transition planning teams have this information before they establish a post-secondary employment goal in the student's individualized educational plan. Otherwise, many transition teams may establish and pursue post-secondary employment goals that do not involve integrated employment because they believe integrated employment is not an option the managed care system will support.

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As well, if the transition team wishes the student to move directly into work after graduation, employment service providers must be connected with the student prior to graduation.

Recommendation 5.8 When people are offered the choice of integrated employment, this choice should be clearly and thoroughly explained so that each person can make an informed choice about whether to pursue integrated employment. As a possible means of providing information to Family Care clients, MCOs can consider utilizing integrated employment service providers as resource experts by MCO teams when those teams are assisting individuals with disabilities to consider and explore the option of integrated employment.

Discussion and Rationale: Because so few people who receive long-term care services are involved in integrated employment, individuals and families, and MCO teams that assist individuals and families in considering integrated employment, may lack a full understanding of how integrated employment services really work, including: what people can do while job development is going on; how people are supported when they are not working; how people can pursue micro-enterprise or self-employment; how transportation is ensured for individuals working in the community; what happens if a person loses or chooses to leave a community job; how the safety of the individual worker is addressed; how benefits issues are monitored on an on-going basis; etc. Integrated employment service providers can be invited to join MCO teams to fully explain the integrated employment option and help ensure the member can make an informed choice about whether to pursue integrated employment.

Recommendation 5.9 When an outcome reflecting an individual member's desire to explore or pursue employment is identified in a member's member-centered plan, details regarding the particular employment goal (type of work; hours; employer preferences; etc.) should be developed, included in the plan, and passed on (ideally in a face-to-face meeting) to the provider who will be providing services to assist the member with achieving his/her employment goal.

Discussion and Rationale: Managed care organizations can best ensure that a member's personally identified employment goal is supported by including details about that specific employment goal in the description of the employment outcome that appears in the member's member-centered plan. Sharing these details with service providers will also ensure that the service provider focuses services on helping the member achieve the specific employment outcome identified. In the process of recording member employment outcomes in the member-centered plan, it should not be possible for an outcome of employment in a work center/sheltered facility to be substituted for an outcome of integrated work, if the member articulates an employment goal that is not consistent with what the work center/sheltered facility offers in the way of specific work opportunities. If MCO's adopt this practice, they would be operating consistently with the school and vocational rehabilitation systems, which define the specifics of an individual's employment goal in their respective plans (transition plans and individual plans for employment).

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Recommendation 5.10 Consumers should have more choices around how they can access and participate in integrated employment. Where an individual may only work part-time in integrated employment, the MCO should ensure the individual service plan includes other services, if needed and desired, when the individual is not working in integrated employment. The Committee notes and supports that under Family Care mixed services in a given day or week, which meet an individual's unique support needs and defined outcomes, are possible.

Discussion and Rationale: Integrated employment opportunities are often part-time. Many individuals who opt for day services or employment in a work center/sheltered facility do so because they are provided with a full week of activities where the supports they need are consistently available. In order to encourage more individuals to participate in integrated employment, the system must ensure that people can receive other services during the hours they are not working in integrated employment. Under the waiver programs, the opportunity to receive mixed services was not always offered. Where this is the case, there is a strong disincentive for individuals to pursue integrated employment, as they can be left with no services and supports for a portion of their week.

Recommendation 5.11 MCOs should consider including in their provider contracts a provision that allows payment not only for face-to-face service delivery time, but also the non face-to-face time spent by the provider to support the client. This will enable providers of integrated employment services to be reimbursed for all hours of service provided to a member, regardless of whether they are face-to-face or not. Allowing billing for all hours of direct service, whether face-to-face or not, will ensure that the rates for integrated employment are determined in a way that is comparable to how the rates for other services are determined.

Discussion and Rationale: Including only face-to-face hours in the service authorization forces providers of integrated employment services to increase their hourly rate for integrated employment services to account for the non-face-to-face hours of service they are providing. This artificially inflates the hourly cost of integrated employment services in relation to other services where face-to-face contact is the normal mode of service delivery. Best practices in providing integrated employment services often involve non-face-to-face service delivery (e.g. benefits analysis; job development; employer support and technical assistance; etc.).

Recommendation 5.12 Providers should have access to high-quality, affordable training that can contribute to developing and maintaining the core competencies of their staff. A statewide core training program, which can help ensure a minimum set of core competencies among provider staff, is a cost-effective way to ensure consistent access to high-quality, regularly updated training that can ensure Wisconsin's providers have access to the best practices (including evidence-based practice and values-based practice) that are coming out of the field. The training offered through this statewide program should address the training needs of agency leadership and program managers, not just direct service staff. These efforts should be coordinated with all other training efforts

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recommended by the Task Force to ensure that a system-wide, comprehensive, consistent and cost effective approach to training around employment results.

Discussion and Rationale: Providers consistently report they are not able to provide their staff with the amount of training they believe is necessary to ensure their staff are providing the best possible services to consumers. Providers report that training on some critical subjects is not readily available. Those topics include: customized employment; micro-enterprise and self-employment; best practice for approaching businesses; making the business case for hiring people with disabilities; developing and supporting integrated work opportunities in rural areas; breaking into unionized workplaces; and best practice job coaching strategies. As well, providers report a need for training focused on best practices for serving people with specific disabilities and barriers to employment: physical disabilities; traumatic brain injury; dual-diagnosis; offenders/felons and sexual predators. Sometimes, training is not offered in ways that make it possible for providers to take full advantage. Providers recommend that efforts to provide training aim to meet the following goals:

- a) Providers are able to determine the specific topics, content, and speakers they want.
- b) The training should be free or as low-cost as possible if providers are not paid higher rates for service provided by trained staff.
- c) The training should be offered on a regional basis so those who wish to attend are expected to travel a reasonable distance, which reduces travel costs and the cost to provider organizations for staff time spent traveling to and from training opportunities.
- d) The training should be offered a few times in each region so all staff that can benefit are able to attend.
- e) The training should have a strong hands-on, practical component, and should offer plenty of opportunities for problem-solving.

It is recommended that, in exploring how to develop the statewide core training program, the current efforts to expand the College of Direct Support's vocational unit and the lessons learned from the past experiences of the Wisconsin Technical College System be considered.

Recommendation 5.13 Providers should be supported to develop and implement cost-effective models for shared job supports, which can allow access to community employment for more individuals. Using the Medicaid Infrastructure Grant, the Department could support the development and piloting of models that offer alternatives to traditional enclaves and work crews – particularly models that offer greater levels of interaction with customers and/or co-workers without disabilities.

Discussion and Rationale: Providers acknowledge that although many individuals need readily available support when they work in integrated employment, many individuals would not require 1:1 staffing for the entire time they are working. Many more individuals, who are currently supported in 1:3 or 1:5 service arrangements, could be supported in integrated employment at very little increased cost if providers are able to develop models for people holding individual jobs to share on-the-job support. Both Project Search and an initiative with Target in Milwaukee offer examples of ways this can be done, where individuals work in different departments in a single business and

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share floating support staff. There is a need to assist and enable providers to develop more expertise and models of how people can share support without using congregate models (work crews and enclaves), and to coordinate individual employment planning processes so those who share similar employment interests, and could benefit from these kinds of models, can be readily identified.

Recommendation 5.14 All employment service providers should be encouraged to develop partnerships with their local One-Stop Job Centers, and to ensure that the individuals they serve are accessing the available services of the One-Stop Job Centers.

Discussion and Rationale: Employment service providers who have developed partnerships with their local One-Stop Job Centers report that this partnership enables their organization to provide a more effective, comprehensive service and in some cases, to reduce costs to the long-term care system to the extent that some services can be provided and/or paid for through the One-Stop system.

7. Committee Support for Full Implementation of Existing Family Care Policies

In addition to the above recommendations, the Committee notes and supports a number of key ways that managed care Family Care differs from the waiver programs that serve to strengthen employment outcomes for clients:

(A) The Committee notes and supports current Family Care policy which does not preclude an individual with significant support needs from receiving MCO-funded services to pursue and participate in integrated employment, if the individual clearly states that integrated employment is his/her desired outcome.

Discussion and Rationale: The goal of service authorization policies (e.g. the Resource Allocation Decision-Making process or “RAD”) is to identify the most effective and cost-effective method for meeting a member’s identified outcome. Cost-effectiveness is defined as “effectively achieving a desired outcome at a reasonable cost and effort.” Per the Family Care contract, the MCO is permitted “to substitute a preferred service or support arrangement with another of comparable quality and efficacy.” It must document this in the member-centered plan along with the reason for not meeting the member’s preference and whether the member agrees with the substitution. The member may refuse to accept the service and/or refuse to sign the plan.” While service options may be substituted, it appears that the Family Care contract does not permit the member’s desired outcome to be substituted or changed, even if the client has significant support needs.

(B) The Committee notes and supports that under Family Care the amount of support made available for integrated employment is individually determined through the care planning process. Unlike the waiver system, MCO’s are not permitted, either through policy or common practice, to establish artificial caps on the amount of funding or

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amount of service hours an individual wishing to pursue integrated employment may receive.

Discussion and Rationale: A significant change under managed care is that spending on individual service plans is not to be capped based on the rates paid to the MCO for the individual, whereas in the old waiver system, spending on individual service plans was often capped based on waiver daily rates. Under the old waiver system, it was also common for a county to approve supported employment services only if an individual could work with no more than 25% job coaching support. Authorization of supported employment services or other long-term support services for employment under Family Care is not dependent upon the inter-disciplinary team judging that an individual will be able to work with a limited level of support after a pre-determined length of time. As part of its contract and quality monitoring processes, DHFS will be monitor service delivery and spending data reported by individual MCO's and will be able to ensure that MCO's are not setting artificial limits on the amount of weekly or monthly service hours being provided and/or the amount of funds being spent to support members in integrated employment.

(C) The Committee notes and supports that under Family Care, transportation can be paid for as part of employment services or through the specialized transportation services category.

Discussion and Rationale: Transportation is a critical element in ensuring a successful employment outcome. It is very beneficial that under managed care, transportation can be paid for as part of supported employment services or through the specialized transportation services category. Therefore, the inter-disciplinary team would address the employment-related transportation needs of the member as part of the care planning process, and the cost of transportation to and from integrated employment would be covered through the individual service plan.

8. Recommendations Falling Outside of Issue Committee Charge

None were identified by this committee.

9. Appendices

- Appendix A: Summary of results of provider surveys
- Appendix B: Summary of listening session input
- Appendix C: WI APSE training survey results

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #6

Measuring Outcomes and Quality

Final Report

March 20, 2008

1. Issue Committee Charge

- Make recommendations for improving or expanding the personal experience outcomes measures to ensure outcomes related to employment are measured as a component of determining quality in managed long-term care services.
- Learn about the PEONIES project, which is developing ways to measure the personal experience outcomes, and make recommendations to the PEONIES project team regarding effective ways for DHFS to measure MCO performance around member employment outcomes;
- Define agency and individual consumer goals related to employment that should be measurable through a comprehensive, statewide, cross-disability data collection system.
- Make recommendations to guide the development of a data system which can be used to measure MCO and provider performance, as well as consumer outcomes and satisfaction.
- Develop recommendation regarding additional accountability mechanisms that DHFS could consider implementing to ensure managed care organizations facilitate informed choice around employment, and offer the full range of employment-related choices in the member-centered planning process.

2. List of Task Force Members Serving on Issue Committee

Monica Murphy, Disability Rights Wisconsin [Committee Chairperson]
Fredri Bove, Deputy Administrator, Division of Long-Term Care
Greg Smith, Vocation Peers Coordinator, Grassroots Empowerment Project
Jennifer Ondrejka, Executive Director, Board for Persons with Developmental Disabilities
Tim Sheehan, Executive Director, Center for Independent Living for Western Wisconsin, Inc.

3. List of Other Participants and Contributors to Issue Committee

Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Molly Michels, Pathways to Independence, DHFS
Ellie Hartman, UW-Stout Vocational Rehabilitation Institute
Sara Karon, UW-Center for Health Systems Research & Analysis
Steve Stanek, Board for Persons with Developmental Disabilities
Tammy Hofmeister, Developmental Disabilities Section, DHFS
Karen McKim, Office for Family Care Expansion
John Reiser, Director, Office on Independence and Employment
John O'Keefe, Developmental Disabilities Section, DHFS
Nachman Sharon, Managed Care Section, DHFS

Sharon Ryan, Office for Family Care Expansion
Maribeth Hartung, Center for Independent Living for Western Wisconsin, Inc.
Allison Lourash, Pathways to Independence, DHFS
Brenda Reiser,
Eric Grasso,
Dave Varana, Virchow Krause
Christine Smith, Virchow Krause

4. Issue Committee Meetings

August 8, 2007
October 12, 2007
November 29, 2007
January 31, 2008
February 27, 2008

5. Introduction

One of the four key goals of the Family Care initiative is quality: to “improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.” The Department of Health and Family Services (The Department/DHFS) defines the term “outcome” as: “a condition or circumstance that is of value in and of itself.” With regard to employment outcomes in particular, this committee reached consensus that employment should be defined as “any activity where an individual is compensated for that activity, at least in part, through a monetary payment.” The committee agreed that if people wish to be supported to work, the broad outcome the system should be seeking to support for all members is meaningful work, both in terms of content and remuneration.

Wisconsin’s managed long-term care system is a system built on assisting members to achieve their personally identified health and social outcomes. It is critical that employment-related personal outcomes of long-term care recipients are identified and measured as part of quality assurance, quality improvement and performance monitoring activities carried out by managed care organizations (MCO’s) and DHFS. What gets measured gets done. The fact that the Department measures employment outcomes sends the message to all system stakeholders that employment is important.

“Live, work and play” is in many ways, the essence of each of our lives. As Wisconsin’s managed long-term care system strives to provide citizens with disabilities with the same set of opportunities that are typical for citizens without disabilities, work inevitably takes on a prominent role, as it does in all of our lives. Work is a common way that people contribute to their communities, stay productive and realize their full potential. Research tells us that unemployment can be associated with poorer quality of life, while

employment, particularly integrated employment, can contribute to higher quality of life (Eggleton, et al., 1999; Garcia-Villamizar et al., 2002).

The managed care system is intended to provide consumers choice regarding employment options and services that reflect the personal outcomes they seek. The new managed care system faces the challenge of countering historically low expectations regarding employment options and services, and promoting quality through high expectations regarding:

- What the system can/will provide;
- Individual member capacities and potential (with these high expectations shared by members and guardians/families, if involved);
- The wider community's interest, willingness and ability to embrace consumers as full members and valued contributors.

It is critical that quality assurance activities also ensure that care managers and other professionals involved in outcome identification and service planning/authorization operate from and communicate high expectations in each of these areas, as their opinions may significantly influence consumers, guardians and families.

6. Recommendations

Recommendation 6.1 Until full implementation of Recommendation 6.8, the Task Force supports the current Department efforts to integrate employment into the existing PEONIES interviewing process. The current approach, which directs the PEONIES interviewer to ask about employment if an individual does not spontaneously bring it up, and which tracks employment outcomes separate from other outcomes that fall under the “*I do things that are important to me.*” Personal Experience Outcome area, should be continued.

Discussion/Rationale: In the absence of a personal experience outcome distinctly focused on employment, these efforts maximize the likelihood that employment will be discussed as part of the interviewing process used to discover and identify members' desired outcomes. These efforts also provide a mechanism for producing data regarding the number of members who: have employment outcomes; are receiving services to help them achieve those outcomes; and report having achieved their employment outcomes. The committee fully supports the recent efforts by the Department to integrate employment into the interviewing process being developed to provide care management teams with an approach for identifying members' personal outcomes, and to provide quality reviewers with an effective method to measure MCO performance in relation to member outcomes. The committee also fully supports the recent efforts by Department staff to integrate employment into the written manual and training sessions for care management teams and quality reviewers who will be using the PEONIES interview process. These efforts provide the groundwork for any future adjustments needed if Recommendation 6.9 is supported by the full Task Force and adopted by the Department.

Recommendation 6.2 For the purposes of tracking participation in employment among managed care members, employment should be defined as any activity where an individual is compensated for that activity, at least in part, through a monetary payment. This is intended to include self-employment and micro-enterprise, which typically involves selling goods an individual produces (e.g. art, crafts, jewelry, etc.) or selling services on an individual basis.

Discussion/Rationale: In order to accurately identify all managed care members who are participating in the wide variety of types of employment options which exist, the committee agreed that a broad definition would be necessary. The committee also agreed that unpaid activities designed to prepare people for employment (e.g. volunteering) are valuable but should not be counted as employment. While participating in “any activity where an individual is compensated for that activity, at least in part, through a monetary payment” does not convey the committee’s position regarding what should count as a quality employment outcome, it was agreed that it is an appropriate definition for tracking broad employment participation by managed care members.

Recommendation 6.3 The Department should annually measure individual MCO performance in the area of employment by using the Functional Screen data and by tracking:

1. Wages earned by members who are employed.
2. Hours worked by members who are employed.
3. Number of months, in the last 12 months, that each employed member was employed.
4. Type of employment for each employed member (from limited, pre-established list of categories).
5. Number of employed members who report their employment matches their preferences and abilities.
6. The number and percentage of MCO members who:
 - a. Have an employment outcome/goal included in their member-centered plan.
 - b. Have services/supports for employment included in their individual service plans.
 - c. Have, in the last 12 months, utilized DVR services.
 - d. Are receiving prevocational services in integrated settings, of the total number and percentage receiving prevocational services.
 - e. Have, in the last 12 months, partially or fully transitioned from prevocational services to integrated employment at minimum wage or higher.

It is recommended that the Department begin measuring MCO and system-wide performance using these criteria and then establish appropriate progress goals for MCO’s and the system as a whole to achieve in relation to: (a) working age members; and (b) all members. Data systems should be developed, integrated and modified, as needed to enable collection and reporting of this data.

Discussion/Rationale: Beyond simply tracking the number of managed care members participating in any paid activity, it is important that the Department track data that provide additional information on the nature and quality of the employment opportunities members are involved in. MCO performance in relation to assisting members to pursue and maintain employment needs to be evaluated in ways that reflect the values the Department has in relation to employment. The Committee recommends that the Department adopt the Policy on Employment being proposed by the Task Force and annually collect the data outlined above as part of a comprehensive approach to performance and quality monitoring. Tracking this information on an annual basis will allow the Department to evaluate the performance of MCO's over time and to regularly update on-going performance improvement goals set by the Department. Because not all data highlighted above is currently available, the Department will need to analyze the modifications needed in its data systems to collect these data.

Recommendation 6.4 The Department should establish a standard unit definition for reporting services so that employment data is reported consistently by all MCOs. The Department should require that all units of service provided to members be reported, not just face-to-face units of service.

Discussion/Rationale: At present, MCO's are not using standardized units of service to report services delivered to assist members to pursue and maintain employment. The lack of standardized units of service makes accurate analysis of service provision and cost impossible. Evaluating the comparative cost of employment services in relation to hours of service provided cannot be done unless units of service are standardized across all MCO's. In addition, analyzing the amount of service individual members receive as compared to the hours they participate in employment cannot be done unless units of service are standardized across all MCO's.

Recommendation 6.5 The Department should review and analyze employment-related data, and annually produce a report regarding system and individual MCO progress and performance with regard to performance indicators and goals established by the Department.

Discussion/Rationale: Annual analysis and publication of data is a tool for on-going quality improvement.

Recommendation 6.6 A consistent approach to tracking employment outcomes in and data should be used for both managed care and the self-directed services waiver.

Discussion/Rationale: Given that the Self Directed Support (SDS) waiver will be an alternative to managed care, the issue committee recommends that a consistent approach to tracking employment outcomes and data be used across both long-term care program options so comparative analyses can be done.

Recommendation 6.7 To reflect the importance the Department places on meaningful work opportunities for managed care members, the Department should ensure that annual contracts with MCO's:

1. Include employment as a MCO quality indicator. (Quality indicators are listed in Appendix V of the CY 2008 contract.)
2. As for all MCO quality indicators, establish minimum levels of performance for MCO's with regard to employment, particularly integrated employment, among MCO members.
3. List annual progress goals related to employment, and how MCO performance in this regard will be measured and evaluated.
4. Clearly state that quality assurance and quality improvement (QA/QI) activities conducted by the MCO's should in part address member employment outcomes.
5. Require MCO's to submit employment-related data specified in the contract, using standard measurement specifications also specified in the contract, to enable DHFS to measure each MCO's performance in relation to employment.

Discussion/Rationale: The MCO contract governs the relationship between the Department and its MCO's, and articulates all of the responsibilities that MCO's have. The MCO contract currently includes a number of quality indicators in areas other than employment, such as health and safety, and includes performance measures and data reporting requirements for the indicator. Adding a quality indicator in the area of employment, and establishing minimum levels of performance for MCO's could help explicitly convey to MCO's the Department's expectations regarding employment. As well, establishing annual progress goals for MCO's in the area of employment, and requiring MCO's to submit data that will enable the Department to measure MCO performance on these goals, has been an effective strategy used by other states to improve outcomes.

7. Recommendations Falling Outside of Issue Committee Charge

None were identified by this committee.

8. Recommendations to be brought to the Full Task Force for Final Decision

Note: Recommendation 6.8 is similar to a draft recommendation made by Issue Committee #1 (See Appendix B). Since consensus could not be reached in Issue Committee #6 regarding whether to bring Recommendation 6.8 forward to the full Task Force, the committee is asking the Task Force to consider the issue and reach a final

*decision about whether to make this recommendation part of the final report to the Department. Given that Recommendation 1.26 is concerned with the same issue, this recommendation should be considered and discussed by the full Task Force when Recommendation 6.8 is considered and discussed. **Staff to this committee prepared a discussion paper summarizing the issue and the arguments for and against approving Recommendation 6.8. This discussion paper will be distributed to the Task Force as a supporting document to this report.***

Recommendation 6.8 In order to ensure consistent, high quality outcomes in the area of employment for managed care members around the state, the Department of Health and Family Services (DHFS) should:

- Re-establish employment as one of the personal experience outcomes used to guide member-centered planning and used to measure and evaluate quality in the managed long-term care system. [The personal experience outcome that currently subsumes employment – *I do things that are important to me* – should continue to be maintained.]
- Establish method(s) to measure MCO performance with regard to its progress in supporting members to achieve their personally identified employment outcomes.

Alternative Recommendation Language Considered by the Committee:

A. Recommend re-establishing employment as one of the personal experience outcomes areas, in addition to *I do things that are important to me*, for working age adults only. This would address the objections elderly advocates have to a personal experience outcome that directly references employment being used with elderly individuals. This would also better ensure that the things people want to do (that are not employment-related) can be fully identified, in addition to employment, and will not be treated as less valued than employment.

Specific outcome language that was discussed included:

- I am working as much as I want in a job that I like. [Some people did not like this because they believe it is a satisfaction statement, not an outcome statement.]
- I am achieving my employment goal. [Some people raised concerns that having this as a personal experience outcome area presupposes people have an employment goal.]

B. Recommend the Department consider whether and how an employment outcome could be added without pre-supposing that it applies to all people.

9. Appendices

Appendix A: Data Elements Grid

Appendix B: Discussion Paper

- Appendix C: Current List of Personal Experience Outcomes
- Appendix D: *Recommendation 1.26 in the report from Issue Committee #1*
- Appendix E: The Evolution from COP RESPECT Values to Family Care
Personal Experience Outcomes
- Appendix F: Long-term Care Adult Outcomes Crosswalk

Appendix A: Data Elements Grid

Column 2: See next page for list of outcomes. Column 3: A = All; E = Employed; N = Not Employed

Item to be tracked	Outcome Addressed	Which Members? (A, E, N)	How it's currently being tracked	How it could be tracked in the future
Occurrence of being employed where member chooses (consistent with person's abilities and preferences)	1; 5	A	Member Centered Plans	1. Member Centered Plans 2. PEONIES
Current Employment	All	A	Functional Screen	1. Functional Screen: Provide detailed instructions and definitions with employment defined as any paid activity 2. Member Centered Plans
Type of Work Setting: Community Individual, Community Group, Sheltered, Home	2	E	Functional Screen	1. Functional Screen 2. Member Centered Plans
Occurrence of employment status satisfaction	1; 5	A	Functional Screen as "interest in new job"	1. Functional Screen: Provide detailed instructions and definitions and include interest in new, more (either increase in hours or seeking additional employment opportunities), or different (e.g., career advancement, different type of employment, changing work setting, or splitting work between two settings) employment as separate items. Add an interest item to determine if individuals are interested in new or more community employment. 2. PEONIES

Item to be tracked	Outcome Addressed	Which Members? (A, E, N)	How it's currently being tracked	How it could be tracked in the future
Work Earnings	3	E	Unemployment Insurance (UI) data (quarterly)	<p>1. Member Centered Plans: Record for each work setting. Check off if at least minimum wage or below minimum wage. (Reliability and validity of self-reported wages?)</p> <p>2. UI data [Please note: self-employment, employment in other states, typically federal employment, and some types of sheltered employment (non-profits and government) are not included in UI data]</p>
Hours worked during last week	3	E	Functional screen records part time and full time employment	<p>1. Functional screen: Continue to record part time and full time employment, with full time employment meaning more than 35 hours worked within the last week</p> <p>2. Member Centered Plans: Numbers of hours worked during the past week for each work setting.</p> <p>Note: Only record hours worked. Hours at sheltered workshop, but not working should NOT be recorded</p>
Job retention: Number of months employed at a job	4	E	Member Centered Plans	Member Centered Plans: Record for each job
Reason not interested in employment	1	N	n/a	<p>1. Functional Screen</p> <p>2. Member Centered Plans</p>
Presence of interaction in the workplace with non-disabled peer within the last week	2	E	n/a	<p>1. Member survey?</p> <p>2. Observation checklist at workplace?</p> <p>3. How would "interaction" be defined?</p>

Column 2: See next page for list of outcomes. Column 3: A = All; E = Employed; N = Not Employed

Dimensions of a Positive Employment Outcome

1. INDIVIDUAL CHOICE IS OFFERED:

Consistent with the person's strengths, capacities and preferences, employment options are identified, offered and secured.

2. COMMUNITY INTEGRATION OCCURS:

At the workplace, the number of people with significant disabilities is similar in proportion to the number of people with significant disabilities in the general population.

Employment by a community business, through self-employment or as owner of a micro-enterprise is preferred. A community business is a business whose primary source of income is not disability services funding.

3. FINANCIAL BENEFIT OCCURS:

Employment income creates net increase in person's total monthly income, taking account of unearned and earned sources, as well the financial value of participation in means-tested subsidy program.

Compensation at minimum wage or higher and weekly hours of 20 or more is preferred.

4. APPROPRIATE SUPPORT IS AVAILABLE:

Effective strategies including customization/carving in job development; accommodations and adaptations; assistive technology; and natural supports are utilized as appropriate.

Time between creation of the employment plan and first day at work is 6 months or less.

After an initial, time-limited period of training, the person is able to achieve a substantial level of independence (working without paid supports 50% or more of the time unless higher levels of support are required by a protective services order, or there are health & safety issues not specific to the work situation which justify higher levels of on-going support).

Retention occurs with no unplanned gaps in employment, and support for job change and advancement is possible.

5. CONSUMER CONFIRMS HIS/HER EMPLOYMENT OUTCOME MET

The person indicates that his/her employment outcome has been met and she/he is satisfied with the supports and services being provided.

APPENDIX B:

Managed Care and Employment Task Force
Issue Committee #6: Measuring Outcomes and Quality
Discussion paper on employment as a Personal Experience Outcome

Background:

Wisconsin's Long Term Care System uses Personal Experience Outcomes, or PEOs, to "provide a framework for learning about and understanding the individual's needs, values, preferences and priorities in the assessment and care planning process and in monitoring the quality of...long-term care programs." Until late in 2006, the Family Care and Partnership programs utilized a set of 14 Personal Experience Outcomes, which included a distinct outcome related to employment: "People achieve their employment objectives." This set of 14 outcomes was developed by a working group of participants, providers, and waiver program staff during the planning that led to the creation of Family Care. Subsequent to this, a Quality Management Cross-Unit Team subgroup worked with the Quality Close to Home Project, refining and ultimately reducing the list of outcomes to 12. This was the result of the following specific changes:

1. "People are satisfied with their services" was eliminated.
2. "People have personal dignity and respect" and "People are treated fairly" was combined into one outcome: "I am respected and treated fairly."
3. "People achieve their employment objectives" was replaced with "I do things that are important to me." The definition of this PEO states:

"My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose."

The PEONIES system, which is an interviewing process designed to assist care managers in the identification of an individual's personal outcomes, uses the PEOs as a framework. The PEONIES system is currently being developed and field tested. PEONIES will also be used as a quality assurance tool, to track how many Family Care members have outcomes under each of the PEO outcome areas, and how many report having achieved those outcomes or being supported by the managed care organization to pursue those outcomes.

The issue committee spent a significant amount of time discussing the implications of maintaining the current list of Personal Experience Outcomes (PEOs) and the implications of restoring a distinct employment PEO. The two approaches are summarized below. Both positions are based on the principle that members should not be required to adopt any outcome that does not reflect their personal preferences.

Restore a distinct employment outcome to the list of Personal Experience Outcomes:

There are a number of long-standing challenges to achieving strong employment outcomes for people with disabilities, including: (1) a long history of low expectations of people with disabilities; (2) misperceptions that employment triggers a loss of health care and other benefits; and (3) a historical lack of availability (or investment in) long-term care services to support employment, particularly integrated employment.

To ensure that Family Care members have sufficient opportunity to consider the range of employment options that are available, and to subsequently identify any personal outcomes in relation to employment, employment should be given strong visibility and attention in the care planning process, without imposing an obligation or expectation to work on members. Restoring employment as a distinct Personal Experience Outcome area will help ensure that employment is recognized as an outcome that is valued equally with the 12 existing Personal Experience Outcomes.

Restoring employment as a distinct Personal Experience Outcome area would not impose an obligation to work on members, particularly if the language for the PEO is chosen carefully. The presence of an outcome area does not require that an individual identify an outcome within that area. When a care manager raises options regarding outcomes an individual might want to consider, this should be valued as an important step toward ensuring informed choice. Care managers have the skill to present options in ways that do not impose a value judgment if an individual declines to express an outcome in a particular area.

Restoring employment as a distinct PEO also provides the opportunity to inform individuals who may have very limited life experiences, particularly in relation to employment, to be informed about the possibilities as part of making choices about the personal outcomes they wish to pursue.

PEONIES staff have developed an interview protocol to raise the topic of employment under the “I do things that are important to me” outcome, if an individual does not spontaneously raise employment in the interview. This protocol is designed to avoid imposing the Department’s values and policy objectives into an individual’s own planning process. This same protocol, or techniques based on this protocol, could be used if a separate employment PEO was established, thereby preventing the problem of imposing a certain set of values or expectations through the introduction of the topic of employment.

The list of Personal Experience Outcomes is used to guide the member-centered planning approach used by managed care organizations. Restoring employment as a distinct PEO outcome ensures that client employment interests and goals will be discussed, even if a tool other than PEONIES is used in the future. Restoring a distinct employment Personal Experience Outcome area helps ensure that employment is given full consideration.

Maintain the Current List of Personal Experience Outcomes:

The current list of 12 PEOs reflects the work of the Quality Close to Home Project and the Quality Management Cross-Unit Team sub-group. The removal of the employment-specific outcome, “People achieve their employment objectives” was done as a means to better reflect Family Care members’ right to choose their outcomes based upon their own personal values. Having employment as a specific Personal Experience Outcome area was thought to impose the value and expectation of employment upon Family Care members.

The PEO process is the part of the Family Care assessment and planning process which enables members to express in an uninhibited manner their “hopes and dreams”. It was noted that it is already a challenge for care managers to guide members through this process without imposing their own values and views with regard to what is socially acceptable. Certain members, particularly elders, may not have employment goals. If elders (and other members who choose not to work) are asked about employment, they may feel that they are being pressured into valuing something that is not a part of their interests and aspirations.

The elimination of a PEO distinctly focused on employment does not mean that employment has been eliminated from consideration. Instead of having employment stand out as a distinct outcome area, the Quality Management Cross-Unit Team incorporated employment into a new outcome: “I do things that are important to me.”

The fact that employment is the first activity mentioned in this PEO’s definition gives it a level of importance within this broader outcome, without implying that those who choose not to work are rejecting a value established by the Family Care system. Care managers who are working with members to develop individual plans use this definition to guide the conversation about things that are important to members. Through this PEO, members have the opportunity to indicate whether employment is part of their hopes and dreams. They also have the opportunity to express that other things are important to them without feeling devalued for not wanting to work.

The PEONIES approach goes a step further in ensuring the members are given the opportunity to express their employment goals. The PEONIES interview process will raise employment under the “I do things that are important to me” outcome, if an individual does not spontaneously raise employment in the interview.

The PEONIES system is also developing a separate measurement area (as a sub-set of the data tracked in relation to the “I do things that are important to me” Personal Experience Outcome) that will specifically track employment outcomes. This will allow Family Care to effectively track employment without it being restored to a distinct outcome.

Appendix C:

Member Outcomes in Managed Care: Twelve Personal Experience Outcomes

What's So Special About Personal Experience Outcomes?

There are many ways of defining things that appear similar to the Personal Experience Outcomes. The Personal Experience Outcomes are different because each person defines their own outcomes. For example, the best possible health can mean being pain free, not being depressed, being able to walk a mile everyday, getting good dental care, or many other things. What is important is what each outcome means to the person. Other ways of measuring outcomes assume that the goals are the same for everyone. The Personal Experience Outcomes emphasize that they are not.

Personal-Experience Outcomes for Long Term Care

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of our long-term care system. The following statements and definitions demonstrate the areas of life that people in long-term care programs have identified as being important to their quality of life. They are stated in the first person to emphasize the importance of the personal voice and experience of the individual. These statements provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs.

CHOICE

When people participate in human service systems, they often feel a loss of control over their lives as professionals or others in authority get involved. In our long-term care system we strive to empower the individuals who receive services (participants, members, or consumers) to have choices—to have a "voice" or say about things that affect their quality of life and to make decisions as they are able. People with cognitive disabilities are supported to actively participate in the ways they are able, and their decision-makers (guardians or POA) keep their perspectives in mind for making decisions. The following statements reflect some of the ways in which the system can help support people to maintain control over their lives.

I decide where and with whom I live.

One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.

I make decisions regarding my supports and services.

Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.

I decide how I spend my day.

Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible.

PERSONAL EXPERIENCE

A person's day-to-day experience should meet his or her expectations of a high quality life. People who participate in a long-term care programs need to feel they are 'citizens', not parts of a 'program' and that they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take them over or get in the way of the experience.

I have relationships with family and friends I care about.

People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.

I do things that are important to me.

My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.

I am involved in my community.

Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.

My life is stable.

My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me (paid and unpaid) is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I think I am reasonably well prepared.

I am respected and treated fairly.

I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.

I have privacy.

Privacy means that I have time and space to be by myself or with others I choose. I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me a sense of dignity.

HEALTH AND SAFETY

Health and safety is an essential and critical part of life that can affect many other areas of a person's life. The following outcome statements represent the person's right to determine what is important to him or her in these areas, and what risks he or she is comfortable with. It's about what the person feels he or she needs to meet personal priorities. It is **not** an assessment of whether or not the person's circumstances meet others' standards for good health, risk, or safety.

I have the best possible health.

I am comfortable with (or accepting of) my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to me to make informed decisions about my health.

I feel safe.

I feel comfortable with the level of safety and security that I experience where I live, work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, I have access to those that can support me in making those determinations.

I am free from abuse and neglect.

I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.

Appendix D:

From Issue Committee #1 Report

Recommendation 1.26 A distinct personal experience outcome focused on employment should be restored for the purposes of member-centered planning and the personal outcomes identification which is an integral part of this planning.

Discussion/Rationale: The personal experience outcome areas are used to guide the member-centered planning process at MCO's. At present, managed care has twelve specific personal experience outcome areas. Some members might have more than one desired outcome in a particular area while others may have no desired outcomes in that area. Consistent with a commitment to individual choice, the presence of a particular outcome area does not lead to a requirement that a member have an identified outcome in that area. However, the presence of an individual outcome area does ensure that the area will be discussed as part of the outcomes identification interview. At this time, employment is not a specific outcome in the list of personal experience outcomes being used in managed care. It appears the change was made in late 2006. Employment is now one example of an outcome that would fall under the "I do things that are important to me" personal experience outcome area. Prior to this, employment was addressed as a distinct outcome area in an earlier list of personal experience outcomes adopted by the Department for managed care and the Community Options Program (COP), "People achieve their employment objectives" was the identified outcome that addressed employment. As well, in the Community Integration program (CIP), "I am working as much as I want in a job that I like" was the identified outcome that specifically addressed employment.

As mentioned earlier in this paper, the committee agreed that employment should be given equal consideration with all other outcome areas, and in order to ensure this, employment needs to be recognized as one of the core outcome areas, along with health, living arrangement, etc. The committee agreed that helping people identify and achieve employment outcomes should have the same value and status as helping people achieve the other outcomes identified in the current list of twelve personal experience outcomes. One of the greatest challenges to enabling more individuals to access the opportunity to work is that employment is often overlooked or dismissed as impossible, impractical or ill-advised during the planning process. Eliminating employment as a distinct personal experience outcome area to be addressed in planning is only likely to reinforce the status quo. The committee agreed that there is a need to lift up the importance of employment so that employment is given equal value, treatment and consideration. A move to eliminating employment as a distinct outcome area seems to go against what is needed most.

Appendix E: The Evolution from COP RESPECT Values to Family Care Personal Experience Outcomes

All the Family Care programs (Family Care, Family Care – Plus, and Family Care – Partnership) are built upon the values of the predecessor programs – the Community Options Program and the Home and Community Based Waiver programs, including COP-W, CIP IA/IB, and CIP II. The Community Options Program was enacted in 1981 to provide the assistance an individual needs in order to continue to live in his or her own home, in his or her own community, at a cost which averages no more than that of nursing home care. Inherent in this purpose were certain values about how people with long-term care needs should be served. These values were articulated as guiding principles that were incorporated into the acronym RESPECT. These RESPECT values were the basic grounding for care managers in the COP program. Now that COP and the home and community based waivers are transitioning to the Family Care managed care programs, those same care managers may be wondering how to make that change while still adhering to the RESPECT values.

Stakeholders who came together to discuss how to make COP and the waiver programs even better began talking about consumers’ personal experience outcomes – the real life results people want from their long-term care and supports. These stakeholders’ approach was that individual consumers should define what quality-of-life outcomes they want to achieve. These outcomes stated in the first person to emphasize the importance of the personal voice and experience of the individual. They provide a framework for learning about and understanding of the individual’s needs, values, preferences, and priorities in the assessment and care planning process. They are consistent with the RESPECT values statements and provide an important advance – we can actually measure whether the long-term care system is being effective in helping people achieve their own, individual outcomes.

A project funded by the Wisconsin Department of Health and Family Services is developing a way of measuring and using Personal Experience Outcomes for people receiving long-term care services. The measurement will be done by interviewing interviewing people to learn about the outcomes they want in their lives, and whether they are being supported to achieve those outcomes. This information can be used to:

- Help care managers and consumers work together to make sure services are supporting the things that are most important to the consumer.
- Help long-term care programs (COP, CIP, Family Care, Partnership Program, other managed long-term care programs) monitor and improve quality.
- Help DHFS ensure that the programs they fund are helping people achieve the quality of life they desire.

Following is a table that cross-walks the RESPECT values with the twelve Personal Experience Outcomes. Some of the outcomes appear more than once, in order to best show relationships with the RESPECT values.

RESPECT Values	Personal Experience Outcomes
<p>Relationships. Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.</p>	<p>I have relationships with family and friends I care about. People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.</p> <p>My life is stable. My life is not disrupted by unexpected changes for which I am not prepared. The amount of turnover among the people who help me (paid and unpaid) is not too much for me. My home life is stable, and I am able to live within my means. I do not worry about changes that may occur in the future because I think I am reasonably well prepared.</p>
<p>Empowerment to make choices. Individual choice is the foundation of ethical home and community-based long term support services.</p>	<p>I decide where and with whom I live. One of the most important and personally meaningful choices I can make is deciding where and with whom to live. This decision must acknowledge and support my individual needs and preferred lifestyle. My home environment has a significant effect on how I feel about myself and my sense of comfort and security.</p> <p>I decide how I spend my day. Making choices about activities of daily life, such as sleeping, eating, bathing, and recreation enhances my sense of personal control, regardless of where I live. Within the boundaries of the other choices I have made (such as employment or living with other people), I am able to decide when and how to do these daily activities. It gives me a sense of comfort and stability knowing what to expect in my daily</p>

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	<p>routine. It is important to me that my preferences for when certain activities occur are respected and honored to the extent possible. A person's day-to-day experience would meet his or her expectations of a high quality life. People who participate in a long-term care programs need to feel they are ‘citizens’, not parts of a ‘program’ and that they are treated with respect. The focus of supports and services is to assist people in their daily lives, not to take them over or get in the way of the experience.</p>
<p>Services to meet individual need. Individuals want prompt and easy access to services that are tailored to their unique circumstances.</p>	<p>I make decisions regarding my supports and services. Services and supports are provided to assist me in my daily life. Addressing my needs and preferences in regard to who is providing the services or supports and how and when they are delivered allows me to maintain dignity and control. To the extent that I desire and am able, I am informed and involved in the decision-making process about the services and supports I receive. I am aware that I have options and can make informed choices.</p>
<p>Physical and mental health services. Intended to help people achieve their best level of health and functioning.</p>	<p>I have the best possible health. I am comfortable with (or accepting of) my current physical, mental, and emotional health situation. My health concerns are addressed to the extent I desire. I feel I have enough information available to me to make informed decisions about my health.</p> <p>I am free from abuse and neglect. I am not experiencing abuse or neglect of my person, property, or finances. I do not feel threatened or mistreated. Any past occurrences have been adequately dealt with or are being addressed.</p> <p>I feel safe. I feel comfortable with the level of safety</p>

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	<p>and security that I experience where I live, work, and in my community. I am informed and have the opportunity to judge for myself what is safe. People understand what I consider to be an acceptable level of risk and respect my decisions. If I am unable to judge risk for myself due to my level of functioning, I have access to those that can support me in making those determinations.</p>
<p>Enhancement of participant reputation. Services maintain and enhance participants' sense of self-worth and community recognition of their value in every way possible.</p>	<p>I am respected and treated fairly. I feel that those who play a continuing role in my life respect me. I am treated fairly as a person, program participant, and citizen. This is important to me because it can affect how I view myself in relation to others and my sense of self-worth.</p> <p>I have privacy. Privacy means that I have time and space to be by myself or with others I choose. I am able to communicate with others in private as needed. Personal information about me is shared to the extent that I am comfortable. Privacy allows me to be free from intrusion by others and gives me a sense of dignity. Health and safety is an essential and critical part of life that can affect many other areas of a person's life. The following outcome statements represent the person's right to determine what is important to him or her in these areas, and what risks he or she is comfortable with. It's about what the person feels he or she needs to meet personal priorities. It is not an assessment of whether or not the person's circumstances meet others' standards for good health, risk, or safety.</p>
<p>Community and family participation. Participants are supported to maintain and develop friendships to participate in their families and communities.</p>	<p>I have relationships with family and friends I care about. People for whom I feel love, friendship, and intimacy are involved in my life. These relationships allow me to share my life with others in meaningful ways and</p>

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	<p>helps affirm my identity. To the extent that I desire, people who care about me and my well-being provide on-going support and watch out for my best interests.</p> <p>I am involved in my community. Engaging in the community in ways that I enjoy provides me with a sense of belonging and connection to others. Having a presence in my community enhances my reputation as a contributing member. Being able to participate in community activities gives me opportunities for socialization and recreation.</p>
<p>Tools for independence. People are supported to achieve maximum self-sufficiency and independence.</p>	<p>I do things that are important to me. My days include activities such as employment or volunteer opportunities, education, religious activities, involvement with my friends and family, hobbies, or other personal interests. I find these activities enjoyable, rewarding, and they give me a sense of purpose.</p>

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**Appendix F:
Long-term Care Adult Outcomes Crosswalk**

“Outcomes” in this document refers to aspects of the **participant’s personally-experienced quality of life**, particularly as it is affected by long-term care services or supports. In this document, ‘outcome’ does not refer to clinical conditions or functional abilities that can be assessed by a professional, or to the presence, absence, or attributes of services or supports.

Participant choice IS included as an outcome, although it can be argued that providing choice to the participant is a ‘process’ rather than an ‘outcome.’ It is included here as an outcome based on studies that have shown that having choice in services has inherent value and benefit for participants’ experienced quality of life.

COP / FC/ WPP	CIP I	PES (Elder & PD version)	PES (DD version)	Alzheimer’s (2 nd Level)
HEALTH & SAFETY				
People have the best possible health.				I am well-hydrated. I am well-nourished.
				I am comfortable, free from pain
		I always get my medicine when I need it.	I always get my medicine when I need it.	
	Person gets regular exercise.			I am physically active.
	Weight is stable.			
				I am clean.
People are safe.	Staffing levels are adequate for safety. Medical instructions are available. Environment appears safe.			I am safe.
People are free from abuse and neglect.		The people who are paid to help me have not injured me. ...are not mean to me and do not yell at me. ... have not taken my things without asking.	No one hits me or hurts my body. ...does mean things to me such as yell at me. ...takes my things without asking me first.	I am free from all forms of abuse.

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COP / FC/ WPP	CIP I	PES (Elder & PD version)	PES (DD version)	Alzheimer's (2 nd Level)
CHOICE & ACTIVITIES				
				I participate to my capacity in all decisions affecting my life.
People choose where and with whom to live.	Person is satisfied with their living arrangement.		I helped to pick the place where I live. I chose to live alone. I like the people I live with.	
				My environment is anchored in things I value that are familiar to me.
People choose their daily routine.	Person chooses own schedule. Person is satisfied with their daily routine.		I can eat/watch television/go to bed/be by myself when I want to.	My orientation to time and reality is respected and supported. I continue my familiar routines.
				I practice rituals that comfort and calm me.
				I continue my own cultural lifestyle.
				I am able to do things independently with safe supports.
People achieve their employment objective (or engage in meaningful activities).		I am working as much as I want to work in a job that I like.	I am working as much as I want to work in a job that I like.	I am useful and make contributions of value. I engage in activities that are meaningful to me daily.
				I plan and do things I've wanted to while I still can.
				I have positive things to look forward to and to do.

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COP / FC/ WPP	CIP I	PES (Elder & PD version)	PES (DD version)	Alzheimer's (2 nd Level)
People participate in the community.	Person participates in the community. Person participates in integrated activities. Person is satisfied with their community participation.	I always get to the places I need to go, like work, shopping, the doctor's office, friend's house.	I always get to the places I need to go, like work, shopping, the doctor's office, friend's house.	I have opportunities to participate in the life of my community.
		I do everything outside my home that I want to do.	I pick where I go shopping, out to eat.	
				I have the opportunity to be outdoors.
	Person is free from isolation and restraint.			I receive the least restrictive intervention for my behavior symptoms.
				I enjoy the tastes, smells, sounds, and feelings of the real world.
				My previous wishes are honored as my capacity diminishes.
	Person participates in religious expression.			I continue practices that nourish me spiritually.
People choose their services. (COP & FC) I feel that my team involves me in decisions relating to my care to the extent that I like. (WPP)				
		I help pick the people who are paid to help me.	I help pick the people who are paid to help me.	
	Person is free from isolation and restraint.			

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COP / FC/ WPP	CIP I	PES (Elder & PD version)	PES (DD version)	Alzheimer's (2 nd Level)
RELATIONSHIPS & RESPECT				
People are connected to natural support networks.	Person participates with family members.	I can see the people I like to visit with when I want to.	I can see the people I like to visit with when I want to.	
				I am supported in maintaining relationships and given opportunities to develop new relationships as desired.
				I have the opportunity to maintain an intimate relationship w/ my spouse.
				I have the emotional support and encouragement I need.
				I am able to communicate with others to my highest capacity.
People are treated fairly.				
People have personal dignity and respect. (COP & FC) I feel that I am treated with respect. (WPP)		The people who are paid to help me treat me respectfully. ...listen carefully to what I ask them to do.	The people who are paid to help me treat me respectfully. ...listen carefully to what I ask them to do. ...say 'please' and 'thank you' when they ask me for something.	
				I am treated as a person not a disease, and am acknowledged as present.
				My sexual identity is treated with respect.

Managed Care and Employment Task Force
Issue Committee #6

COP / FC/ WPP	CIP I	PES (Elder & PD version)	PES (DD version)	Alzheimer's (2 nd Level)
People have time, space, and opportunity for privacy.			No one comes into my room when I don't want them to.	I have physical privacy.
People experience continuity and security.				I have a legally supported plan for my future needs and wishes. I have continuity in relationships with caregivers.
				I am cared for by people who understand me and about my dementia.
				I have regular opportunities to access and share my rich and meaningful past.

DHFS/DLTC Managed Care and Employment Task Force

Issue Committee #7

Wisconsin Work Incentives and Employer Supports

Final Report

March 20, 2008

1. Issue Committee Charge
 - Review current “work incentives” found in Wisconsin’s Medicaid programs
 - Recommendations for changes and enhancements to the Medicaid Purchase Plan that will support provision of employment services in managed care and support high level employment earning, saving (asset development) and retirement.
 - Review of existing, and recommendations for new or enhanced, supports for employers to intentionally hire and retain employees with disabilities.
 - Review of and recommendations for expansion and sustainability of benefits counseling in support of benefit continuity and work incentive utilization.

2. Task Force Members Serving on Issue Committee
 - Kelly Zolinski Consumer**
 - Don Becker Disability Claimant/Beneficiary Attorney**
 - Mary Neubauer Consumer**

3. Other Participants and Contributors to Issue Committee
 - Cayte Anderson, Pathways to Independence projects, SVRI**

Lisa Mills, Medicaid Infrastructure Grant Consultant, DHFS
Glenn Olsen, Division of Education and Training, DWD
Dan Johnson, Coordinator of Resources for Physical Disability, DHFS
Mary Ridgely, Medicaid Infrastructure Grant Consultant, DHFS
Amy Thomson, Pathways to Independence projects, SVRI
Susan Bohn, Pathways to Independence, UW Waisman Cntr.
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Dennis Liphart, Pathways to Independence, SVRI
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Terrie Lannan, Pathways to Independence, SVRI
Tammie Liddicoat Exec. Dir., ERI and WDBN
Jeff Ulanski DHFS/DHCF
Joe Entwisle Health and Disability Advocates

Guest Contributors:

Dan O'Brien, Social Security Administration

4. Issue Committee Meetings

August 27, 2007

October 11, 2007

November 19, 2007 [Joint meeting with Issue Committee #4]

January 22, 2008

5. Summary of Issue Committee Process

Kelly Zolinski agreed to chair the Issue Committee meetings. Pathways staff collected background materials that were sent out electronically, generally a week in advance of the meetings. Meeting agendas were developed by Issue Committee staff (John Reiser), in consultation with Task Force members. All meetings were held in 1 West Wilson Street SOB, with telephone access for members not in attendance. Meeting discussion summaries were developed to reflect the presentations made and subsequent discussions. Draft recommendations were developed prior to each meeting concluding. Content Experts participated fully, including suggesting recommendations. Final drafts of all recommendations was only sent to MCETF Issue Committee members for approval.

6. Recommendations

Introduction

Family Care program values effectiveness, efficiency and cost reductions, in an employment context, may accrue from a variety of care management activities and strategies:

- Integration of employment services into managed long-term care planning promises achievement of additional member identified outcomes (effectiveness),

less time coordinating services and increased funding for vocational needs (efficiency).

- Employer sponsored health care is among the most highly valued benefits of employment. Increased and substantial employment as a Family Care outcome holds promise for Medicaid cost reductions.
- There is empirical support for a connection between employment and better health, as a result of health care access or intrinsic to the activity of working. Either way this also holds promise for lower public expenses for working participants in Family Care.

The following set of recommendations were developed to enhance the effectiveness of managed care planning for members with employment outcomes; for their potential to lead to efficiency and additional funding across systems (workforce, public instruction and long term care); and for their potential to lower public expenditures.

(Note: Recommendations 7.1 through 7.5 are not within the jurisdiction of the Division of Long Term Care.)

Recommendation 7.1 Raise the income limits for participants in the Medicaid Purchase Plan (MAPP).

Discussion and Rationale: In Wisconsin, SSI beneficiaries are automatically entitled to Medicaid. The SSI program contains a “work incentive” termed “1619(b)” that allows continued Medicaid coverage after the SSI cash benefit has been reduced to zero by employment earnings. The annual SSI 1619(b) upper limit on earnings is \$32,991, and recipients can earn even more by establishing an “individualized threshold”. Wisconsin had 2284 employed SSI recipients in 1619(b) status in 2006.

Although 1619(B) recipients may be earning relatively high salaries but are unable to save more than the standard \$2000 Medicaid asset limit. These consumers have expressed their desire to transition to the Medicaid Purchase Plan (MAPP) in order to save more, but their earnings are above the annual MAPP eligibility limit of roughly \$51,000 (as indexed for 2008). Raising the income cap on MAPP would allow transition from SSI 1619(b) to MAPP for the highest earners. These new MAPP participants would begin paying a premium for health care coverage that is now free under SSI

Lifting the cap on earnings would not increase the state’s Medicaid population, or decrease the number of participants leaving Medicaid due to earnings. (Federal participation in MAPP would end for every enrollee earning over 450 % of the federal poverty level.)

Recommendation 7.2: The MAPP premium formula should be changed to eliminate the impact on the monthly premium amount related to a participant’s monthly disability/retirement cash benefit payment.

Discussion and Rationale: The MAPP premium formula has a feature that makes the monthly premium very sensitive to the amount of a participant's monthly disability or retirement cash benefit, which is assessed as "unearned income". The higher the monthly disability/retirement cash benefit, generally the higher the premium; the lower the cash benefit, generally the lower the premium. The premium formula has created substantial inequities, e.g. two people with equal income may have wildly different monthly MAPP premiums based on their different mix of "earned" and "unearned" income.

The premium formula was instituted, in part, to motivate higher employment earnings and reduced reliance on public cash benefits among MAPP participants with Social Security Disability Insurance (SSDI) entitlement, a group that makes up over 80% of the approximately 12,000 participants. However the SSDI cash benefit cannot be reduced gradually as earnings rise-it automatically is reduced to zero when substantial earnings are reached in a month, resulting in a "cash cliff". The premium formula does not provide the intended incentive for MAPP participants to increase their earnings. In fact, it may inhibit increasing earnings as it results in a higher MAPP premium.

Recommendation 7.3: Create a means for people participating in MAPP to retain their accumulated employment-based assets at retirement. Create a MAPP "vesting" feature that encourages work participation with post-enrollment earnings at or above the Social Security "substantial" level (\$940 per month in 2008). MAPP vested beneficiaries would retain their assets and withdrawals would be considered "earned income" for premium purposes. A period of MAPP participation of 24 months or longer (not necessarily consecutive) at a substantial level should be the minimum requirement for vesting.

Discussion and Rationale: MAPP was created as a means for Medicaid dependent people to accumulate assets and become economically self-sufficient through employment, and presumably be able to share in the long-term goal of most employed people, retirement. MAPP participants are permitted to retain eligibility for health coverage regardless of the amount of their post enrollment assets deposited in their "Independence Account". This feature was created to permit long-term savings for retirement. However, when participants retire, they no longer meet the program's work requirement and must "spend down" the accumulated assets to as little as \$2,000 in order to be eligible for a different Medicaid program. Even if minimal employment is maintained to meet the basic work requirement of MAPP, withdrawals from retirement savings are considered unearned income and dramatically increase the monthly premium, as discussed above.

It is reasonable to assume a vesting feature would not have a substantial impact on Medicaid participation either by inducing people to enter MAPP who otherwise would not have, or decreasing the number of people leaving MAPP due to high earnings, which is presently nil.

Recommendation 7.4: Eliminate the “marriage penalty” for MAPP participants. A spouse's income should not be considered in determining eligibility.

Discussion and Rationale: MAPP provides single coverage yet considers the combined assets and income of a married couple for eligibility. This is widely viewed as a disincentive to work, earnings and marriage. Note: there is Wisconsin legislation pending that would eliminate inclusion of spousal income for Medicaid eligibility.

Recommendation 7.5: Under the authority of the Deficit Reduction Act create an array of integrated employment services for MAPP participants that may be funded through Medicaid. The clearest example is work incentive benefits counseling.

Discussion and Rationale: Other than a limited set of service categories, there is little fundable under Medicaid that supports community, integrated employment at or above minimum wage.

Recommendation 7.6: Conduct public outreach to people not working or enrolled but likely to benefit from MAPP participation and employment, and to MAPP participants to ensure their understanding of MAPP and other work incentive programs.

Discussion and Rationale: In a 2007 survey of a sample of MAPP participants, 30% did not realize they were enrolled in the program; 17 % reported not having ever learned anything about MAPP; only 3% learned about MAPP via state VR or their employer; and just under 50% reported having been provided little or nothing in the way of information about employment and work income.

Recommendation 7.7: The *Pathways to Independence* Medicaid Infrastructure Grant team should be technically, and possibly financially, supporting pilots that, under the new (Social Security) *Ticket to Work and Self Sufficiency* program, combine Care Management Organizations (CMO), their Provider Networks, and possibly other partners (state VR, DPI) as “Employment Networks” and thus eligible for federal outcome payments subsequent to member employment.

Discussion and Rationale: The new “Ticket” regulations are scheduled for release in April 2008. The revised regulations encourage non-traditional vocational providers to partner with traditional elements of the vocational system to help Social Security beneficiaries return to work or increase their employment. Social Security will make incentive payments for relatively modest increases in consumer employment, and substantial incentive payments for substantial employment increases. This represents a possible source of income for CMO employment services and supports that are not covered through the capitation. These payments could prove useful for staff training, as additional incentives to service providers, or to consumers themselves for purposes of sustaining employment such as uniforms, shoes, transportation to work etc.

Recommendation 7.8: The Wisconsin Disability Benefits Network (WDBN), currently in the initial year of a four year agreement with DHFS, should be instructed to carry out

statewide outreach to inform stakeholder of the availability and value of work incentive benefits counseling.

Discussion and Rationale: A study conducted in Vermont reports to have demonstrated a connection between benefits counseling and employment earnings. Outside of Wisconsin, no state has the number of work incentive counseling resources available at no cost to the consumer. Yet there appears to be limited awareness of what is available and how to access the service. The DHFS administers an annual grant to the WDBN to train practitioners in benefits counseling (DBS and Work Incentive counselors) as well as to provide training on benefits issues statewide to consumer groups. The WDBN, under the grant agreement in force, should convene an expert panel to develop more effective means of conducting outreach leading to greater awareness and use of work incentive benefits counseling.

Recommendation 7.9: When the DHFS send consumers notification of eligibility for the Medicaid Purchase Plan, new participants should be encouraged to seek work incentive benefits counseling, with information provided that directs them to the nearest counseling resource.

Discussion and Rationale: same as Recommendation 7.8

Recommendation 7.10: The DHFS will purchase work incentive benefits counseling services only from credentialed practitioners (when available) and will seek similar support from the Departments of Workforce Development and Public Instruction.

Discussion and Rationale: The WDBN, the National Rehabilitation Association and the National Association of Benefits Specialists are collaborating in Wisconsin to develop a credentialing process to ensure high quality, ethical and comprehensive work incentive counseling to state residents. When this system is in place, and assuming it is judged as effective, the profession and practice of work incentive counseling can be best supported with public resources by specifying credentialed practitioners in contracts and grants when benefits counseling services are funded.

Recommendation 7.11: In order to increase the pool of Wisconsin employers open to hiring qualified applicants with disabilities to fill existing or customized positions, the Department should join with relevant state-level partners, including its state partner with primary responsibility for employment, to collaborate on expanding and raising awareness of existing efforts, or where necessary developing new efforts, to:

- Educate employers about the benefits of hiring people with disabilities and the significant untapped labor pool which is represented by people with disabilities in our state. As part of these efforts, specifically : (1) engage Chambers of Commerce to ensure their member benefit includes this education; and (2) offer this education through Society of Human Resource Managers (SHRM) chapters. Consideration should also be given to possibility of undertaking a statewide marketing initiative aimed at raising business/employer awareness of people with disabilities as a significant, untapped labor pool and how employing people with disabilities can help

businesses capture greater market share. If such a marketing initiative is deemed a worthwhile effort, MIG resources should be made available to support the marketing initiative.

- Support an initiative to encourage business leaders/owners and other employers to develop and deliver their own message about the value of employing people with disabilities;
- Explore and encourage governmental units to pursue intentional hiring initiatives;
- Engage with the state's union organizations to encourage and assist them to adopt policies that allow individuals with disabilities to join them as co-workers in businesses that are currently unionized;
- **And most critically, provide interested employers with a single point of contact which they can turn to for responsive customized assistance when they need or want to seek qualified applicants with disabilities. As part of these efforts, consider whether and how business liaisons might be created and sustained to offer customized assistance, which should ideally include: (1) someone coordinating and communicating to employers the details of what and who is available from each of the different agencies and resources; (2) someone assisting the employer to recruit candidates (consumers) as well as to support candidates (consumers) once employed (e.g. setting up a job coach to assist with orientation to the workplace, training, etc.).**

Discussion and Rationale: Increasing the pool of Wisconsin employers open to hiring qualified applicants with disabilities to fill existing or customized positions is a critical goal that needs to be achieved as part of an overall strategy to increase integrated employment outcomes for individuals in managed long-term care. The five specific strategies summarized in this recommendation are considered to be the most promising strategies for achieving this goal. As the state agency most responsible for the welfare of individuals with disabilities who need long-term care, DHFS should join with DWD – the state agency with primary responsibility for employment - in a coordinated, collaborative effort to implement these strategies and where possible, build on existing efforts that DHFS or its key partners may already be engaged in. Key partners include DVR; the One-Stop System; the school system; GROW Wisconsin; the Council on Workforce Investment; Wisconsin Manufacturers and Commerce; and Wisconsin's Chambers of Commerce Association. These state-level efforts should help encourage and support similar implementation of these strategies on the local level, which will also be critical for success.

Recommendation 7.12: The Department should engage with relevant state-level partners, including the Department of Revenue and Workforce Development, to consider how the State of Wisconsin could offer a work opportunity tax credit, modeled after the federal tax credit, but offering tiered credit amounts to encourage the hiring of individuals with more substantial disabilities. Higher credits should be available to employers who hire people with more significant levels of disability (e.g. category one under Division of Vocational Rehabilitation guidelines). The amount of the credit could also be tied to the hours offered to a new hire with a disability, where the larger number the hours employed, the larger the credit an employer is eligible for.

Discussion and Rationale: The federal Work Opportunity Tax Credit is an important incentive that encourages employers to hire individuals with disabilities; however, this tax credit does not create specific incentives for employers to hire individuals with the most significant disabilities who are those typically served by Wisconsin's long-term care system. A state tax credit could create an additional incentive for employers to employ individuals with the most significant disabilities. The possibility of building on the existing Enterprise Zone tax credit should be explored.

Recommendation 7.13: Wisconsin employers should be publicly recognized for their commitment to hiring individuals with more significant disabilities, and should benefit from the increased consumer patronage that is likely to result from this commitment. The Department should engage with relevant state-level partners to consider how meaningful awards (perhaps presented by the governor) could be given on annual basis.

Discussion and Rationale: While there are existing programs that honor employers for hiring individuals with disabilities, there is a need to give special recognition to employers who adopt intentional hiring initiatives and employers who hire individuals with the most significant disabilities. Raising the profile of all awards like this for employers will also contribute to greater employer awareness of the benefits of hiring individuals with disabilities.

Recommendation 7.14: Require Work Source Wisconsin, a DHFS Division of Long Term Care funded initiative, to offer Continuing Education Units (CEU) or their equivalents (e.g. CLEU or Continuing Legal Education Units) at all public training sessions.

Discussion and Rationale: Work Source, as the employer-to-employer technical assistance center it's designed to be, has a substantial role to play in drawing in professionals to its training courses. A primary means of accomplishing this for other similar programs is to offer the required continuing educational units of their target audiences. This strategy would be a logical extension of an existing WorkSource feature that provides CEUs to Human Resource professionals.

7. Recommendations Falling Outside of Issue Committee Charge

None identified. Several fall outside the jurisdiction of the Division of Long Term Care, as noted earlier.

8. Appendices

Appendix A. Meeting agendas

Appendix B. Minutes for each meeting;

Appendix C. Key background materials supplied to the Committee