State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

22 E. MIFFLIN ST., STE. 500
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

December 12, 2002

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

Dear Senator George and Representative Leibham:

In its authorization of the Family Care pilot program in 1999 Wisconsin Act 9, the Legislature also directed the Legislative Audit Bureau to contract with an organization other than an agency of the State to evaluate the pilot program. Under the terms of a contract with the Audit Bureau, The Lewin Group, Inc., has completed its third report on implementation of the Family Care pilot program. The first two implementation reports were released in November 2000 and November 2001. In early 2003, The Lewin Group will also provide a report on the program's outcomes and cost-effectiveness. A final implementation report is expected in June 2003.
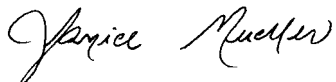
Family Care is operating as a pilot program, under the terms of federal waivers, in nine counties. Jackson, Kenosha, Marathon, and Trempealeau counties operate Resource Centers, which provide information and assistance concerning services and program operations to both consumers and providers of long-term care services. Fond du Lac, La Crosse, Milwaukee, Portage, and Richland counties operate both Resource Centers and Care Management Organizations (CMOs), which coordinate care and manage capitated payments for those determined eligible for the Family Care benefit. Eligibility is limited to the elderly and adults with physical and developmental disabilities whose financial and functional status meet established criteria.

This third implementation report notes the progress made in implementing the Family Care model in the pilot counties, as well as issues the State and the counties will need to address as program expansion is considered. For example, to ensure unbiased information is available to consumers making decisions about long-term care services and to comply with federal requirements, a Family Care enrollment consultation function was established in 2002 in each of the five counties operating CMOs. The number of inquiries to Resource Centers continues to exceed goals established by contract, and CMOs have worked to expand the availability of service providers to better meet their members' needs. Finally, waiting lists for home and community-based waiver services have been eliminated in each of the five counties operating CMOs. Total program enrollment has increased from 5,485 in March 2002 to 6,302 by July 2002, with over 97 percent of these enrollees eligible for Medical Assistance.

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We appreciate the cooperation and courtesy of the Department of Health and Family Services
and the many county staff, citizen members of local long-term care councils, and provider
representatives who have worked with The Lewin Group throughout the evaluation process. This
third implementation report is available on our Web site at www.legis.state.wi.us/lab, or it can be
obtained by contacting our office at (608) 266-2818.

Sincerely,

Janice Mueller
State Auditor

JM/KW/bm

Enclosure

FAMILY CARE PILOT PROGRAM

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

The legislation authorizing Family Care required an independent evaluation of the program to be administered by the Legislative Audit Bureau. In 1999, the Lewin Group was awarded a contract for this evaluation. The Lewin Group has submitted its third report on program implementation, and we have summarized its findings. A report from the Lewin Group on the program's early outcomes and cost-effectiveness is expected in early 2003.

Infrastructure Development

The Lewin Group report notes that enrollment in the Family Care program increased from 2,875 in March 2001 to 5,485 in March 2002, or by 90.8 percent, and is expected to increase throughout 2002 in all five counties with a CMO. Lewin reports that staffing levels in the pilot counties also increased, from 344.9 full-time equivalent (FTE) positions in March 2001 to 425.3 FTE positions in March 2002, or by 23.3 percent. Additional staff include CMO case management and fiscal staff, and Resource Center information and assistance (I & A) workers.

Information technology systems continue to evolve to support Resource Center and CMO functions at the county level. Lewin's November 2001 implementation report detailed the approach taken by each county to meet its information technology system needs. In this report, Lewin describes counties' progress with building information technology systems, noting variations among the counties. For example, La Crosse County is in the planning stages of automating claims processing; Portage and Fond du Lac counties are planning to integrate case notes, prior authorization, and some billing and claims processing; and Richland County has plans to integrate its systems within the next two years.

At the state level, the Department introduced a Web-based system for completing functional eligibility assessments in October 2001. Although this system creates the potential for improved coordination among Resource Center, Care Management Organization, and other staff involved in the pilot program, Lewin reports that confidentiality concerns among the counties have limited the degree of information sharing.

Governance

Implementation of an enrollment consultant function marks a significant infrastructure change that is intended to address governance concerns. The consultant is to provide unbiased

information to participants about their long-term care choices. In January 2002, the Department contracted with the Southeastern Wisconsin Area Agency on Aging to provide 3.0 FTE staff to implement the consultant function in the five CMO counties. The Department reports that funding for these positions was reallocated from the Resource Center budgets. Each county has developed a unique way to incorporate the consultant into the enrollment process. Lewin indicates that it is too early to comment on the effectiveness of the consultant on Family Care, but notes some preliminary concerns. For example, some county staff reported that participants were confused by the number of individuals temporarily involved in their care before a long-term care manager was assigned. There is also a concern that different processes in each county will be difficult to manage if Family Care is expanded statewide in the future.

Lewin also notes some concern with whether the annual recertification of participants' functional and financial eligibility by the CMOs creates incentives for the CMOs to retain only low-cost participants. The Department notes that CMOs are required to monitor the results of the recertification process, thereby guarding against manipulation of the system, and that its own staff reviews automated reports that identify questionable recertification results.

Finally, Lewin reports a number of concerns related to the role of participants in Family Care governance. For example, some advocates are concerned that the statutory definition of consumer representation used to appoint individuals to local long-term care councils and to the state long-term care council is overly broad and does not ensure effective representation of participants' interests. Lewin reported in November 2001 that the counties had met their contractual obligations to include participants on Resource Center and CMO governing boards and notes in this report that the Department has received $32,000 from a federal grant to improve, through the use of training materials, the capacity of program participants to serve on these local boards.

Access to Services

Lewin reports that the transition from the Community Options Program (COP) and other community-based services to Family Care has been completed. Further, waiting lists for program services have been eliminated.

Excluding Milwaukee County, where Family Care is limited to the elderly, 46 percent of CMO enrollees as of March 2002 were elderly, 34 percent were developmentally disabled, and 20 percent were physically disabled. Including Milwaukee County, 74 percent of CMO enrollees were elderly. Family Care is not limited to Medicaid-eligible individuals; rather, it is to be available as an entitlement to individuals who are functionally and financially eligible once the CMO has been operational for two years in their county of residence. In practice, however, 97 percent of enrollees are Medicaid-eligible. Lewin notes that between October 2001 and August 2002, Family Care was not available to non-Medicaid-eligible individuals in Fond du Lac, La Crosse, Portage, and Milwaukee counties because available funding was limited. In August 2002, the Department reinstated the ability of Family Care counties to enroll certain non-Medicaid-eligible individuals.

Choice is an important principle of Family Care, and participants reside primarily in the community; only 5 percent of Family Care participants reside in nursing homes. Since the start of 2001, 123 Family Care participants have been relocated from nursing homes to alternative

community settings. Lewin also reports that 348 individuals enrolled on June 30, 2001, had disenrolled by June 30, 2002, and that two-thirds of these disenrollments were the result of deaths. At a later date, Lewin hopes to quantify the number of individuals who disenroll while residing in nursing homes. Nursing home providers have reported that some individuals have been disenrolled from Family Care when it has been their preference to reside in a nursing home.

Contracts between the Department and the nine Resource Centers contain goals for contact with the three target populations. While most goals have been exceeded and reported contacts continue to increase, two of the nine pilot counties - Kenosha and Marathon - did not meet the contact goals for the developmentally disabled population.

Care Management, Consumer Direction, and Quality

Care management in Family Care involves forming and operating multi-disciplinary care management teams, honoring participant preferences for care, ensuring advocacy for participants' preferences, ensuring high-quality services, and monitoring caseloads. Lewin reports that the counties are continuing to adapt to the managed care model and that a private foundation grant of $98,600, matched by Medicaid funds, has enabled the development of an orientation manual to assist county staff in these new tasks. Since the 2001 report, participants have been added as members of each care planning team; a social worker and a registered nurse are also required members of the team.

Lewin reports that caseloads for social workers and registered nurses varied across the counties. For social workers, caseloads ranged from 30 to 50 for elderly or physically disabled participants and from 30 to 45 for developmentally disabled participants. Lewin reports that caseloads for registered nurses remain high; in May 2002, they ranged from 55 in Richland County to 120 in Milwaukee County. No county met its goal for caseload size for registered nurses.

Family Care requires consideration of cost-effectiveness of service delivery, participant preferences, and quality. The Resource Allocation Decision method includes a clinical tool, developed by the Department, that balances participant preference and cost in making long-term care decisions. Lewin reports significant training in the use of this method in the past year, although some advocates reported complaints related to service reductions near the time that counties began using the method consistently. Care planning has also changed in the past year as all CMOs, with the exception of Richland County, are offering a self-directed care option. Lewin reports that the Department is working with the counties, with additional federal grant funds, to reconcile the challenges inherent in having participants manage their own care in a "managed care" program model.

Another area of change in the past year has been advocacy. Internal advocacy positions have been developed in the CMOs, but an external, independent advocate program was eliminated in October 2001. Lewin notes that elimination of the independent advocate may reduce the influence of the advocates in shaping the future of Family Care.

Participant outcome interviews are being used in each county to help improve quality of care. The Department has conducted two rounds of interviews, including 847 Family Care participants and their care managers. These outcome interviews will be continued. Lewin advises the

Department to consider adjusting the resulting reports to reflect the participants' care needs and the services they received, noting also that changes in the Department's administration of the first two rounds of surveys prevented a comparison of the results from those rounds. Lewin also notes the Department has entered a contract with an external, independent organization to monitor quality.

Cost-Effectiveness and Outcomes

Lewin reports that it will use two comparison groups in its upcoming analysis of the cost-effectiveness and outcomes of Family Care: counties that have long-term care systems similar to those of the CMO counties, and the remainder of the state. Challenges noted by Lewin in conducting the cost-effectiveness analysis include capturing all costs and quantifying benefits derived through the program. Lewin recommends to both the Legislature and the Department that costs and outcomes continue to be collected and analyzed, and it cautions that data will be reliable only if they are accurately reported by the counties and CMOs.

Lewin notes several challenges in identifying the full costs of Family Care. Costs are incurred at several levels, including participant payments, county support, state funding, and federal Medicare and Medicaid expenditures. Furthermore, capitated rates for the CMOs do not include county start-up costs, the Department's staffing costs, or Medicare and Medicaid expenditures for prescription drugs, physician or dental visits, and several other services. For nursing homes, there is no variation in rates, so a point of comparison for individual Family Care participants is not available. Benefit identification is similarly challenging, as the functional information collected for all participants is not precise.

Future Considerations

Lewin concludes that commitment, cooperation, and trust among state and county staff have been pivotal to Family Care and will be necessary if the program expands in the future. Lewin identifies several issues that will need to be addressed in the future, including how necessary technical assistance will be provided; whether economies of scale will necessitate a regional approach in less-densely populated areas; and whether there are options for partnerships with providers or other organizations to meet federal competition requirements.

Lewin also notes steps the Department has taken to implement new practices in non-Family Care counties, based on lessons learned in the pilot counties. For example, the Web-based functional screen is being used in non-Family Care counties and will make comparative, individual-level data available. The Department has also drafted a readiness assessment to use in determining the adequacy of information technology for the Family Care program.

Wisconsin Family Care Implementation Process Evaluation

Final Report III

Prepared for:

Wisconsin Legislative Audit Bureau

Prepared by:

The Lewin Group

Lisa Maria B. Alecxih
Christina Neill
Sharon Zeruld
BrieAnne Olearczyk

November 22, 2002

THE LEWIN GROUP

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PART ONE:

INTRODUCTION

I. OVERVIEW OF EVALUATION

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

Lewin Evaluation Reports
Implementation Evaluation Process Update Report I -November 2000
Implementation Evaluation Process Update Report II - August 2001
Implementation Evaluation Process Update Report III
Outcomes and Cost-Effectiveness Evaluation Report - Early 2002
Final Update Report - Spring 2003

This report serves as an update to The Lewin Group's August 2001 report. The information in this report updates the baseline fidelity measure (see *Appendix A*), a measure of program progress outlined in the previous report, with information as of May 2002. It also begins to consider the implications of continuing and/or expanding the Family Care model.

A. Phase I

The primary activity during Phase I of the evaluation was to monitor and assess the process of implementation of the Family Care Program in the five counties that are implementing both components of the Family Care model – Resource Centers (RCs) and Care Management Organizations (CMOs). The process evaluation of implementation examined program organization, service delivery, context, and other key data elements to assess the effectiveness of implementation and identify lessons that can assist in replicating the program in other parts of Wisconsin, as well as in other states. The process evaluation also will provide a contextual basis for the Outcomes and Cost-Effectiveness report.

The Lewin Group began conducting Phase I of the evaluation in February 2000. The first Implementation Process Report submitted to the Governor and the Legislature on November 1, 2000 (www.legis.state.wi.us/lab/Reports/00-0FamCaretear.htm) involved the establishment of baseline information on the major structural features of the program, as well as a preliminary assessment of procedural and structural program information. The second Implementation Process Report provided an update (www.legis.state.wi.us/lab/Reports/01-0FamilyCare.htm).
This report offers a bridge to the outcomes and cost-effectiveness evaluation phase (Phase II) as we begin to assess implications related to program outcomes while continuing to monitor program implementation. The data and information found in this report provide an update of program progress, primarily as of May 2002.

B.   Phase II

The level of program stability, as documented using the fidelity measure in this report, will inform the subsequent outcome and cost-effectiveness evaluation phase. We expect the measure to evolve as implementation matures and the pilot counties reach greater program stability. The outcome phase will assess the extent to which the program is meeting overall goals of Family Care. These goals, referenced on the Family Care web-site[1], include:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.

- Improving access to services.

- Improving quality through a focus on health and social outcomes.

- Creating a cost-effective system for the future.

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

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[1]   Available at http://www.dhfs.state.wi.us/LTCare/Generalinfo/WhatisFC.htm. Accessed November 20, 2002.

II.   METHODOLOGY

This report provides an update of the August 2001 report prepared by The Lewin Group and examines the implementation progress of Family Care from the November 2000 baseline assessment through the end of May 2002, using information collected from:

- Site visits;

- Telephone communication;

- Review of the documentation and data provided to us by DHFS and the Family Care pilot counties; and

- Provider telephone interviews.

A.   Site visits

1.   Timing and Structure

The Lewin Group conducted a one-and-a-half week site visit to Wisconsin in May 2002. During the visit, we interviewed the pilot counties currently operating both a CMO and a RC: Fond du Lac, La Crosse, Milwaukee, Portage, and Richland, as well as state-level program staff and numerous stakeholders.

In each CMO county, we met separately with a group of staff representatives from the CMO and RC for approximately two hours each. The RC and CMO groups consisted of management staff and, in some cases, direct service workers. We also interviewed a group representing each county's Local Long-Term Care Council (LLTCC) for approximately one hour. We met with two of the Southeastern WI Area Agency on Aging's enrollment consultants: one serving Milwaukee and Fond du Lac, and one serving La Crosse, Portage, and Richland. We also met with local and regional consumer advocacy organizations in La Crosse and Milwaukee, such as Great Rivers Independent Living Services, WI Centers for Independent Living, WI Coalition for Advocacy, and Legal Aid Society. We interviewed via telephone one staff member from Options for Independent Living, a regional advocacy organization serving the Fond du Lac area. Meetings with advocates were approximately one hour in length.

In addition to county level representatives, we met with State staff from the Department of Health and Family Services' (DHFS) Center for Delivery Systems Development. We also met with representatives from the following groups: State Long-Term Care Council, WI Survival Coalition, WI Coalition of Aging Groups, WI Association of Homes and Services for the Aging, and WI Health Care Association. A list of interviewees appears in *Appendix B.*

Interview protocols for CMO staff, RC staff, and LLTCC representatives were drawn from the main components of the fidelity measure (see *Appendix A*). Prior to the site visits, The Lewin Group forwarded a draft of the CMO protocol to the Legislative Audit Bureau (LAB) and DHFS for comment. Suggested changes were incorporated and also used to revise the protocols for the RC staff and the LLTCCs (copies of the protocols appear in *Appendix C*). Prior to the site visits, copies of the protocols were sent electronically to each pilot county to facilitate meeting preparation.

2. *Follow-up Telephone Calls and E-mail Communication*

Subsequent to the site visits, we conducted follow-up telephone calls with and sent e-mails to county staff to obtain additional information and to confirm information already collected, in order to report consistent and accurate data about implementation across counties.

B. Telephone Communication

The Lewin Group also monitored the development of the program through our regular calls with LAB and DHFS, and through other calls on an as-needed basis. We solicited input from a list of several legislators provided by LAB. Three offices responded with comment. We spoke with Senator Rodney Moen, Chair of the Senate Committee on Health, Utilities, Veterans and Military Affairs, and staff from the offices of both Senator Mark Meyers, Chair, Committee on Universities, Housing, and Government Operation and Representative Kitty Rhoades, Chair, Assembly Committee on Aging and Long-Term Care.

C. Documentation Review and DHFS Data

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

- DHFS Monthly Activity Reports and Quarterly Family Care Activity Reports;

- RC and CMO 2002 Contracts;

- DHFS Quality Site Visit Review Reports; and

- Pilot County Quarterly Narrative Reports.

In reviewing these documents, we assessed county procedures and plans. The information also informed our data collection around the site visit and provided a context to monitor the Family Care program evolution. Since we did not interview the Resource Center-only counties, documentation and DHFS data served as the primary source of information for these counties. We called Kenosha County to clarify information regarding staffing from their quarterly reports.

D. Provider Telephone Interviews

We interviewed sixteen providers over the telephone, in addition to meeting with provider representatives from the LLTCCs. To select the providers for telephone interviews, we used provider lists from 2001 and contact information provided by the pilot counties. We interviewed a range of providers from the following service areas: personal care, home health, homemaker services, employment, daily living skills, adult day services, and durable medical equipment and supplies. A total of 18 providers were contacted from the five CMO provider networks. Of this group, two did not respond. We interviewed four providers from both La Crosse and Fond du Lac counties, three providers from both Portage and Milwaukee, and two from Richland for a total of 16 interviews. We updated the script used for telephone interviews used last year, including additional questions about consumer choice (*Appendix D*). The majority of providers had long-standing relationships with the counties. The interviews lasted approximately one-half hour and covered issues related to target populations, communication, competition, consumer direction, prior authorization, billing, and quality assurance.

PART TWO:
PROGRAM PROGRESS—THE FIDELITY MEASURE

III.   OVERVIEW OF PROGRAM PROGRESS

We continued to monitor the progress of the Family Care model using the fidelity measure, introduced in our 2001 report. The measure provided a baseline assessment of Family Care implementation by county for each of the core domains and program components. This report provides updates as of May 2002 on each of the following same core domains: 1) System Structure; 2) Governance; 3) Outreach; 4) Service Access; 5) Care Management; 6) Consumer Direction; 7) Quality; and 8) Funding/Capitation. A detailed discussion of capitation does not appear in this report because it will be addressed in the 2003 Outcome and Cost-Effectiveness report. Please see *Appendix A* for the complete fidelity measure.

This section is organized around the core components of the fidelity measure in the following manner:

- Infrastructure development;
- Governance;
- Access to services and information; and
- Care management, consumer direction and quality.

The fidelity measure is an evolving measure of the extent to which counties and the state adhere to the central tenets of the Family Care model. The development of this measure serves the following purposes:

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

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

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

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

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

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

In collecting data for this report, we sought information at the county site visits about progress in relation to the core domains of the fidelity measure. It is important to note that the fidelity measure is a fluid model that has evolved and been refined as the program progresses. The information we collected during the county site visits, coupled with suggestions from the Department of Health and Family Services (DHFS), further informed the development of the fidelity measure. The fidelity measure serves as a metric by which the progress of a Family Care pilot program can be charted, with the expectation that fully mature programs will fall within the definitions or range for each component. Models meeting the minimum requirements for Family Care and innovative pilot programs will establish the floor and ceiling endpoints for the

range associated with each component. The completed fidelity measure will be a tool to assess each program on the eight domains and components. These assessments will then be integrated into analyses regarding the outcomes and cost-effectiveness of Family Care implementation.

The Family Care pilot counties have now achieved many of the implementation milestones established by DHFS. The **Family Care Timeline** on the following page highlights some of the markers of program progress and offers a map for reference while reading about the status of implementation across the pilot counties. Additionally, *Appendix E* contains a glossary of terms.

**Exhibit III-1
Family Care Timeline**

State Programmatic Events		County Events				
		Fond du Lac	**La Crosse**	**Milwaukee**	**Portage**	**Richland**

State Programmatic Events column (left to right on timeline):
- Startup all RCs except Richland
- DFHS contracts with WCA for independent advocacy
- DFHS suspends PAC referral req. for hospitals
- First round of member outcome Interviews
- Second round of Member Outcome Interviews
- CMS approval of b/c waiver combination
- RCs receive increase in annual budget
- Governor signs budget eliminating Independent Advocate
- State freeze of Non-MA Enrollment
- Web-base funct. screen
- DHFS capitation formula incorporates functional status
- Enrollment consultation begins
- Non – MA freeze lifted

Timeline years: 1998, 1999, 2000, March, June, Sept., 2001, March, June, Sept., 2002, March, June, Sept., 2003

Fond du Lac:
- RC Startup
- CMO startup
- Delayed enroll. begins
- CMO assumes full risk
- Transition enroll. complete*
- Waiting lists eliminated
- SDS opt. begins
- Delayed enroll. ends
- Transition enroll. complete*
- Entitlement

La Crosse:
- RC Startup
- CMO startup
- SDS option begins
- Transition enroll. complete
- Delayed enroll. begins
- Waiting lists eliminated
- Delayed enroll. ends
- Entitlement
- CMO assumes full risk
- CMO Reliance on County funds ends

Milwaukee:
- RC Startup
- CMO startup
- SDS options begin
- Waiting lists eliminated
- Transition enroll. complete
- Entitlement
- CMO assumes full risk

Portage:
- RC Startup
- CMO startup
- SDS option begins
- CMO assumes full risk
- Waiting lists eliminated
- Transition enroll. complete
- Entitlement

Richland:
- RC startup
- Delayed enroll. begins
- CMO Startup
- CMO assumes full risk
- Transition enroll. complete
- Waiting lists eliminated
- Delayed enroll. ends
- Entitlement

*Fond du Lac had the majority of transitions completed by 1/01 except for two high cost cases and previously COP-R individuals who wanted to wait as long as possible (11/02) to start paying the cost share under MA.

Note: Transition enrollment refers to enrollment of Family Care-eligible individuals previously receiving long-term care services from the county through a county or waiver program.

IV. INFRASTRUCTURE DEVELOPMENT

As the CMOs moved into a "business as usual" mode, they continued to adjust staffing and clinical and operational processes to serve greater numbers of individuals, while expanding their business expertise. In addition, the RC and CMO enrollment process incorporated the enrollment consultant position as required by the Centers for Medicare and Medicaid Services (CMS). This section provides detailed information on evolving program structures and clinical, operational, and fiscal processes of the Family Care pilots with a focus on staffing and information technology.

A. Family Care Structural Entities

The addition of the Enrollment Consultant (EC) marked the most significant change in structure since our last report. The EC, described in detail in the next section, offers enrollment counseling to consumers after they have been deemed financially and functionally eligible for the program. As an independent entity from the county, the EC provides objective information regarding a consumer's choice to enroll in Family Care, to receive fee-for-service care, or to enroll in other programs in the county, if applicable. Previously, Care Management Organizations (CMOs), Resource Centers (RCs), and Economic Support Units (ESUs) constituted the entities necessary to operate Family Care at the county level. With the addition of the ECs, Family Care pilots continued to develop into productive, four-fold units for processing and re-certifying enrollment in Family Care.

Secondly, the pilot counties and DHFS developed an understanding of ESUs as an essential part of the Family Care model. Initially, ESUs did not participate in the development of the model, even though eligibility determination must pass through this entity. We reported last year that the pilot counties all had established regular meeting times with their ESUs to work on issues surrounding the enrollment process. Challenges with the enrollment process continue to be addressed through such meetings. In La Crosse and Richland (see *Chapter IV: Governance*), the ESU even joined the CMO and RC to plan the EC procedure. Additionally, materials produced by DHFS regarding Family Care now include ESUs in the description of the Family Care model (e.g. DHFS Medicaid provider handbook).

The close proximity of entities contributed to the smooth flow of information. The ESU resides in the same building with both the RC and the CMO in La Crosse and Milwaukee. In Fond du Lac, two ESU workers reside with the CMO to handle re-certifications. In Portage and Richland, the ESU is located with the CMO only. Co-location with the RC offered an opportunity for frequent communication when the RC staff referred individuals to the ESU for financial screening. Fond du Lac CMO staff reported processing of enrollment and communication between entities has assisted in monitoring disenrollments from Client Assistance for Re-Employment and Economic Support (CARES), the system which stores all enrollment information, due to delays in re-certification. This was not expressed as an issue in La Crosse or Portage. Milwaukee CMO staff experienced the disenrollment problem, but did not see co-location as a crucial factor in resolving the problem (for further information on this disenrollment issue see *Chapter VI: Access to Services and Information*).

B. Family Care Processes

Exhibit IV-1 is an adaptation of a DHFS framework depicting the major clinical, operational, and fiscal processes and responsible entities of the Family Care model. The clinical processes include those involving direct service to consumers. Traditionally, such service delivery has been a staple of local long-term support programs. They include intake, eligibility screening, options and benefit counseling, provider resources, prevention and outreach activities, assessment, care planning, and service authorization. Pilot county staff had extensive experience in these areas prior to Family Care. Operational processes refer to those necessary to operate the CMO as a managed care organization including provider contracting, pricing, claims processing, claims history, benefit codes, and information technology (IT) development and management. Fiscal processes include budget management, coordination of benefits, accounting, reimbursement, financial reporting, and forecasting. County human service entities had less experience with managed care oriented operational and fiscal processes. One CMO director stated, "We didn't know what we didn't know." In implementing the Family Care program, pilot counties have continued to build capacity in staffing and information technology to carry out all of the processes.

Exhibit IV-1
Family Care Function and Process Model
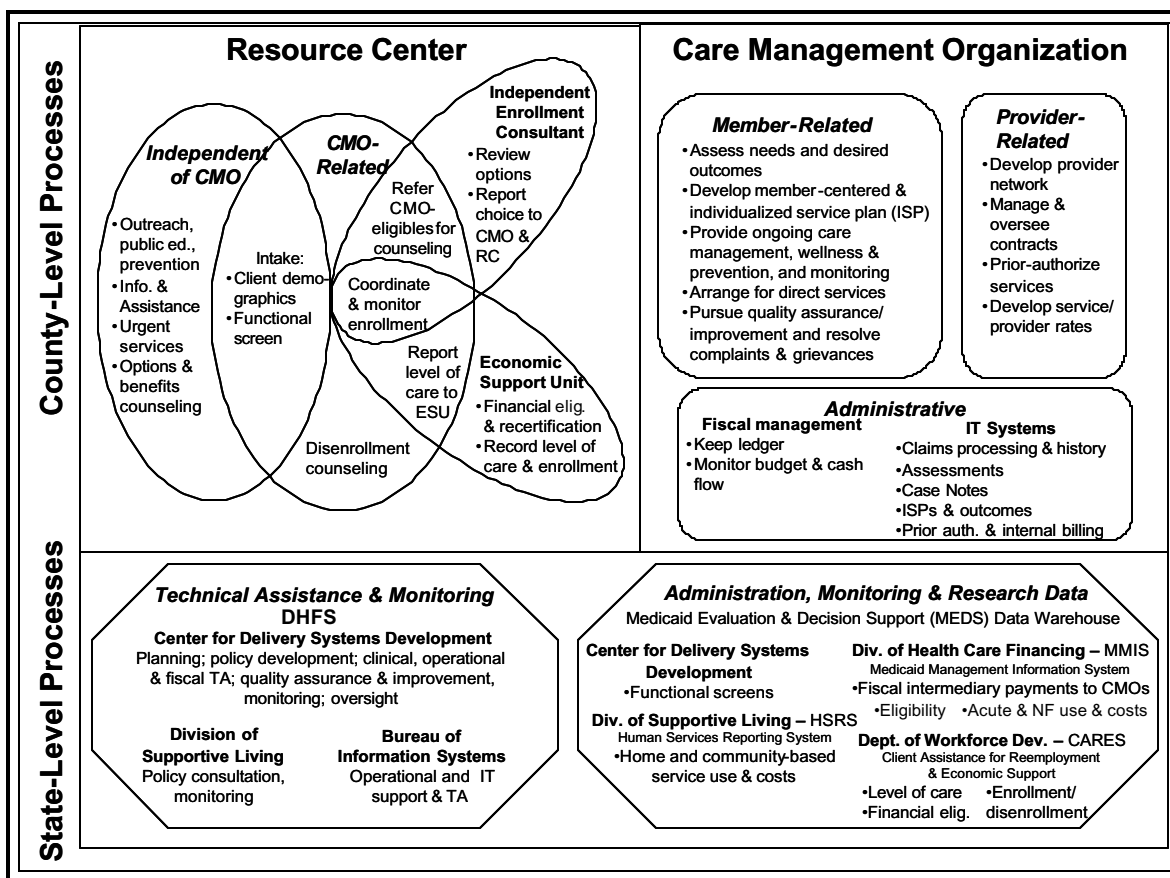
> **Source:**   Lewin adaptation of DHFS Family Care Business Process Model 5/02 and Family Care
> Organizations and Functions 11/02.

1. *Staffing*

Overall, the Family Care program experienced a 23% increase in full-time equivalent staff (FTEs). CMO staffing increased across the board while RC staffing decreased slightly in Fond du Lac, and increased by at least 10% in the other eight counties (see *Exhibit IV-2*). Detailed information on full-time equivalent (FTE) staffing levels and specific positions in 2001 and 2002 appears in *Appendix F.*

Exhibit IV-2
Absolute and Percent Increase of RC and CMO
Full-Time Equivalent Staff (FTE), by County

	RC			CMO			Total		
	2001	2002	% Change	2001	2002	% Change	2001	2002	% Change
Fond du Lac	11.80	11.05	-6.4%	39.00	45.95	17.8%	50.80	57.00	12.2%
Jackson	2.52	2.77	9.9%	N/A	N/A	N/A	2.52	2.77	9.9%
Kenosha	13.75	15.68	14.0%	N/A	N/A	N/A	13.75	15.68	14.0%
La Crosse	8.50	12.00	41.2%	30.80	44.85	45.6%	39.30	56.85	44.6%
Marathon	13.00	17.60	35.4%	N/A	N/A	N/A	13.00	17.60	35.4%
Milwaukee	55.25	66.75	20.8%	119.60	143.84	20.3%	174.85	210.59	20.4%
Portage	5.58	6.61	18.5%	25.30	33.34	31.7%	30.88	39.95	29.4%
Richland	3.00	5.40	80.0%	16.78	19.38	15.5%	19.78	24.78	25.3%
Trempealeau	2.25	2.70	20.0%	N/A	N/A	N/A	2.25	2.70	20.0%
Total	**115.65**	**140.56**	**21.5%**	**231.48**	**287.36**	**24.1%**	**347.13**	**427.92**	**23.3%**

Source: Pilot County Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county and DHFS staff.

a. *Clinical Processes*

The RCs' clinical tasks include providing information and assistance (I & A), conducting community outreach and prevention activities, administering the LTC functional screen, providing options counseling[2], and tracking demographic information about callers (*Exhibit IV-1*). Additional hiring in the RCs during the past period has allowed them to reduce previously heavy workloads for clinical tasks. As seen in *Exhibit VI-3*, staffing increased by more than 10% in seven of the nine RC counties from 2001 to 2002, and changed only slightly in Fond du Lac and Jackson.

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[2] Options counseling differs from enrollment counseling provided by the ECs. See definition of options counseling in *Appendix E.*

Exhibit IV-3
Resource Center Overall Staffing Changes, 2001-2002

Source: Pilot County Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

Generally, the RCs reported less difficulty completing screens in a timely fashion due to reduced workload. *Exhibit IV-4* indicates that La Crosse, Marathon, and Portage, and Richland increased FTEs for completing functional screens from 2001 to 2002. The increased FTEs appeared to have resulted in a lighter workload for those staff, known as "screeners," in all these counties (see *Exhibit IV-5)*. Since our 2001 report, Fond du Lac, Milwaukee, and Richland transferred the responsibility for re-certification from the RCs to the CMOs, which appears to have resulted in a significant decrease in workload for Fond du Lac (26%) and Richland (46%). This reduction occurred despite Fond du Lac's decrease in screeners due to efforts to develop specialized roles for RC workers who previously completed all I&A and screening tasks (see *Appendix F* for detailed FTEs). Shifting re-certification responsibility to the CMO did not affect Milwaukee's workload as the county completed screens for many individuals transitioning from the waiver programs.

La Crosse had the most significant reduction (63%) in screener workload due to 1.5 additional FTEs. Jackson and Milwaukee experienced a large increase in workload, due to a constant staffing level and a dramatic increase (75%) in the average number of functional screens completed between the first quarters of 2001 and 2002.

Exhibit IV-4
Resource Center Screener Staffing Changes, 2001-2002

Source: Family Care Pilot Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

Note: FTEs in Jackson and Milwaukee remained constant.

Exhibit IV-5
RC Screener Workload for Functional Screens,
1st Quarter 2001 and 2002
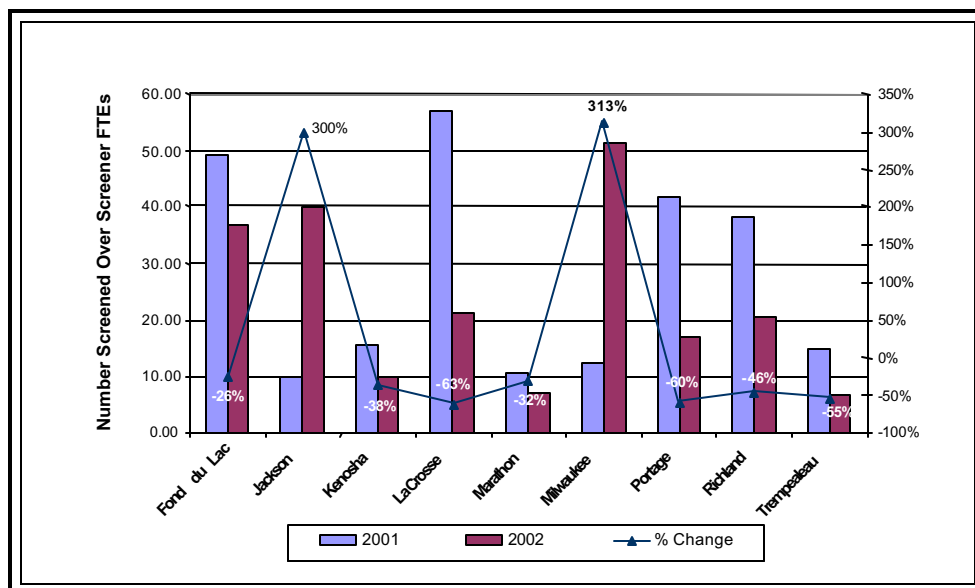
Source: Lewin analysis of DHFS data of functional screens completed by the RC. Total number of screens from January 2001 to March 2001 from FC Monthly Monitoring Report May 2001. Initial screens completed from January to March 2002 from FC Quarterly Activity Report March 2002. FTEs from Family Care Pilot Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

The majority of the RCs increased FTEs for I&A workers by at least 10% with the exception of Jackson and Trempealeau, which remained constant, and Portage, which increased 7%. (see Exhibit IV-6). As a result, I&A workload decreased in six of the nine RC counties, and increased in La Crosse, Richland, and Trempealeau (see *Exhibit IV-7*).

Exhibit IV-6
Resource Center I & A Staffing Changes, 2001-2002
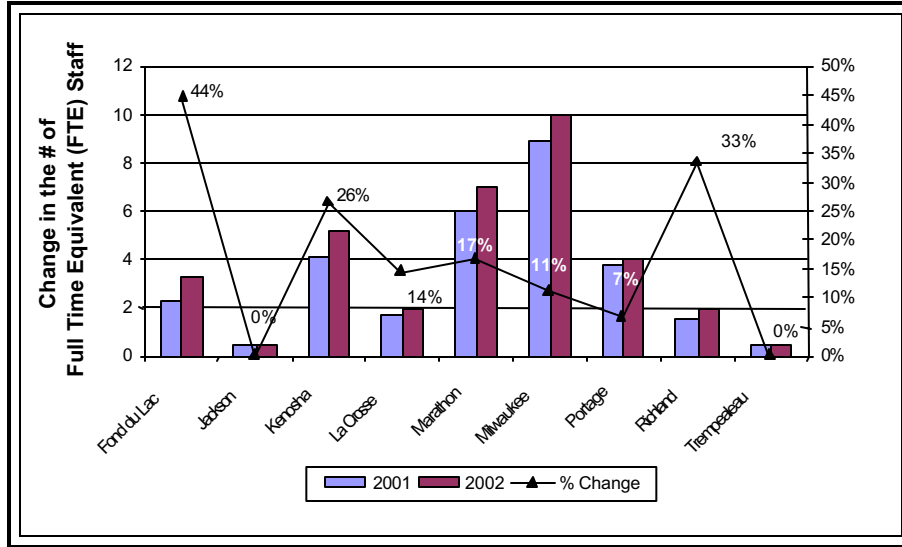
Source: Family Care Pilot Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

Exhibit IV-7
RC I & A Workload, February 2001 and March 2002
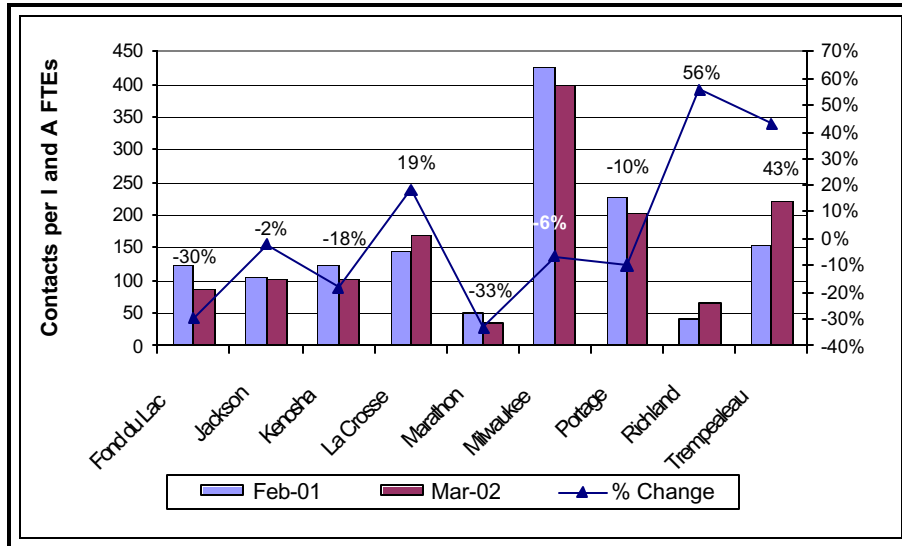
Source: Lewin analysis of DHFS data. March 2002 are an average of contacts from January to March 2002 from the Family Care June 2002 Quarterly Activity Report, 1st Quarter 2002. February 2001 con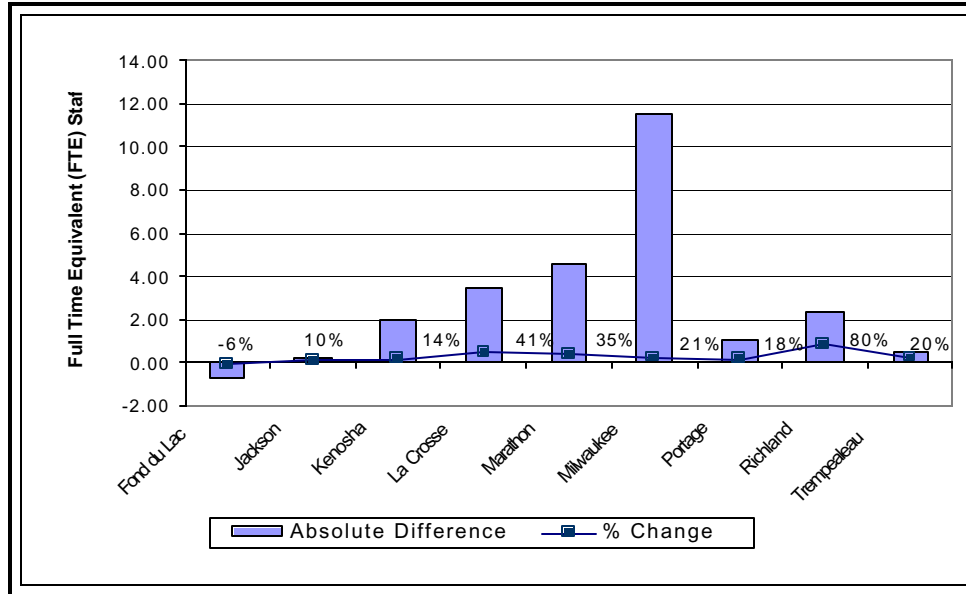tacts from the April 2001 Family Care Monthly Monitoring Report. FTEs from Family Care Pilot Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

The number of FTE positions working as Disability Benefit Specialists (DBSs) increased across all counties within the last year, except for Kenosha where the DBS remained the same (see *Exhibit IV-8*). Though the DBS has been part of the Family Care pilot since its inception, the recent increase may be attributable to the increased understanding and appreciation of the role of the specialist and DHFS' emphasis on additional funding for this position. The Bureau of Aging and Long-Term Care Resources (BALTCR) contracted for the formation of a workgroup ($6,500 from state General Purpose Revenue [3]) which involved a background paper and a report noting a full-time DBS as ideal.[4]

DBSs assist adults under age 60 with disabilities while the elderly benefits specialists (EBSs), which were in place state-wide through Wisconsin County Aging Units and Area Agencies on Aging prior to Family Care Resource Centers, focus on older individuals. DHFS reported that the DBS position deals with more complicated cases than the EBS due to the multiple benefits beyond Family Care available to the disabled population. The DBS has three main functions which differentiate its duties from those of an RC social worker familiar with benefits for individuals with disabilities, including: (1) information provision about available benefits; (2) assistance with benefit applications; and (3) advocacy in appealing benefit denials. Social workers at the RC can complete these tasks, but the resources needed to research benefits detracts from RC outreach, I & A, and Family Care enrollment processes. Additionally, the DBS has benefit assistance responsibilities as a primary function and is continually trained and monitored by attorneys knowledgeable in elder or disability law. The state-wide DBS attorney, funded by General Purpose Revenue through Family Care (CY 2002, $53,679), offers consultation to DBSs in determining appropriate interpretation of the law for benefits. *Appendix G* provides a sample job description Lewin adapted from information provided by the pilot counties, the RC contract, and the BALTCR commissioned report.

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[3] Most state GPR funding used in Family Care is funding re-allocated from existing programs including Medicaid fee-for-service, Community Options, and the adult protective services portion of Community Aids Programs.

[4] Abramson, B. (November, 2001). Disability Benefit Specialist Program: Summary of Issues and Recommendations. Prepared for Wisconsin Department of Health and Family Services , Division of Supportive Living (DSL), and Wisconsin Bureau of Aging and Long-Term Care Resources (BALTCR).

Exhibit IV-8
RC Disability Benefit Specialist Staffing Changes, 2001-2002
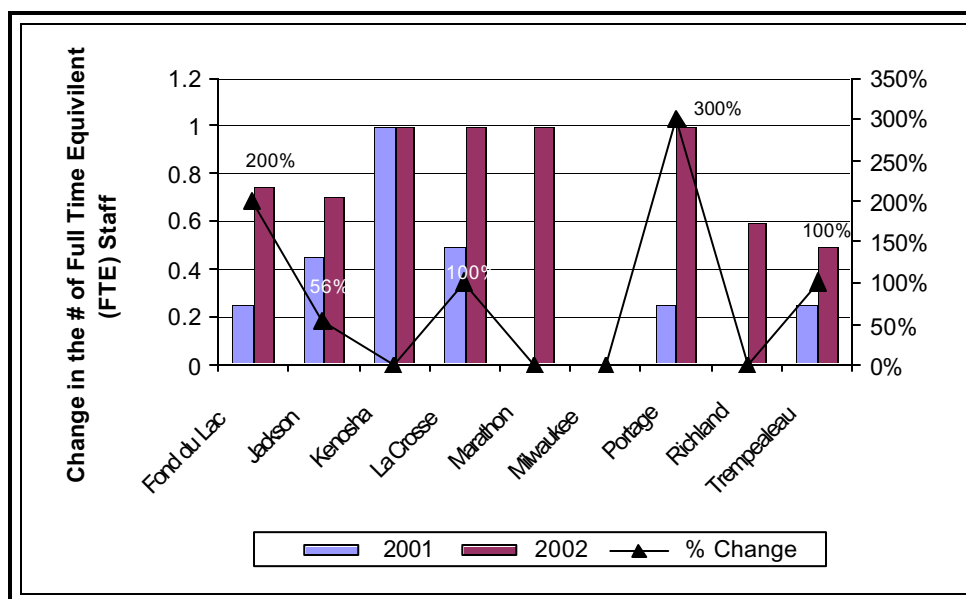
Note: Milwaukee is not required to have a Disability Benefit Specialist because of the program's focus on the elderly and the already established Elderly Benefit Specialists available in Milwaukee.
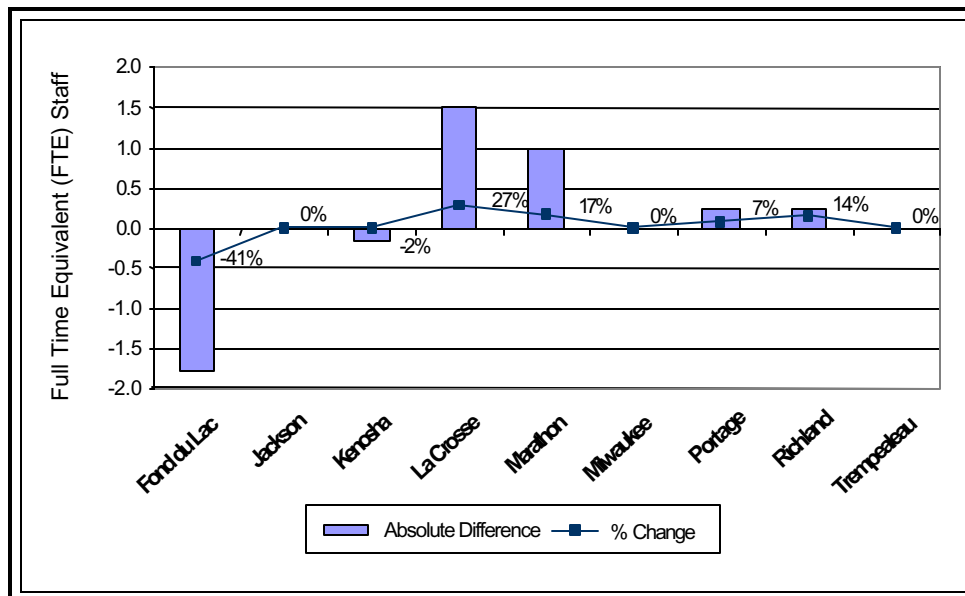
Source: Pilot County Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

RC staff noted they valued the expertise of the specialist. The ability of the DBS to offer training and to provide consultation to social workers about the most current regulations regarding benefits helped to maximize social work resources. During the past year, RCs reported that more FTE hours allowed the specialists to better serve consumers by increasing availability. Prohibitive restrictions in information flow between RC social workers and DBSs due to legal confidentiality rules have also been addressed. All the RC's have now set up either confidentiality agreements with DBS supervising attorneys (Fond du Lac and Portage) or release of information processes to allow more continuity in service delivery to RC consumers (La Crosse and Richland).

CMOs have increased clinical staff in order to handle increased enrollment. As *Exhibit IV-1* displays, CMO clinical processes include conducting and recording client assessments, care planning, monitoring and coordinating care, and conducting prevention activities with CMO members. CMOs increased care management staff from 2001 to 2002 including supervisors, RNs, member advocates, and care managers (see *Exhibit IV-9* and *Appendix F* for further detail on FTEs). In terms of percentage increase in care management staff, La Crosse experienced the largest growth, with a 46% increase or about 12.0 FTEs; Portage experienced a 36% increase or about 6.0 FTEs; Richland had a 24% increase or 2.6 FTEs; Milwaukee had a 15% increase or 15.7 FTEs; and Fond du Lac had a 9% increase, representing the smallest absolute growth of 2.5 FTEs.

Exhibit IV-9
Change in the Number and Percentage of Care Management Staff
from 2001 to 2002
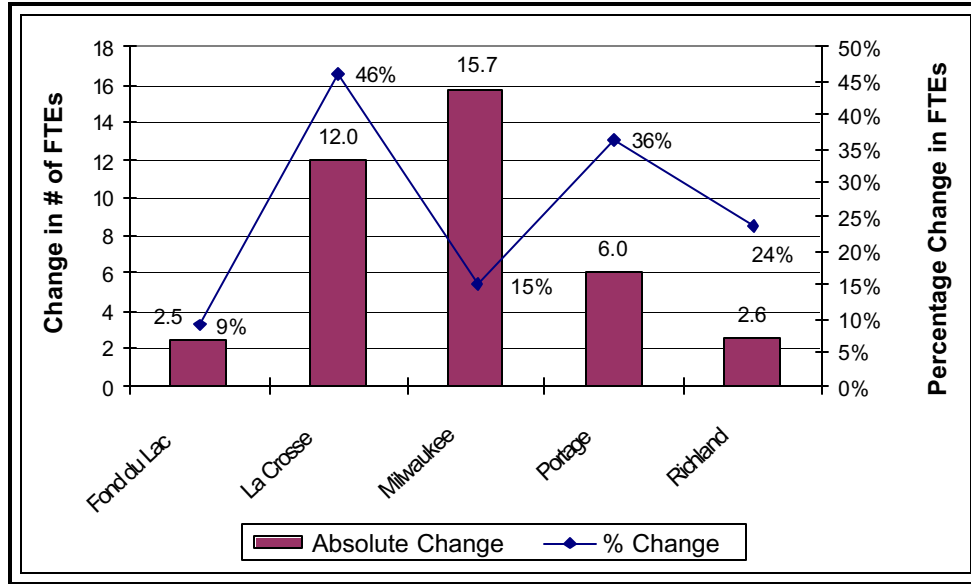
Source: Pilot County Quarterly Narrative Reports, 1st Quarter 2001 and 1st Quarter 2002 and correspondence with pilot county staff.

*Exhibit IV-10* shows the ratio of enrollees to overall care management staff across CMO counties from 2001 to 2002. Portage and La Crosse are the only counties that experienced both an increase in staff and a decrease in the number of CMO members per care management staff. La Crosse also had the highest CMO enrollment per total care management staff in March 2001 and the smallest enrollment growth during the past year of all the CMOs. The result is a ratio that was still the highest, but more similar to the other CMOs than last year. Each CMO increased RN FTEs—Portage and Richland had the most dramatic percent increases in RN FTEs, with 100% and 150% respectively. Portage has projected staff needs for the next two years and they anticipate needing an 100% increase in overall care management staff to handle the expected volume of enrollees.

Exhibit IV-10
CMO Enrollment Per Total Care Management Staff
March 2001 and 2002
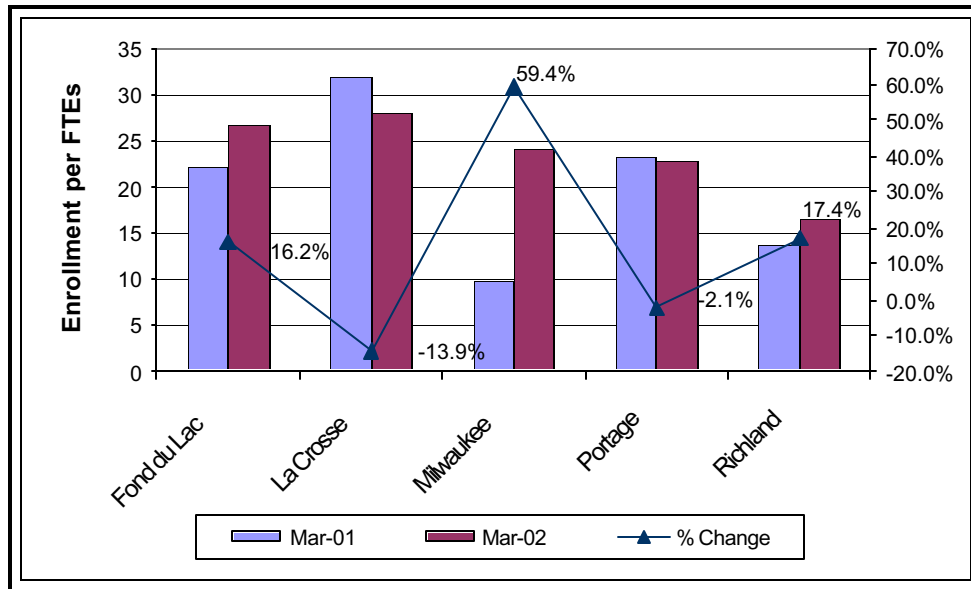
The CMOs have placed differing emphases on the management/supervisory positions among their clinical staff. The proportion of care management staff in supervisory positions in 2002 ranged from none in Fond du Lac to between 7 and 9% in the other four counties. The absence of care management supervisors in Fond du Lac is due to a greater supervisory role played by the CMO management. Fond du Lac noted that this structure has promoted staff accountability and empowered staff to consult with team members and peers.

b. Operational and Fiscal Processes

As *Exhibit IV-11* displays, CMOs added significantly to their fiscal staff. They hired staff with sufficient business backgrounds to handle the operational and fiscal functions of the Family Care model. Some CMOs reported that they initially did not consider the need to hire individuals trained in business but quickly realized staff support in the fiscal area, including claims management and financial management, would help the CMOs understand program costs. DHFS assisted the counties with an analysis of the type and number of positions. The CMOs added business analysts, financial analysts, and accountants. They also hired account clerks and clerical support staff to respond to increasing demand as enrollment continued to increase.

Growth in fiscal staff represented the largest increases in overall staff in Fond du Lac and La Crosse, and the second largest increase in staff next to administrative support in Milwaukee. Every county increased fiscal staff by at least 45%, except for Richland which remained the same; La Crosse, which started with only one FTE, had the most dramatic increase at 400%. Portage introduced the caseload concept into the structure of the fiscal staff, which involves

grouping fiscal staff and assigning each group to specific CMO members. DHFS noted this as a best practice in keeping the entire organization member-focused.

Exhibit IV-11
Care Management Organization Fiscal Staffing Changes,
2001 - 2002
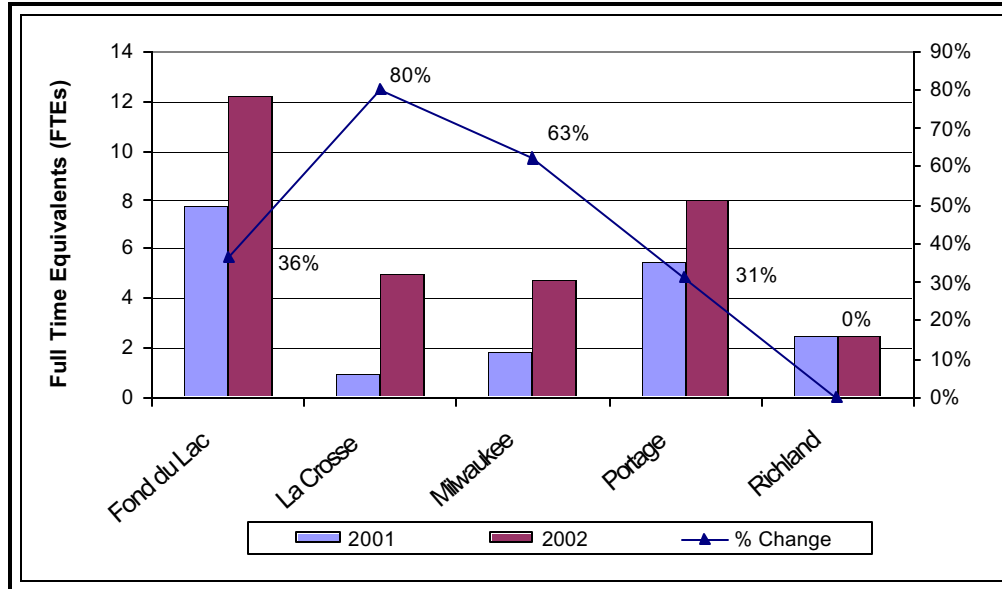
c.   Hiring Issues

Collective bargaining agreements and county politics heavily influenced the ability of the pilot counties to hire and train sufficient staff. Issues with unions in Milwaukee and Fond du Lac had an impact on the staffing composition during the past year. In Milwaukee, as a result of seniority, Child Welfare workers replaced 45% of the combined CMO and RC county workforce when the Child Welfare Program was terminated in Milwaukee County. Much staff time and energy was devoted to this major transition. The new workers had to be trained in the field of aging as well as the processes of the CMO. This change did not affect the Care Management Units (CMUs) — private agencies Milwaukee County contracts with to provide care management. In Fond du Lac, the CMO could offer contracted entry-level workers a higher salary than the entry level pay for union-represented social workers. Thus, the Fond du Lac CMO tried to hire care managers outside the union in order to offer more competitive salaries to assure quality and improve staff retention.

The relationship between the local Family Care agencies and the county boards also impacted hiring practices. Even though capitated payments increase commensurate with enrollment, some county boards still held the RC and CMO at their discretion for approval to hire. The county board in Fond du Lac tabled a request for new staff from February to May 2002, delaying necessary hiring. Other pilot counties developed agreements with the county board to hire staff as needed, without coming to the board for approval. However, in these counties, Family Care staff reported that there was resentment from other county departments placed

under a hiring freeze due to the State's budget deficit. Many county boards had enacted hiring freezes due to the Governor's proposal to eliminate shared revenue, a traditional funding mechanism for the counties.

d. Staff Turnover

In CY 2000, the CMOs experienced less than 10% turnover, except for Milwaukee. Measurements of staff turnover by necessity, lag by one year. Percentages among their care management staff (including nurses): Fond du Lac, 5%; La Crosse, 8%; Milwaukee, 22%; and Portage, 6% (*Exhibit IV-12*). Comparable estimates for CY 2001 indicated lower turnover rates. Milwaukee's turnover rate was lower despite transitioning a substantial number of former Child Welfare care managers to the internal county care teams.

Exhibit IV-12
Care Management Organization Care Management Staff Turnover,
CY 2000 and 2001

	2000	2001
Fond du Lac	5%	4%
La Crosse	8%	3%
Milwaukee	22%	14%
Portage	6%	0%
Richland	--	8%

Source: DHFS provided data based on CMO reporting.

2. Information Technology

IT systems continue to evolve to support RC and CMO functions. Each county has taken its own approach to developing IT systems that support the Family Care model. These approaches were detailed in the Lewin Implementation Evaluation Report II, released in 2001. Counties have considered IT capability in three areas: 1) degree of automation – generally computerized systems offer more efficiency and better tracking ability, 2) degree of integration – the ability of a system to share information across Family Care entities, and 3) data reporting and monitoring capabilities - the ability to track the success of initiatives and create plans for future service delivery. This section details county progress with building IT systems around these capabilities that support the clinical, operational, and fiscal processes of the Family Care model.

a. Degree of Automation

Since our 2001 update report, the degree of automation of county IT systems has remained the same. All of the clinical processes in Milwaukee and Fond du Lac are computerized with the exception of prevention and outreach activities. La Crosse computerized their Individualized Service Plan (ISP)[5], and plans to computerize case notes, but does not plan to automate the

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[5] The Member-Centered Plan (MCP), developed by CMO staff and the Family Care member, outlines the member's preferences and personal outcomes. The plan should inform the Individualized Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.

assessment. The Portage ISP is computerized, but the CMO continues to test the assessment, case notes, and outcome functions. Richland has adapted components of the Portage system for fiscal functions and plans to automate both the assessment and the Member-Centered Plan (MCP)/ISP. All of the counties have operational and fiscal procedures computerized with the exception of La Crosse. La Crosse is in the planning stages of automating claims processing.

The State moved from a PC-based, dial-in upload for the functional screen, to the Web-based screen in October 2001. DHFS noted that the Web-based screen increases screener reliability by subjecting the information to cross-edits and other checks as it is entered. In addition, DHFS staff review automated system-generated reports to identify patterns of screening that might indicate questionable screening practices, such as numerous screens recorded on one person during a short time period. As a result, manipulating the screen for eligibility purposes is less likely to occur with this system.

The counties differ in the degree to which confidentiality affects system compatibility and integration. County philosophy regarding confidentiality has influenced IT integration. With the introduction of the Web-based functional screen in October 2001, authorized users are able to view client information via the Web. This has the potential to reduce the amount of paperwork transfer between the RC, CMO and the enrollment consultant (EC). The CMO is able to view the screen completed by the RC through the Web-based system. Due to confidentiality and consumer privacy concerns, La Crosse provides the EC with a copy of relevant parts of the screen, but they do not let the EC view the screen on the Web. They believe that the EC does not need that high level of detail to talk with someone about his or her enrollment options. At the other end of the spectrum, the ECs in Milwaukee have access to the RC database with client records and thus receive minimal paperwork in exchanges with the RC.

b. Degree of Integration

The counties differ in the degree of system integration regarding clinical functions. Portage and Fond du Lac are planning to integrate case notes and the MCP/ISP with the rest of the clinical function, such as the assessment and prior authorization, and with some operational functions, the billing and prior claims processing. Richland hopes to be able to integrate systems within the next two years. The Milwaukee CMO database contains assessments, case notes and the MCP. A separate system houses service authorizations which are matched to the claims to generate provider letters. The provider letters inform the vendor of the status of the authorization, service type, amount and duration of the authorization. CMO staff can access both systems on the CMO homepage. La Crosse is not considering integration of clinical and billing processes.

c. Data Reporting

Clinical data reporting in Family Care continues to evolve. The counties transfer data on demographics, enrollment, costs, and services from county to state data systems. The Medicaid Evaluation Decision Support (MEDS) data warehouse holds the HSRS (Human Services Reporting System), MMIS (Medicaid Management Information System), and the functional screen database. The MMIS, although not part of the Family Care rate setting, allows DHFS to monitor acute and primary care spending for research purposes. Currently, county CMO staff manually enter service units and spending into the HSRS, but are moving toward encounter

level data. Because the CMOs receive a capitated amount for each member, they have more incentive to report costs than units of services. The CARES (Client Assistance for Reemployment and Economic Support) system used by the Department of Workforce Development's (DWD) economic support units records eligibility information and cost-share amounts. Because the MMIS does not interface with the CARES system, information must be re-entered manually at the state level.

d. HIPAA Compliance

DHFS has made considerable efforts assisting the pilot counties in preparation for Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and encounter report planning and implementation. The act offers improved portability and continuity of health insurance coverage and regulations to guarantee patients rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information.

Health plans must be HIPAA compliant. DHFS applied to the Centers for Medicare and Medicaid Services (CMS) for a b/c waiver combination to operate Family Care. The "b" portion of the waiver authorizes a managed care model. Therefore, DHFS health programs and the CMOs, which operate as health plans, must comply with HIPAA privacy (by April 14, 2003), security (compliance date not yet final), and transaction (October 16, 2003) rules. The Bureau of Information Systems has offered technical assistance of approximately 0.5 to 1.0 FTE staff to the counties to help them become HIPAA compliant.

V.   GOVERNANCE

Potential conflict of interest and adequate consumer participation guided governance issues in Family Care during the past period. Governance, in this section, refers to issues broader than pilot county governing boards, including consumer participation in the development of the Family Care model. The concern of a potential conflict of interest was raised by the Centers for Medicare and Medicaid Services (CMS) in approving the b/c waiver combination. CMS expressed concern that if the same entity (the county) is ultimately responsible for intake, enrollment, and service delivery, it may have the incentive to influence eligibility determinations or enrollment decisions. Thus, the Department of Health and Family Services (DHFS) originally required that CMOs and RCs have separate governing boards. As reported last year, RCs and CMOs created separate 'governing boards' with consumer participation, but these boards are advisory to the county boards. Recognizing that the RC and CMO both report to the elected county board, CMS required the inclusion of an enrollment consultant independent of the county to ensure that consumers receive objective and complete information before their enrollment in Family Care. Additionally, the pilot counties have taken various steps to involve consumers in the development, implementation, and administration of the Family Care model. This section documents the enrollment consultation process, recertification, and consumer involvement in Family Care governance.

A.   Enrollment Consultation

Beginning in January 2002 (April 2002 in Milwaukee), as a requirement under the 1915 b/c waiver, counties had to incorporate an independent enrollment consultant (EC) into the enrollment process for the Family Care benefit. Funding for the ECs was reallocated from the state budget for RCs. The EC must be independent of the county and functions to provide unbiased information to the consumer about his or her choices. Additionally, the EC ensures the consumer's freedom of choice in enrolling with a managed care organization, a standard part of the managed care portion of the 1915 b/c waiver combination. In all of the pilot counties, with the exception of Milwaukee, which offers other managed care programs such as PACE and Partnership, eligible consumers must choose between Medicaid fee-for-service and the CMO to receive publicly-supported home-and-community-based waiver services. Consumers who choose Medicaid fee-for-service long-term care can either reside in a nursing facility or stay at home with services limited to what is available through the State plan.

DHFS contracted with the Southeastern Wisconsin Area Agency on Aging (AAA) to provide staff for the consultant role. The agency employs three full-time equivalent staff to conduct the enrollment consultant function. One full-time staff person covers La Crosse, Portage, and Richland. The other two full-time positions, divided among three employees, serve Milwaukee and Fond du Lac. During a two-month period in 2002, DHFS provided two staff to assist in completing enrollment consultations for individuals on waiting lists in Milwaukee County. This assistance, unlikely to be needed in other counties, occurred due to the deadlines of April 2002 to transition individuals receiving waivers to Family Care and July 2002 to reach entitlement (entitlement is detailed in *Chapter VI: Access to Services and Information*).

DHFS provided requirements and guidance on the roles and responsibilities of the enrollment consultant, and the RCs, ESUs, and ECs in each county determined how they would interact to complete enrollments. Generally, once a consumer has been determined functionally and financially eligible for Family Care, the EC: 1) receives notification and information from the RC or the ESU, 2) contacts the consumer within three days, 3) conducts the consultation over the phone or in-person, 4) notifies the RC or the CMO of the individual's decision, and 5) reports the decision to the State (*Exhibit V-1*). Steps two, three, and five include uniform processes. The ECs and counties use a standard State enrollment form to record notes about the consumer level of care (LOC), contact names, phone number, cost share, and the consumer's decision.

Exhibit V-1
Enrollment Consultant Process

Step	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
1 -Information provided to the EC	• RC contact sends winzip file that includes notes about client, LOC, contact names, cost share, phone number and enrollment form	• RC sends packet (pre-enrollment form, detailed notes) • ESU emails tentative approval (LOC determination, enrollment date)	• RC contact faxes client demographics *	• RC sends information (enrollment form, notes, part of functional screen)	• RC calls • Receive information from ESU/RC (enrollment form, limited functional information)
2- Contact Consumer					
3- Enrollment Consultation					
4 -Notify RC or CMO of consumer's decision	• Fax to RC contact signature page and winzip file back to RC	• Email notification RC worker • Email ESU worker • Give enrollment form to RC worker	• Fax form back to the RC contact with signature of client	• Fax enrollment form to CMO supervisor • Fax enrollment form to CMO fiscal • Fax enrollment form to RC	• Email notification RC • Email enrollment form to ESU • Email enrollment form to CMO fiscal and Long-Term Support (LTS) • Send RC enrollment form • Call CMO • Receive confirmation email from ESU
5 – Notify State of consumer's decision via win-zipped database once a month					

* Milwaukee allows the enrollment consultants access to the consumer database with case notes and history.

Steps one and four vary by county. Counties differ in the flow and type of information shared among entities. The enrollment consultant process in Fond du Lac, Portage, and Milwaukee involves no communication with the ESU. In Fond du Lac and Milwaukee, the ECs have a single contact person at the RC with whom they communicate throughout the entire process.

The ECs noted this single contact proves very beneficial, especially for cases in which they have questions.

As a temporary procedure that will be replaced once HIPPA transaction requirements are implemented in October 2003, each EC sends completed enrollment forms monthly to the State. DHFS shared specific guidelines with the counties concerning confidentiality and the need to protect client social security numbers during transfers of information. As a result, the counties using electronic transfers adopted secure transfer procedures, such as password protected win-zipped files.

Staff in the pilot counties noted that the enrollment consultation process has not delayed enrollment by more than two or three days, with the exception of Milwaukee, which experienced an increase of approximately one week. However, every pilot has procedures for urgent services and expedited enrollment if necessary. For example, if an individual screened by the RC was at imminent risk of institutionalization without in-home services, the county can begin to serve that individual immediately and process their enrollment promptly. None of the RCs currently track the frequency of this occurrence. RC staff in La Crosse, Portage, and Richland estimate that one urgent case occurs in their counties per month. Fond du Lac and Milwaukee staff each estimate 5-10 cases per month.

It remains too early to assess the full impact of the EC on Family Care since the process has only been effective since early 2002 in all counties. Through May 2002, although different in each county, the process reportedly operated smoothly. However, the ECs noted if the program were to expand statewide, 72 different processes would be unwieldy. Stakeholders had reservations about the effect the EC had on consumers who must now be channeled through yet another person before receiving services. As *Exhibit V-1* shows, enrollment consultation added five additional steps to the overall process of accessing the CMO benefit and one additional step for the applicant. Advocates and RC and CMO staff expressed concern that consumers were confused about the many individuals temporarily involved with them prior to the long-term care manager at the CMO, who becomes their tangible link to services. Despite the added steps and additional person involved in the consumer's life, the enrollment consultant process was generally viewed as an opportunity to review the Family Care benefit package and answer questions. The ECs noted they frequently answered questions about estate recovery, type of benefits possible, and cost-share amounts.

B. Recertification

Functional and financial certification are required annually. The ESU completes annual recertification of financial eligibility in all counties. For recertification of functional eligibility, CMO staff in Fond du Lac, Milwaukee, and Richland assumed this responsibility, while in Portage and La Crosse, the RC staff complete functional recertification. In either case, the CMO care managers are involved and provide much of the information. There are advantages and disadvantages of the CMO assuming responsibility for functional recertification. The advantages include the CMO's long-term relationship with the client, which offers maximum continuity for the consumer. This has particular relevance for cultures who value privacy, such as the Hmong. The CMO staff also have the potential to more accurately assess the individual due to their long-term relationship with the consumer versus one assessment each year by RC staff.

However, a potential conflict of interest emerges if the CMO performs the annual functional recertifications. For example, incentives exist for the CMO to adjust level of functioning to keep low-cost consumers in the program. Consumers requiring a less costly array of services subsidize the cost of those requiring a more costly array of services. Also, as DHFS' rate setting methodology evolves to correspond to functional status, CMOs could have the incentive to screen individuals into higher functional impairment levels. However, DHFS remains confident that the functional screen cannot be manipulated and has automatic review mechanisms for changes from the previous level of care. Each CMO is required to comply with requirements for on-going testing for inter-rater reliability for the CMO screeners. The Automatic Reviews for the first quarter of 2002 identified 159 cases for further investigation. DHFS reviewed 72 or 45% of the cases and sent questions back to the counties for response. They concluded that 11 or 7% required additional follow-up beyond the county explanation.

C.   Consumer Participation

Several opportunities exist for consumers to be involved in the development of the Family Care model. The following avenues have been used by the pilot counties to date:

*   State and Local Long-Term Care Councils;
*   RC and CMO Governing Boards; and
*   CMO and RC Committees.

1.   State and Local LTC Councils

The State Long-Term Care Council was created by statute in 1999 to serve as an advisory committee to the Governor, the Legislature, and DHFS. The Council's charge is to advise DHFS about Family Care, as well as the future of all long-term care programs in the state. The Council is administratively attached to DHFS and includes a majority of consumers or consumer representative members. After the Council lost statutory status in July of 2001 due to sunset legislation, Secretary Phyllis Dubé of DHFS kept the membership intact as a council that would advise the DHFS, and added two additional members to represent the interests of children and individuals with mental illness.

Local Long-Term Care Councils (LLTCCs), by contract, must provide general planning and oversight to the Family Care pilots. They serve as advisory bodies only. According to sec. 46.282 (2)(b)(1), Wis. Stats., each Council must be comprised of 17 members, nine of whom represent consumers in the three Family Care target populations proportional with the number of people in those target populations receiving long-term care in the state as determined by DHFS. The counties all report that they have achieved this membership. As the program evolves, the LLTCC will make recommendations to DHFS regarding the need for additional CMOs.

Since our last report, the LLTCCs have continued to learn from the RC and CMO staff about the Family Care model. The LLTCC must be educated about the goals and progress of Family Care in order to make program recommendations to the county and the State. However, some LLTCCs have played a more active role. The LLTCC has been used in some counties to comment on policies and procedures developed by staff. The LLTCC in Portage, for example, wrote a letter to the Governor expressing satisfaction with the beneficial effects of Family Care

in Portage County and the La Crosse Council significantly contributed to the development of the CMO member handbook. The Portage LLTCC also mediated a situation in which a consumer wanted to hire workers under the age 18 to provide personal care. When a consumer on the Council shared her unsuccessful experience hiring young workers, a policy banning the practice was developed.

County staff noted that maintaining a productive, informed, and consumer-driven LLTCC represented a challenge. In most counties, CMO staff coordinated the LLTCC because they have the most knowledge about the program in the county. The CMO contract simply notes that the CMO must assist the LLTCCs in their duties. Staff reported that the CMO contract does not clearly state coordinating responsibilities of the Council, such as setting the agenda and providing administrative support. Therefore, CMO staff assumed coordinating responsibilities, diverting resources from the more defined CMO activities. In addition to this staffing resource concern, consumer participation and direction could be jeopardized if, as is the general practice, CMO staff set the agenda for the meetings. The LLTCC functions as a less independent group if they do not have responsibility for directing the group by setting the agenda. However, the LTTCC representatives we spoke with noted that the Chair, a member of the LLTCC, most often facilitated the actual meetings and had the ultimate decision regarding the agenda.

Although the LLTCCs offer an avenue of consumer participation, some advocates we interviewed were concerned that the definition of consumer representation on the LLTCCs, as well as on the State Long-Term Care Council, was too loose and should more appropriately represent the consumer level. The definition of consumer representative in the Wisconsin statute reads, "….[O]lder persons or persons with physical or developmental disabilities or their immediate family members or other representatives" sec. 46.282(2)(b)1, Wis. Stats. Advocates noted that the definition of "other representative" did not ensure that the person chosen under that title had the ability to appropriately represent consumers of a particular target population. For example, advocates noted that a provider would not make an appropriate consumer representative.

2. Governing Boards

As indicated in our last report, all RCs and CMOs have met contractual obligations in establishing separate governing boards comprising one-fourth consumer representation. The CMO governing board is responsible for maintaining a plan for the CMO's separation from eligibility determination and enrollment counseling functions. Most counties reported that the governing board reviewed the plan, but did not assist with the development of the plan. However, Richland's board did provide input into the plan. In addition to the separation plans, most pilot county staff reported presenting other program policies and procedures to the CMO board for review.

Pilot county staff indicated that the RCs boards were functioning in accordance with their contracts. This has included providing oversight on the development of a mission statement for the Resource Center, determining relevant structures, policies, and procedures of the Resource Center consistent with state requirements and guidelines, identifying unmet needs, and proposing plans to address unmet needs.

3. *Committees*

Another avenue for consumer participation has been the many committees formed by the RCs and CMOs. All of the CMOs and the Milwaukee RC had consumer representation on a Quality committee. The Portage CMO also had consumers involved in their Grievance and Operations committees; the Milwaukee CMO involved consumers in their Ethics and Grievance committees. A workgroup for prevention and wellness that included consumers existed in Richland. Fond du Lac CMO also had consumers involved in the Self-Directed Support Option (SDS) committee.

4. *DHFS Infrastructure Grant*

DHFS received a Bridges to Work grant for $32,000 from the CMS for use in years 2002 and 2003, to support the development of LLTCCs. The grant will examine effective strategies of involving consumers in the Family Care program. County staff reported that although consumers constituted the required proportions in the governing and advisory bodies, they often did not have a sense of how to play an active and productive role. Through the grant, DHFS contracted to develop training materials to educate the LLTCCs on how to function as an effective advocacy and advisory group, a newsletter for LLTCCs, a video to train new members, and to provide direct education and consultation on site.

VI.   ACCESS TO SERVICES AND INFORMATION

Family Care was designed to provide appropriate long-term care services to all eligible individuals without delay. The two main organizational components of the program, the Resource Center (RC) and the Care Management Organization (CMO), each play an important role in improving consumers' access to long-term care. With the exception of Richland County, which began operating in November 2000, the RCs have been operating for nearly four years and have emerged as a successful model of centralized information and assistance. Pre-Family Care waiting lists have been eliminated in all five counties that implemented CMOs. In each of these counties, consumers have more immediate access to services relative to pre-Family Care. The pilot counties continued to experience increasing enrollment into Family Care, with different rates of enrollment among the elderly, physically disabled, and developmentally disabled populations. This section describes the program's progress in improving access to long-term care for all target populations, with a focus on information and outreach, screening, enrollment, service availability, and home and community-based LTC options.

A.   Enrollment Activity

Generally, the CMOs enrolled existing Community Options Program (COP) and waiver program consumers during an initial enrollment phase followed by new enrollees from the community. As shown in *Exhibit VI-1*, enrollment continued to grow in each county, with Milwaukee experiencing the largest increase.[6] From March 2001 to March 2002, enrollment into Milwaukee's CMO grew by over 180% from 1,020 to 2,889 members, reflecting their efforts to eliminate the waitlist. La Crosse experienced the smallest growth over time, with a 28% increase in enrollment from 826 to 1,060 members. CMO enrollment in Fond du Lac, Portage, and Richland grew by 30, 34, and 50%, respectively. Excluding Milwaukee and Richland, the overall average rate of growth for the CMO counties was 30%.

Exhibit VI-1
CMO Enrollment, March 2001 - March 2002 (% Change)
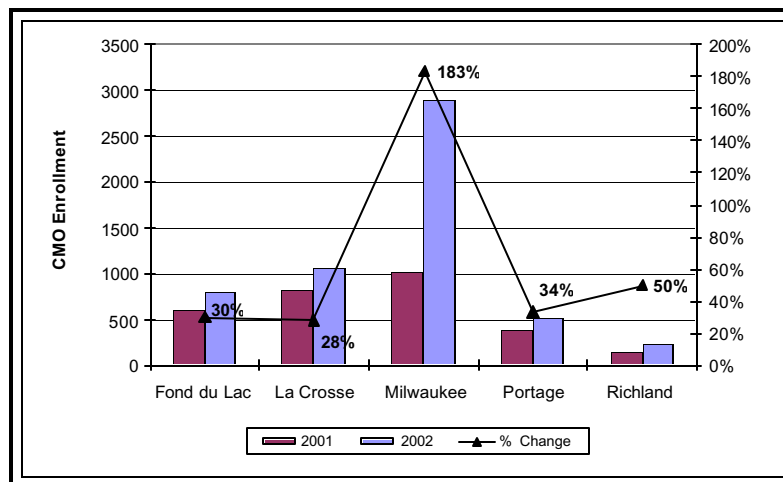
Source: Family Care Monthly Monitoring Report from March 2001 and
Quarterly Family Care Activity Report for the quarter ending March 2002.

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[6]   Milwaukee estimates are based on the county population age 60 and over.

As of March 2002, overall actual enrollment was approximately 12% greater than budgeted enrollment. Milwaukee had the greatest difference in actual versus budgeted enrollment, with actual enrollment 25% greater than budgeted enrollment. Enrollment in Portage was 12% greater than budgeted. Richland was the only county in which actual enrollment equaled budgeted enrollment. La Crosse's enrollment was 4% less than budgeted enrollment, while Fond du Lac's was 1% less than budgeted.

In the 2001 implementation report, we included a graph presenting waiver enrollment per 1,000 county population in each of the CMO counties relative to the non-CMO counties. It was used to measure new enrollment, because individuals who transitioned from the existing waivers would be included in the pre-implementation period. Subsequent to the report, we discovered that the pre-Family Care waiver enrollment did not include all existing waiver recipients. In fact, approximately half of the waiver recipients were classified under the Supplemental Security Income (SSI) category because they had gained eligibility through a Social Security Office and not the county Economic Support Unit (ESU). As those individuals previously classified as SSI moved to Family Care and were classified under the waiver category, this meant that the growth in "new" enrollment for the CMO counties appeared somewhat inflated. For our upcoming outcomes and cost-effectiveness report, we are working to develop a better measure of new enrollment.

Exhibit VI-2
CMO Enrollment per 1,000 County Population
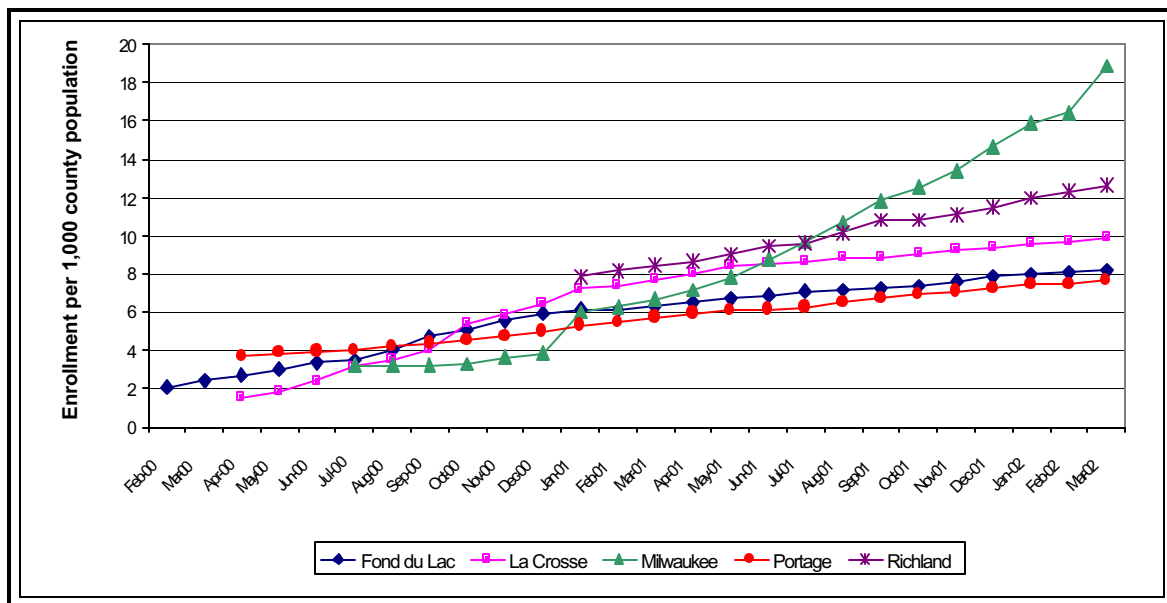
Source: The Lewin Group analysis of data from DHFS Monthly Monitoring Reports from February 2000 to December 2000 and from the Family Care Activity Report.

Note: Enrollment data for January 2001 through April 2001 were updated from that reported in The Lewin Group's *Wisconsin Family Care Implementation Process Evaluation Report II*. Data for 2000 were not updated, which might affect the curve of data presented.

Exhibit VI-2 displays the growth in CMO enrollment. Enrollment was expected to continue to increase throughout 2002 in all of the CMO counties. According to the September 2001 DHFS

Cost Model, Milwaukee, La Crosse, and Richland will likely face the most dramatic growth from March 2002 to the end of the year, with enrollment expected to increase by 16, 16, and 12%, respectively. DHFS budget staff anticipate less dramatic increases in Fond du Lac (4%) and Portage (2%). It is uncertain when the rate of enrollment will stabilize. Fond du Lac expects to experience a steady state of enrollment by the end of 2002. However, they are unsure how the move to entitlement and efforts to conduct nursing facility outreach (discussed later in this section) will affect enrollment. Portage reported that they do not expect to reach a steady state by the end of the year, as did Richland, which operated a delayed enrollment plan to control growth through July 2002.

1. Family Care Composition

The composition of Family Care membership reflects the counties' enrollment strategies. Excluding Milwaukee, 46% of CMO enrollees are elderly, 34% are developmentally disabled (DD), and 20% are physically disabled (PD) (see *Exhibit VI-3*). When Milwaukee's primarily elderly membership is included in the total count of CMO enrollees, the proportion of elderly enrollees jumps to 74%. During the initial transition of waiver program participants to Family Care, the composition of Family Care members mirrored the waiver programs. However, most of the new enrollees from the community, excluding those in Milwaukee, were individuals with developmental disabilities.[7] It is expected that the proportion of elderly members in all CMOs will increase as targeted outreach to nursing facilities advances and the program responds to demographic shifts.

Exhibit VI-3
Enrollees by Target Population as of March 31, 2002
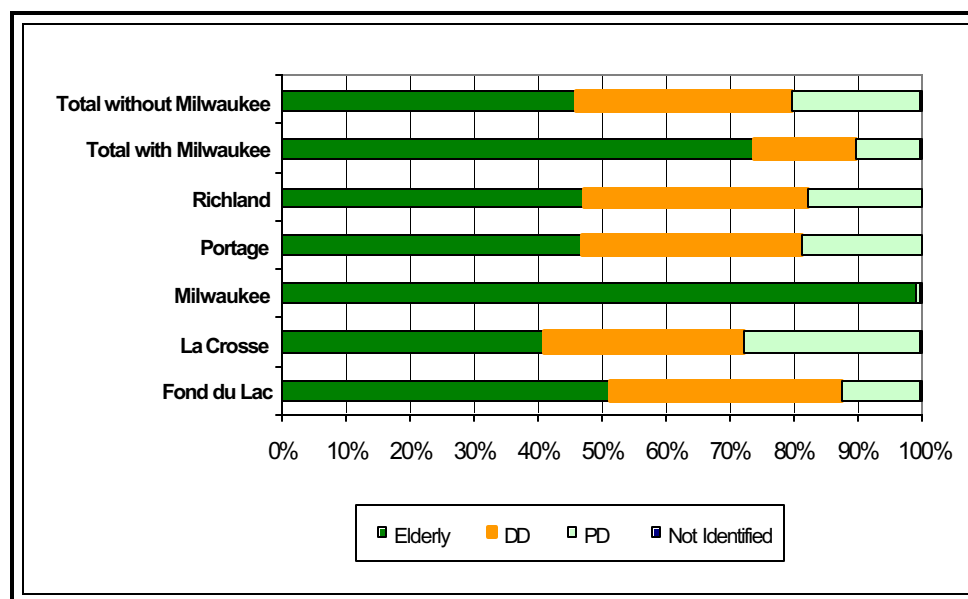
Source: The Lewin Group analysis of DHFS provided data.

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[7] *Family Care: A pilot program for re-designed long-term care. Progress Update.* May 2002. Department of Health and Family Services Center for Delivery Systems Development.

Resource Centers were designed to reach the general public and not just individuals seeking publicly-funded services. It has been argued that by receiving help with making effective long-term care choices, middle- and upper-income consumers and families will use their private resources more efficiently, thereby reducing the chances of exhausting all their resources and relying on publicly-funded services. By targeting non-Medical Assistance (non-MA) eligible individuals, the RCs play a critical role in shifting the point at which individuals receive timely information and potentially enter the service delivery system. No effective data collection means exist to capture the extent to which non-MA individuals use the RC. However, in the first quarter of 2002, 199 or approximately 1% of RC contacts were referred to private long-term care services.[8]

Non-MA individuals have had limited access to the Family Care benefit. As of March 2002, the vast majority (97%) of CMO enrollees were Medicaid eligible. Prior to the State's freeze on non-Medicaid enrollments in October 2001, the counties could enroll non-MA eligible individuals into Family Care. As of August 2002, counties were permitted once again to enroll non-MA individuals with a comprehensive level of care, as well as non-MA individuals, who have both an intermediate level of care and an adult protective services need. DHFS has instructed county staff to contact those individuals who were found functionally eligible for Family Care and who were then placed on waiting lists after October 2001. The lists, estimated at about 18 individuals in Fond du Lac, 15 in La Crosse, 125 in Milwaukee, 8 in Portage and 8 in Richland, might underestimate the true demand due to consumers' lack of incentive to complete the eligibility process only to be placed on a waiting list. DHFS reported that since the State has little experience in serving non-MA individuals, it was difficult to produce budget projections for this population. The initial decision to limit the enrollment of non-MA eligible individuals was reportedly dependent on available state funds rather than projected enrollment levels. DHFS hopes that additional funding in 2003 will allow counties to offer the Family Care benefit to all eligible non-MA individuals.

2.   *Timeliness of Receiving Family Care Benefit*

Our 2001 report indicated that pre-Family Care waiting lists in Fond du Lac, Portage, and La Crosse were eliminated and that these CMOs were beginning to enroll individuals who had not previously sought community-based long-term care services. Since then, Milwaukee reached the end of its COP waiting list in March 2002 and, in July 2002, caught up on its list of individuals waiting for a "needs assessment." Richland reached the end of the pre-Family Care waiting lists in July 2002. The elimination of waiting lists has allowed long-term care consumers more timely access to the service system compared to lengthy pre-Family Care waiting periods, lasting several years in some counties.

As seen in the *Family Care Timeline* (p. 8) all counties, with the exception of Portage and Milwaukee, instituted "delayed enrollment" at different points in time and under different circumstances. Delayed enrollment, as it differs from a waiting list in definition, is an administrative status indicating that individuals will begin receiving services soon after they are found eligible, but not immediately; a waiting list refers to the individuals who were waiting for

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8   From Quarterly Family Care Activity Report for the quarter ending March 2002.

community-based long-term care prior to Family Care. The counties used delayed enrollment and waiting lists in two different ways including:

- eliminating the pre-Family Care waiting list and then instituting a delayed enrollment plan due to a lack of staff capacity at the CMO; and

- instituting a delayed enrollment plan while also working on eliminating pre-Family Care waiting lists in order to slow enrollment and allow the CMO to become accustomed to its new role.

La Crosse and Fond du Lac eliminated delayed enrollment by October and December of 2001, respectively. By October 2001, only institutionalized individuals remained on Fond du Lac's plan since the county prioritized service delivery to individuals in the community at high risk of institutionalization. From the beginning of Family Care until July of 2002, Richland operated using delayed enrollment.

All counties, with the exception of Richland (expected January 2003), have reached "entitlement" (see *Family Care Timeline* p. 8). According to Family Care statutory language, entitlement is a program status all CMOs must reach after two years of operation. In order for a pilot to operate at entitlement, all persons financially and functionally eligible for Family Care must be offered the benefit, and enrollment in the CMO is required for individuals to receive home and community-based waiver services. Therefore, all pre-Family Care waiting lists and delayed enrollment lists must be eliminated to ensure timely access to the Family Care benefit for all eligible individuals, including institutionalized residents. Entitlement has never been required for non-MA individuals at the intermediate level of care without an adult protective service need.

Other programmatic changes since our 2001 report that had an impact on the timeliness of enrollment include:

- An independent enrollment consultant (EC) was added to fulfill federal requirements that someone independent of the county assist consumers in making informed decisions. It appears that the addition of the EC has minimally slowed the enrollment process, by one week at the most.
- A Web-based functional screen was introduced in October 2001 to allow RCs and CMOs to enter data and view the screen electronically by logging into a secure server. This offered an opportunity for increased efficiency and accuracy in transferring information about functional eligibility from the RC to the CMO. Prior to this programmatic change, RCs entered screen information on a select number of computers and sent the information in batches to the State. The county staff reported that the Web-based screen increases accuracy because inconsistencies and some inaccuracies can be automatically identified as the information is being entered.

3. CMO Disenrollment

Exhibit VI-4 shows that 348 or 9.9% of CMO members who were members on June 30, 2001 had disenrolled by June 30, 2002. Portage had the highest rate of overall disenrollment with 14% and Richland had the lowest with 4.1%. Across the CMO counties, approximately two thirds of the

disenrollments resulted from deaths, 21.8% voluntarily disenrolled, and the remaining 11.5% lost their eligibility primarily due to changes in their financial status.

Exhibit VI-4
CMO Disenrollment Among Members as of
June 30, 2001 through June 30, 2002

CMO Counties	Percent Disenrolled	Deceased	Lost Eligibility	Voluntary Disenrollment
Fond du Lac	12.5% (84)	63.1% (53)	7.1% (6)	29.8% (25)
La Crosse	9.2% (84)	66.7% (56)	11.9% (10)	21.4% (18)
Milwaukee	8.6% (115)	66.1% (76)	14.8% (17)	19.1% (22)
Portage	14.0% (58)	70.7% (41)	10.3% (6)	19.0% (11)
Richland	4.1% (7)	85.7% (6)	14.3% (1)	0.0% (0)
Total	9.9% (348)	66.7% (232)	11.5% (40)	21.8% (76)

Source: DHFS provided data based on the MEDS database as of August 31, 2002.

The lost eligibility category may over-represent the number of people disenrolled. The Client Assistance for Re-Employment and Economic Support (CARES) system will disenroll individuals who have not been re-certified within a year of first enrollment.[9] When individuals are automatically disenrolled by the CARES system prior to re-certification, the CMO loses the capitated rate for the month causing accounting and cash flow challenges. The CMO continues to serve the member throughout these disruptions in recorded enrollment, and the CMO receives compensation for those months when the automatic disenrollments are corrected.

Among members as of June 30, 2001, 2.2% chose to return to fee-for-service and forfeit services available through the waiver. These individuals were still able to access Medicaid-funded personal care services under the state plan or nursing facility care. Nursing facility representatives have claimed that Family Care members have been disenrolled when they indicate that they want to remain in the nursing home. A joint survey conducted by the Wisconsin Association of Homes and Services for the Aging and the Wisconsin Health Care Association (the not-for-profit and for-profit nursing home associations) indicated that, "Nine facilities reported instances in which their residents were disenrolled by the CMO because they expressed a wish to remain in the facility." The CMOs counter that there have been a few cases where an individual enters a nursing home for needed skilled care and subsequently the individual stabilizes to the point where the care management team develops a community-based service package that fulfills their care requirements. However, the nursing home resident or their family decides that they would prefer to remain in the nursing home. These disenrollments mean that individuals were able to exercise choice. However, they also mean that the CMO was no longer responsible for financing the individual's nursing home care. If

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[9] This was the case in the waiver programs prior to Family Care as well.

these types of disenrollment constitute more than an anomaly, it would have implications for the program's ability to be cost-effective. As part of our upcoming outcomes and cost-effectiveness evaluation report, we hope to be able to quantify the number of individuals who disenroll from Family Care while in a nursing home.

The CMOs are responsible for informing the RCs about member disenrollment. RCs must counsel Family Care members about long-term care options and grievance procedures before members disenroll from the CMO, either voluntarily or involuntarily, and then inform the CMO of the outcome. The disenrollment process had undergone revisions in some counties. In Fond du Lac, a new committee under the Quality Assurance Plan was created to evaluate the disenrollment procedures after problems were detected. For example, when a member chose to disenroll, the CMO had to refer the member back to the RC. A week or two often passed until the RC contacted the individual for choice counseling. In the meantime, the member's Family Care designation in the MA information system prevented any disenrolling individual from accessing MA fee-for-service providers. The committee developed a new disenrollment form and procedural flow chart for the RC and CMO staff to follow. Milwaukee reported that CMO staff had to learn that they were not responsible for disenrollment processing, and RC staff needed to learn to communicate the outcome of disenrollment interviews to the CMO.

B. Information and Outreach Activities

Aging and Disability Resource Centers continued to play a critical role for long-term care information and service seekers. In the five CMO counties, RCs are involved in outreach and intake related to the CMO benefit, as well as broader information and outreach efforts. In addition to the five counties that have CMOs, four other counties provide information and assistance through RCs.

1. Resource Center Contacts and Pre-Admission Consultation (PAC) Referrals

Examining the average monthly RC contacts per 1,000 people in the county provides an indication of the effectiveness of overall outreach. *Exhibit VI-5* shows that the average RC contacts per month for all of the RCs combined, increased slightly from the period of April 2000-March 2001 to the period of April 2001-March 2002. Except for Portage, all of the CMO counties experienced increases in the number of contacts. Richland, which began RC operations in November 2000, experienced the greatest increase in contacts per 1,000 (2.6 to 4.2). Trempealeau is the only non-CMO county to report an increased number of contacts. The Portage RC continued to report approximately nine contacts per 1,000 county population, in large part due to receiving voluntary PAC referrals from the county hospital even after the requirement was lifted in October 2000. The Portage RC also operates within a senior center and meal site, and therefore experiences more drop-in contacts than other counties.

Exhibit VI-5
Average Monthly Resource Center Contacts
per 1,000 County Population
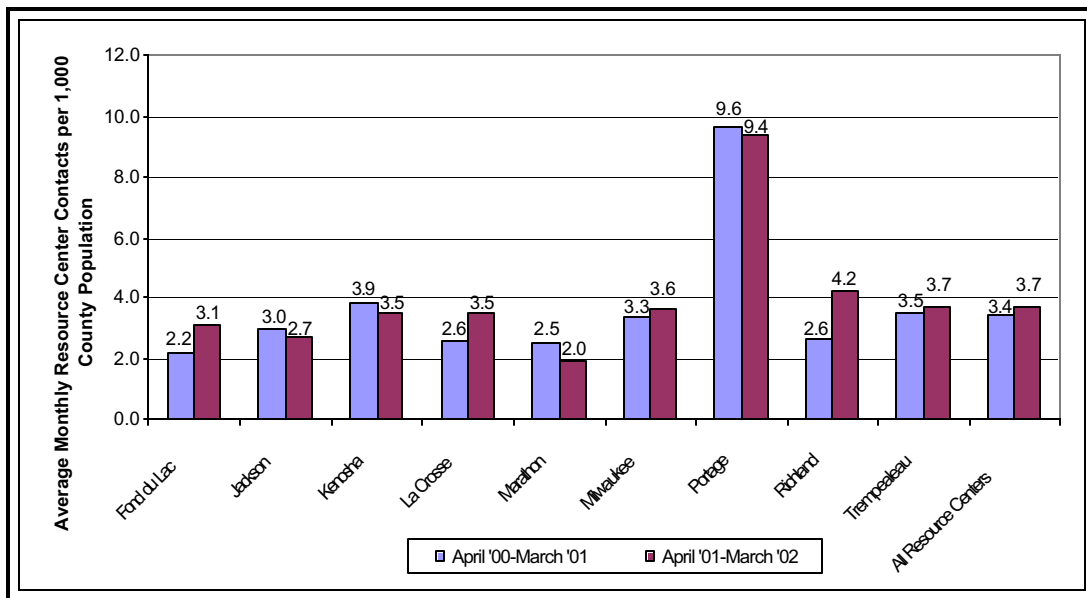
Over the course of program implementation, the Resource Centers have generally met or exceeded their contract goal of eight contacts per 1,000 target population each month. As presented in *Exhibit VI-6*, with the exception of Kenosha and Marathon for the DD population, during the first half of 2001 and 2002, all of the RCs met their contract goals of eight contacts per 1,000 target population. Overall, from 2001 to 2002, the number of contacts per 1,000 increased for each target population; however, besides Milwaukee, which only serves the elderly, no RCs increased the number of contacts per 1,000 for all of the target groups. The Kenosha Aging and Physically Disabled RC saw the greatest increase in contacts per 1,000 target population from 2001 to 2002 for the PD population, rising from 152.8 to 231.0. The contacts per 1,000 among the elderly ranged from 8.4 in Trempealeau to 21.8 in Richland, while among the DD population, the range was from 3.9 in Marathon to 36.4 in Trempealeau. The largest number of contacts per 1,000 was among the PD population, ranging from 37.4 in Marathon to 231.0 in Kenosha.

Exhibit VI-6
RC Contacts per 1,000 per Month
(January to June, 2001 and 2002)
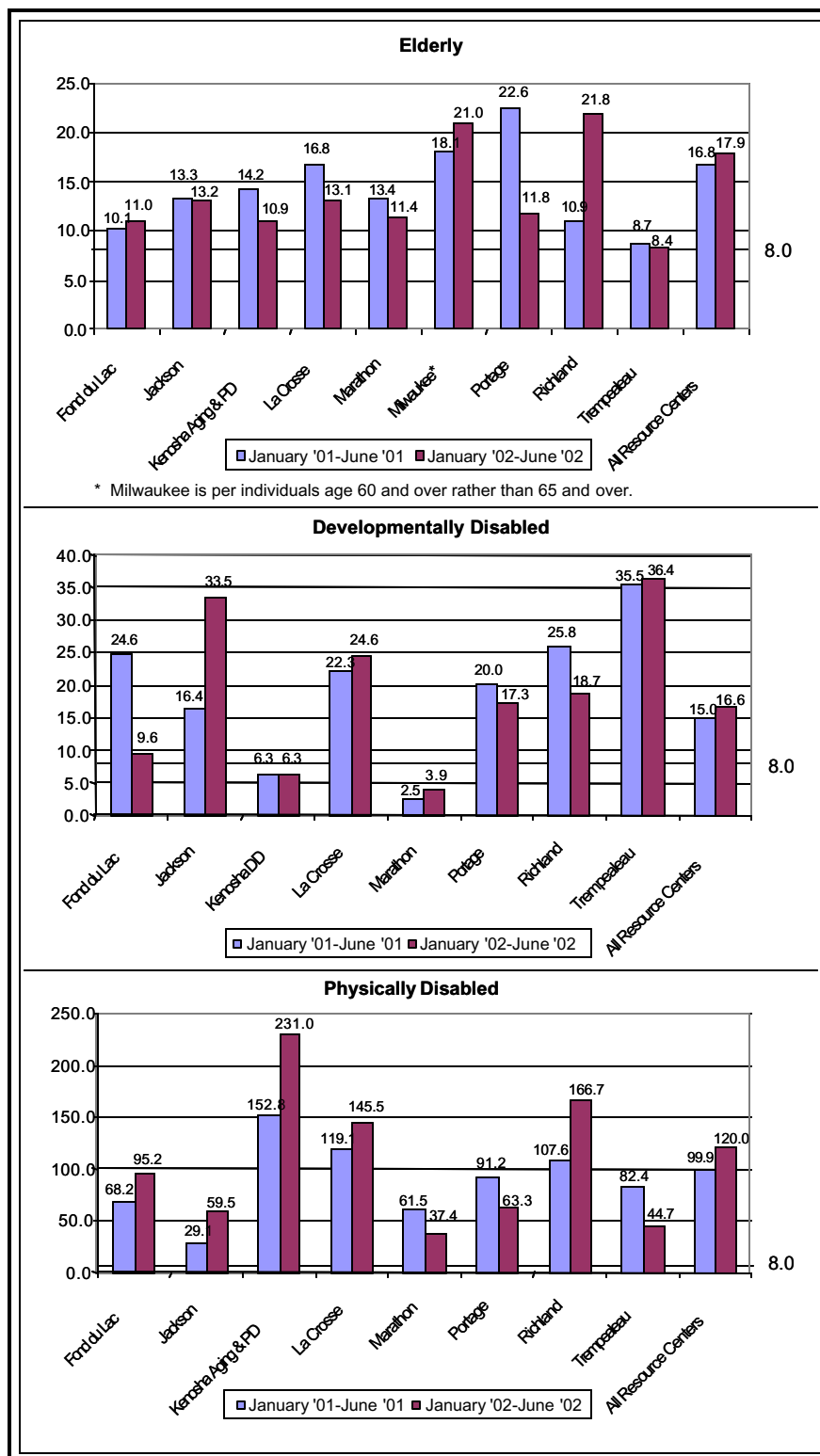
Source: DHFS-provided data based on County Resource Center reports

Exhibit VI-7
Quarterly PAC Referrals, by Facility Source,
April 2001 to March 2002
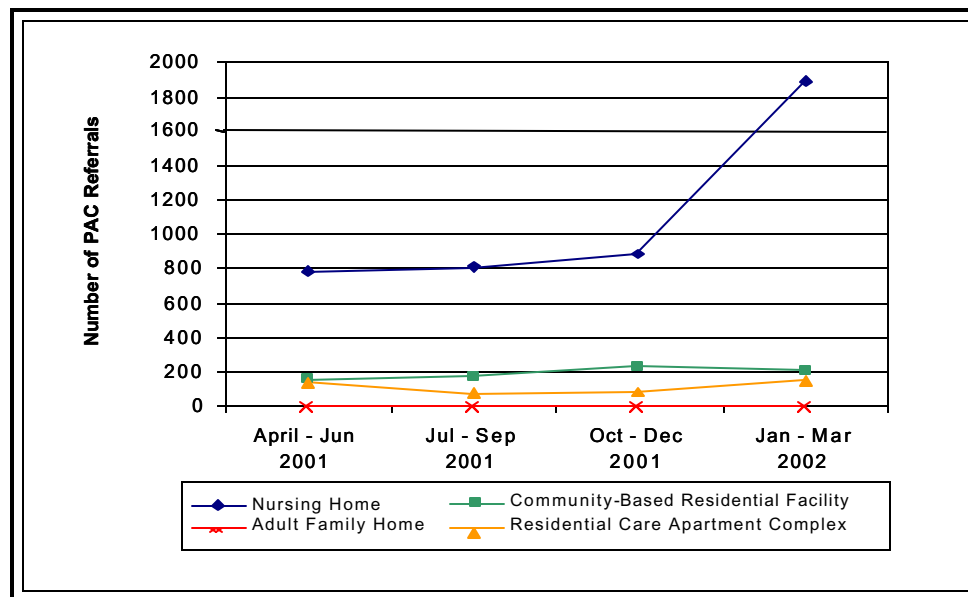
Source: DHFS Quarterly Family Care Activity report, 1st Quarter 2002.

RCs continued to receive pre-admission consultation (PAC) referrals from certain facility and residential providers when an individual with an expected long-term care need of 90 days or more sought admission. *Exhibit VI-7* shows a significant increase in referrals from nursing homes during the first quarter of 2002. In late 2001, the Department increased its efforts to educate nursing homes about the potential enforcement of the PAC requirement. Additionally, state Bureau of Quality Assurance (BQA) began enforcing the rule by asking facilities about PAC during site-reviews. *Exhibit VI-8* presents the PAC referrals received by each county over the most recently reported quarters and indicates that Milwaukee dominated the increase in PAC referrals from nursing homes. DHFS notes that, despite instructions to report PAC referrals separately from Information and Assistance (I&A) contacts, they believe that some counties may be reporting them separately as PAC referrals and also counting them among I & A contacts.

Exhibit VI-8
Quarterly PAC Referrals, by County, April 2001 to March 2002
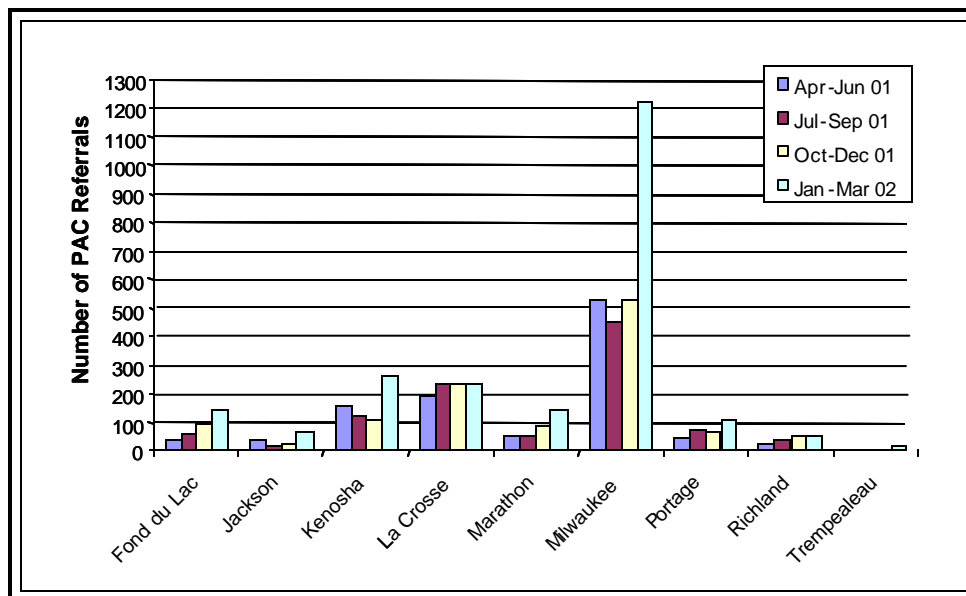
2.   *Resource Center Requests and Outcomes*

The majority of information sought from RCs continued to be: 1) basic needs and general benefits, 2) disability and long-term care related services, and 3) long-term care living arrangements. Most consumers requesting information and assistance from the RCs were given information about long-term care services or resources, or referred to services or resources other than emergency, adult protective service, and long-term care. The RC activities have remained stable largely because the RCs have been operational since late 1998 (with the exception of Richland, which began in November 2000). All counties must report minimal information regarding the source of contact (i.e., self; relative, guardian, friend/neighbor, community member; agency, service provider, official; and unknown/anonymous). Fond du Lac also began to track referral sources by location (area within county, other counties in Wisconsin, and out-of-state). Tracking sources at this level will likely enhance efforts to conduct targeted outreach.

On average, 13% of all of the RC's contacts were referred for the long-term care functional screen from July 2001 through March 2002.[10] ***Exhibit VI-9*** presents the distribution of initial functional screens completed across counties by Family Care target population from the most recent quarter reported. Not represented in the exhibit (due to relatively large numbers) is Milwaukee's screening activity during this quarter, in which 1,328 functional screens for the elderly, 1 for a developmentally disabled consumer, and 8 for physically disabled consumers were completed.

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[10]   Lewin analysis of data taken from DHFS Family Care Activity Reports, Qtr. 3 2001, Qtr. 4 2001, and Qtr. 1 2002.

Exhibit VI-9
Initial Functional Screens Completed, by Target Population,
January to March 2002
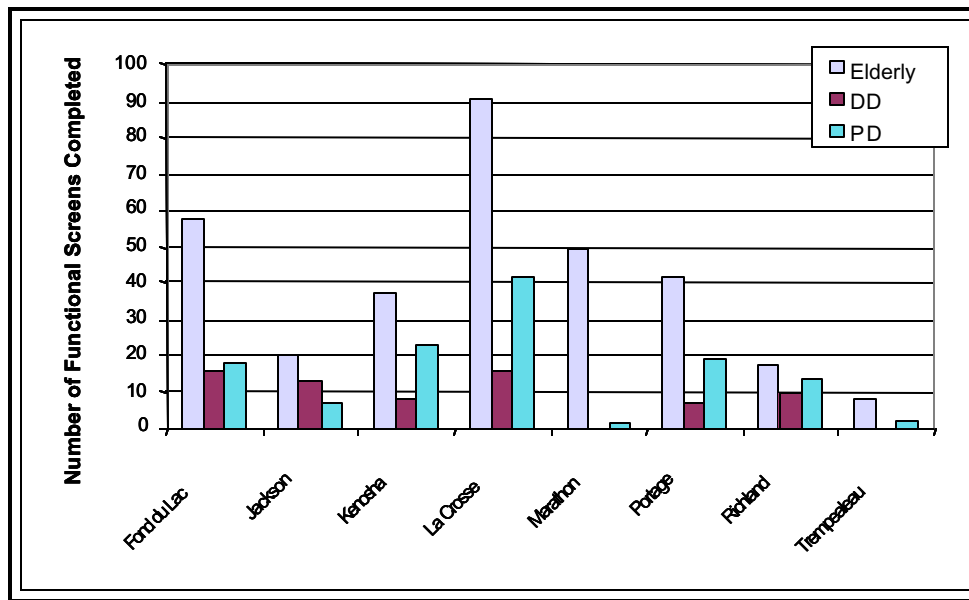
Source: DHFS Quarterly Family Care Activity Report, 1st Quarter 2002.

3. *Outreach Activities*

By May 2001, increased screening activity and limited financial resources had prohibited the RCs from conducting as much outreach as anticipated. The additional funding appropriated in the State's 2001-03 biennial budget allowed RCs to increase their efforts in marketing and outreach activities. *Exhibit VI-10* details the various outreach activities that counties engaged in from April 2000 to March 2001 compared with April 2001 to March 2002, as reported in the RC quarterly reports.

Exhibit VI-10
Resource Center Outreach Activities,
April 2000 to March 2001 and April 2001 to March 2002

Outreach Strategy	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02
General Public																		
RC Literature	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Directory of Services			●	●	●	●			●	●								
Community Presentations	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Presence at Health Fairs	●	●				●		●	●	●		●	●			●		●
Gatekeepers – accountants, grocery, movies, paramedics		●						●		●				●				
Web site	●	●			●	●			●	●	●	●	●	●		●	●	●
University/ College						●						●	●					
Media																		
Radio		●	●	●									●	●	●			●
TV Ad/ Interview Show			●	●			●	●				●					●	●
Newspaper Ads			●	●			●	●						●		●		●
Newspaper Articles	●	●		●	●	●								●		●		●
Targeted Outreach																		
Flu Shots		●								●								●
Hmong Elders Focus Group							●	●										
School System	●				●		●	●								●		●
Provider Presentations (Group)		●	●					●		●					●	●	●	●
Provider Meetings (Individual)	●	●					●	●		●		●	●			●		●
Rural areas		●				●				●								

Source: Quarterly reports submitted by Resource Centers.

During both time periods, every RC provided outreach in the form of literature, such as pamphlets and brochures, which were often distributed at health fairs and other community presentations. Fond du Lac also provided them to individuals receiving home-delivered meals, and Kenosha sent 5,000 brochures to retirees through a United Way mailing. Over time, the RCs expanded their use of media outlets to disseminate information to the community about Family Care. For example, five RCs (Jackson, La Crosse, Portage, Richland, and Trempealeau) reported advertising Family Care in local newspapers, compared to only two RCs previously (Jackson and La Crosse). In addition to using newspaper advertisements, the Portage and Trempealeau RCs also added radio advertisements to their outreach efforts from April 2001 to March 2002. Fond du Lac also added ratio advertisement during the same period. Four RCs (Jackson, La

Crosse, Milwaukee, and Trempealeau) used television advertisements and interviews to inform target populations.

Counties have been experimenting with different outreach strategies. Staff in Fond du Lac, for example, initiated an effort in 2002 to offer information and assistance at two senior centers on one day each month in rural areas - Ripon Senior Center and Waupun Senior Center. They plan to continue this effort through another six months and attempt to assess its effectiveness. Fond du Lac and Richland also partnered with paramedics to identify potentially eligible persons. County outreach activities and associated data collection are still being developed and have not yet been evaluated for effectiveness.

During the six months following full entitlement accordance with sec. 46.283 (4) (e), Wis. Stats., pilot county RCs must conduct outreach to inform residents of long-term care facilities about Family Care and assist them in applying for the Family Care benefit. The counties have been timely in instituting this outreach to residents of long-term care facilities. Fond du Lac began resident outreach activities in March 2002, La Crosse and Portage in April 2002. Milwaukee's outreach efforts have already begun and were expected to increase once entitlement was reached in July 2002. Some RCs felt that the new requirement for resident outreach will help identify more of the short-term nursing facility residents who do not have to be referred for pre-admission consultation (PAC). This might prove effective in intervening at a critical decision-making period for that individual and family and increase receptivity to information about long-term care service options. However, the new resident outreach plan will likely have little immediate impact in Portage and Richland since facilities in these counties were referring *all* residents for PAC since the beginning of the program. Efforts to perform outreach to nursing facilities will likely increase public awareness of the Family Care benefit over time. Outreach to institutionalized residents will be evaluated by DHFS and the RCs. They plan to examine the effectiveness of the outreach in providing information to residents and in enrolling consumers in a CMO by measuring cost, number of contacts, and number of enrollments.

4. Prevention Activities

At the time of our 2001 implementation report, RCs in the counties operating CMOs were focused on enrollment activities and unable to focus on prevention. Since then, these RCs increased their number of FTE staff and have been actively engaged in specific prevention activities. RCs provided a range of activities related to health promotion, disease prevention, and safety.

a. Health-related

Vision, blood pressure, hearing, and bone density screenings were common prevention activities occurring at a variety of events, including congregate meals and health care information sessions. Jackson, for example, offered monthly information sessions on topics ranging from nutrition and fitness to the aging process and elder abuse. Richland provided a monthly health bulletin including such topics as macular degeneration and hypothermia/frostbite. Portage offered an 'Ask Your Pharmacist' session during which individuals received information on prescription and over-the-counter medications. In addition, they partnered with the American Red Cross to provide a first-aid seminar, and offered a stroke prevention session.

> ### b. *Safety Promotion and Falls Prevention*

Portage worked with AARP to offer the '55 Alive' defensive driving course and Marathon partnered with the Neighborhood Watch to educate individuals on crime prevention. Several counties were involved in specific falls prevention initiatives. The 2001 Jackson "Falls Prevention Program" grant led to the development of an exercise group whose members reported increased flexibility and decreased falls. Milwaukee also started several fitness centers through the donation of used gym equipment to prevent falls. Richland provided home safety assessments to identify and remove obstacles leading to falls. Kenosha developed marketing materials for a Falls Prevention Study including a Falls Prevention Study flyer, a letter of intent to medical professionals, and an article for media submission. For more information about prevention efforts by the CMOs, see *Chapter VII: Care Management, Consumer Direction, and Quality.*

C. Service Availability

Resource Centers and CMOs continue to seek additional service resources for individuals.

> ### 1. *Provider Information at the RC*

The RCs continue to play a critical role in identifying, tracking, and disseminating provider information to long-term care consumers. RCs tailor information to the unique aspects of each community. Compared to our initial implementation evaluation in 2000, the RCs in Fond du Lac and Portage track a broader range of service providers. Additional types of services tracked include respite, therapies, interpreter services, and daily living skills. With the exception of the addition of the Disability Benefit Specialist (see *Chapter IV: Infrastructure Development*), RCs did not report any major operational changes related to information and referral from 2001 to 2002.

> ### 2. *Provider Networking at the CMO*

CMOs continued to expand provider availability by procuring formal contracts with providers to form the CMO provider network and by purchasing services without formal contracts with providers outside of the network. The number of providers under contract with the CMOs in Fond du Lac, La Crosse, and Portage increased by 24%, 16%, and 36% respectively, from May 2001 to May 2002 (see *Exhibit VI-11*). Change over time could not be calculated for Milwaukee and Richland due to the methods used for data collection and provider contracting practices.

As noted in our 2001 report, Milwaukee and Richland indicated that the number of providers they contract with does not accurately reflect the options available to Family Care members. It appears that the number of providers in Richland decreased by 34%, as shown in *Exhibit VI-11*, even though Richland noted they did not experience a decrease in provider availability. Richland indicated that they also obtain services with providers outside of the formal network. Further, staff turnover in Richland's provider network developer position prevented confirmation of 2001 numbers. They noted that the contracting process was cumbersome, particularly for "one-time" service provision. The current Richland provider network developer obtained special permission from DHFS to use limited purchase agreements. Other counties

also expressed that they do not procure contracts with every provider. In Milwaukee, the provider network developer did not feel that the number of contracts reflected CMO capacity because the CMO will contract with providers selected by the consumer. Milwaukee CMO staff report that they have expanded the services offered to include specialized services such as acupuncture and massage therapy.

Exhibit VI-11
Number of Providers Contracting with the CMO,
by Type of Service, May 2001 and May 2002

Type of Service	Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
	May 2001	May 2002	May 2001	May 2002	May 2001	May 2002	May 2001	May 2002	May 2001	May 2002
Adaptive Aids	1	5	3	3		[c]	6	6	27	22
Adult Day Care	1	3	8	8		19	2	1	9	4
Adult Family Home	17	28	128	156		26	29	38	30	30
Assisted Living Facility	3	3	4	4		6			5	3
Care Management	1	1	1			20	2	1	8	1
CBRF	23	22	19	16		124	17	19	17	14
Chore Services	4					[c]				
Congregate Meals	1	1	2 (many sites)	1		2 (20 sites)	1	2	1 (6 sites)	
Daily Living Skills	8	12	5	5		10	5	4	1	2
Day Services/ Treatment	5	9	4	5		[c]	2	2	2	2
Employment-Related [a]	9	6	3	2		[c]	6	5	9	4
Guardianship/Money Management		2	4	4		4	1	1	2	3
Home Care (Medical & Supportive)	31	38	8	14		33 [c]	7	11	29	12
Home Modification		3	various	various		6	1	1	12	9
ICF/MRs		1		1		c		3		4
Interpreter Services		[b]	2	4		2	2	2	1	
Meal Delivery	5	5	3	7		2	2	6	4	3
Medical Equipment/Supplies	28	43	17	18		8 [c]	6	6	13	24
Mental Health	4	5	5	6		4 [c]	6	5	4	4
Nursing Facility	11	9	11	11		22 [c]	6	8	12	10
Recreation/Alternative Activities	6					[c]				
Rehabilitation/Therapy	6	10	9	11		[c]	6	7	39	8
Respite Care	10	12	4	3		[c]	14	38	34	25
Speech & Language Path.	5	6	7	7		[c]	4	5	6	6
Substance Abuse	1	5	3	4		2 [c]	2	2	11	2
Transportation	10	12	8	9		12 [c]	6	6	22	8
Total	**195**	**241**	**258**	**299**		**[d]**	**132**	**179**	**301**	**200**
Percent of Change	**24%**		**16%**				**36%**		**-34%**	

[a]   Includes supported employment and sheltered workshop.
[b]   Fond du Lac obtains these services from the county.
[c]   Milwaukee will accept any certified Medicaid and Medicare providers for this service.
[d]   Unable to calculate total for Milwaukee due to the numerous categories in which any certified Medicare or Medicaid provider was accepted.

Source: Data provided by counties in May 2001 and May 2002. Milwaukee 2001 information not available. Lewin did not ask counties to provide numbers of ICF/MRs in 2001.

Note: The total number may not represent the total number of contracts that the CMO has because some providers may be counted twice if they provide more than one service type.

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The expansion of provider networks varied among counties by the type of provider. Noteworthy increases in provider contracts included:

- Fond du Lac – adaptive aids, adult day care, adult family home, daily living skills, day services, home care, medical equipment/supplies and rehabilitation/therapy providers.

- La Crosse – adult family home, home care, interpreter services, and meal delivery.

- Portage – adult family home, home care, meal delivery, and respite care.

Despite the general trend of expanding the number of providers in the network, some significant decreases in providers also occurred. For example, employment providers in Fond du Lac decreased from nine to six providers. The CMOs attributed this decrease to the transition of CMO members from outside the county back to Fond du Lac, eliminating the need to contract with additional providers outside the county. Additionally, some CBRFs in La Crosse converted to adult family homes.

CMOs noted additional increases in service availability not observed by examining the number of providers in the CMO network. Some ways in which service capacity has increased included:

- A daily living skills provider expanded their service offering to include a new recreational service for Family Care clients to help individuals integrate into the community through a smaller, more flexible program. They purchased a van and were authorized to provide transportation as part of the recreation service expense.

- Family Care consumers have increased access to over-the-counter medicines and adult pull-ups (an alternative to traditional adult diapers) through medical supply vendors.

- Counties reported an increase in the number of individual service providers available to serve Family Care members. These providers were most often independent contractors selected by the CMO member (e.g., friends and family members who provide services and receive payment from the CMO).

- In La Crosse County, parents of a group of consumers with developmental disabilities worked with the CMO to find a provider to develop a day center.

Many of the providers interviewed felt that there was healthy market competition. Potentially as a result of this competition, most of the providers voiced disappointment in not receiving increased referrals. However, some providers felt that CMOs used "preferred providers" rather than giving consumers "a real choice." The few providers that experienced increased business under Family Care hired additional staff to meet the demand. All but one provider expressed interest in staying on as a provider under Family Care.

While the counties have focused on several service areas that lacked sufficient providers, they have yet to systematically assess the need to expand their networks in response to growing enrollment. During the annual 2001 quality site review, DHFS found that the CMOs in Fond du Lac, La Crosse, and Milwaukee did not have processes in place to assess future needs for provider network expansion. Portage CMO had begun to analyze service patterns through the use of historical HSRS data and projected enrollment figures to estimate future need in their provider network. In 2003, DHFS plans to use funds from a CMS Medicaid Infrastructure Grant,

Brides to Work, to identify gaps in the provider network of each CMO and help them with capacity building.

3. *Community-Based Alternatives*

Approximately 5% of Family Care members reside in nursing facilities. The pilot counties report institutional relocations to DHFS quarterly. Since the start of 2001, 123 Family Care members were relocated from nursing facilities to alternative community settings (see *Exhibit VI-12*). This count excludes Richland County because they did not begin tracking relocations until August 2002. However, the quality of the data collection and definition of a relocation differ by county. Some CMOs define a relocation as a move to a community setting by a CMO member residing in a nursing home for any length of time. Other CMOs expand the definition to include individuals new to Family Care who relocate upon enrollment into the program. Other counties consider these individuals as nursing facility diversions, which are an estimate of the number of individuals for whom Family Care enrollment prevented institutionalization rather than relocation. Other counties consider all individuals enrolled in the CMO as institutional diversions, but do not report them as institutional relocations.

As a result, facility closings do not appear to have a direct impact on the reported relocations, particularly in Milwaukee. In 2000, three facilities with a total of 684 beds closed in Milwaukee, but the CMO did not track relocations in 2000. Milwaukee lost 557 beds from four facility closings in 2001 and reported relocating 20 individuals. As of April 2002, Milwaukee County experienced two closings with a total of 173 beds and had no relocations during 2002. Additionally, CMO staff reported that they do not feel they have recorded the total number of relocations. In 2001, La Crosse lost 94 beds from one closing and relocated 64 people into the community. Unlike the other counties, Fond du Lac has consistently relocated a few individuals each quarter. Family Care members may also reside in nursing facilities outside of the county. Though there is only one nursing facility in Portage County, two facilities in neighboring counties closed in 2001 (109 total beds). They relocated 14 individuals in 2001.

Exhibit VI-12
Institutional Relocations

Year	Quarter	Fond du Lac	La Crosse	Milwaukee	Portage	Total
2001	Jan - Mar	2	14	6	2	24
	Apr - Jun	3	20	14	1	38
	Jul - Sep	2	12	0	1	15
	Oct - Dec	2	18	0	9	29
2002	Jan - Mar	2	12	0	3	17
Total		**11**	**76**	**20**	**16**	**123**

Source: CMO Quarterly Narrative Reports and correspondence with pilot county staff.

Note: Richland did not track relocations.

Some providers, particularly nursing facility administrators, assert that Family Care has not significantly altered the existing trend to promote community living. They indicated that the nursing facility industry in Wisconsin remains focused on transitioning individuals into the community and that facilities continue to have a discharge plan in place for each resident. In a Wisconsin Association of Homes and Services for the Aging (WAHSA) and the Wisconsin

Health Care Association (WHCA) survey of nursing facility administrators, and Family Care counties with a CMO, 33 administrators indicated that 115 residents were relocated. Of the relocations, the administrators reported only 21% occurred prior to the date originally posted by the facilities' discharge plan.

Family Care counties reported increased community residential options for members. The CMO in Fond du Lac reported a 25% increase in the number of residential beds for the elderly in the last year. In response to consumer requests for greater privacy, the size of CBRFs in Fond du Lac was reduced to four beds, allowing members to have private rooms. La Crosse added 28 adult family homes to their network. The CMO in La Crosse noted that at least 40 Hmong homes have been certified as adult family homes in the network so that Hmong families can care for their older members in a more culturally appropriate way.

CMO representatives noted specific service gaps in meeting the full range of need. It is the responsibility of the CMO provider network developer to identify and address gaps services. Fond du Lac reported a need for more accessible housing and CBRFs willing to serve medically-complex cases. La Crosse identified unmet need in the areas of RCACs, CBRFs, and supported employment for adults with developmental disabilities. Also, some providers felt that adult foster care is utilized more in non-Family Care counties.

D. Administrative Issues

The CMOs faced provider administrative issues related to communication with providers and prior authorization.

1. Communication Issues

Overall, most of the providers reported that the CMOs were responsive to both providers and consumers. Most providers spoke positively about their interactions with their respective network developer and many of the care managers. However, many providers expressed a need to improve communication. They noted two areas of concern: 1) providers had to initiate contact with the CMO to get updates on administrative and care planning matters, rather than the CMO keeping the provider in the loop, and 2) providers were confused about the CMO's expectations. Several CMO representatives, consumers, and providers noted confusion, in part due to a lack of clear communication regarding the population served jointly by CBRFs and adult day services. CMOs terminated adult day center services for some CBRF residents because day activities are included in CBRF contracted services. The Milwaukee CMO planned to hold a discussion group with adult day service and CBRF providers to improve coordination and seek innovative approaches to coordinating their functions.

CMOs conducted provider trainings on topics, such as the Resource Allocation Decision (RAD), method disease management, and billing. In two counties, the providers participate in ongoing meetings with other providers and the network developer to share information and learn from one another. Some counties also offered provider training after identifying issues needing improvement after the first round of member outcome interviews. (Member outcome interviews will be discussed in more detail in *Chapter VII: Care Management, Consumer Direction, and Quality*). However, several providers in a few CMO counties reported that they received an initial introduction into Family Care but then no follow-up information. CMOs,

providers, and consumers could benefit from clearly defined and continuously reinforced roles and expectations.

Providers had differing levels of familiarity with the county Resource Center. Some reported that they made referrals to the RC when appropriate. Some were just aware that the RC disseminated the providers' brochures. And some had not heard of the RC. Because providers are intimately involved with consumers and their families, they provide a critical connection to long-term care services for existing and potential consumers. A greater understanding of the function of the RC and the role that providers can play in communicating with the RC would be helpful for the Family Care providers and the RC.

2. Prior Authorization and Billing

Most of the providers interviewed in May 2002 indicated satisfaction with the authorization process. Though many found the process to be cumbersome, they noted that accuracy had improved since April 2001. Providers generally received a verbal referral followed up by a written authorization. A few providers reported that they do not receive authorizations in a standard format, which they found burdensome. In two counties, several providers indicated that the authorization list sent by the CMO is routinely outdated and requires follow-up to resolve. In general, they were pleased with the improved speed in which consumers are authorized to receive services as compared to the non-Family Care system. Most CMOs have eliminated prior authorization for small items such as disposable medical supplies (DMS).

It appears that most of the problems that providers experienced with denials for payment during 2000-2001 have been resolved. Many providers made adjustments to their processes to avoid denials and promote timely payment. Some noted that billing was still a manual process and that converting services to billing codes can result in human errors. Billing cycles ranged within and across counties from 15 days to two months. Most providers reported claim payment between 30 to 60 days from submission.

VII.   CARE MANAGEMENT, CONSUMER DIRECTION, AND QUALITY

The pilot counties continue to implement the care management, consumer direction, and quality components of the Family Care model. Family Care involved a substantial overhaul of the existing system of long-term care service delivery in these areas. The CMOs have begun to adopt an entirely new culture of care management practice with Family Care. This new practice demanded the formation of care management interdisciplinary teams and monitoring of caseload size and structure. This section highlights the progress of these changes, strategies the CMOs have employed to balance consumer direction and cost, including the use of the Resource Allocation Decision (RAD) method, consistency across interdisciplinary teams, prevention strategies, the self-directed support option, and quality initiatives. We also detail internal and external advocacy activity. While all of the counties have moved beyond the initial start-up phase, the CMO counties still have progress to make before realizing the full intention of the Family Care model.

A.   The New Culture of Care Management

The counties have gradually begun to implement structural and procedural changes to adopt the care management philosophy of Family Care. As shown in ***Exhibit VII-1***, adopting this new philosophy marked a major shift in county practice.

Exhibit VII-1
Comparison of Traditional Case Management with
Care Management Philosophies under Family Care

Old System/ Case Management	Family Care / Care Management
Service focused	Outcome focused
Primarily considers social and functional needs and finances	Considers the whole person including preferences and physical health
Care decisions made at management level	Care decisions made at the consumer/care manager level
Groups consumer need into specific service categories	Services are person-centered
One social worker	Interdisciplinary team (consumer, provider, RN, family members, social worker, etc)
Matches available services to consumers	Examines strategies about the most appropriate ways to meet consumer needs
More service = better service	More services are not always the best way to meet consumer need
Allows providers discretion over number of hours or amount of service	Exerts pressure on providers to provide only needed services
Does not consider prevention	Includes prevention activities

Source: Derived from DHFS Family Care Case Management Orientation Manual compiled by the Wisconsin Center for Excellence in Long-Term Care, University of Wisconsin School of Nursing, January 2002.

Case management, as defined by previous county programs, involved the brokering of services by a single social worker. This approach centered on grouping consumer need into specific, pre-defined service categories. In contrast, care management or support coordination under Family Care is a strategy for balancing consumer preference and cost through addressing the core issues facing consumers. In this model, care management is an organizational approach to control costs, facilitate consumer direction, and consider acute and primary care needs. Family Care care management focuses on the unique needs of the individual and involves a holistic approach by the use of an interdisciplinary team, consisting of the CMO member (consumer), social workers, RNs, providers, and family members.

Progress has been made since our 2001 update report, but because care management in Family Care requires such a shift in practice, infrastructure, and philosophy, the pilot counties are still in an elementary stage of adapting to this model. DHFS continued to support the adoption of the new culture during the past period by devoting resources to both training the care managers and influencing the administrative procedures that support the goals of care management (e.g., expanding the range of staff taking RAD method training). DHFS set up a state-wide care management workgroup for pilot county staff to collaboratively develop techniques for implementing the care management model in practice. This group has been meeting for the past two years.

Under a Robert Wood Johnson Foundation grant, DHFS established the Wisconsin Center for Excellence in Long-Term Care in partnership with the University of Wisconsin School of Nursing to support all Wisconsin long-term care programs. The Robert Wood Johnson Foundation provided $98,638, which was matched by Medicaid to provide a total budget of $197,276. The Center enabled the development of a "Case Management Orientation Manual," which includes information on consumer outcomes, interdisciplinary teams, assessment, person-centered planning, the RAD method, risk taking, and mediation. The Center for Excellence in Long-Term Care has applied to the AARP to develop geriatric courses for the University of Wisconsin's Nurse Practitioner program. Additionally, DHFS has applied for a Best Practices grant from the Center for Delivery Systems Development Medicaid Managed Care Program to fund the development of best practice guidelines for working with consumers labeled as non-compliant.

B. Interdisciplinary Teams

The CMOs created interdisciplinary teams early in the program implementation and initially focused on the respective roles of social workers and RNs and the demands of converting to the new system. During this past year, counties continued to perfect procedural practices of the teams to improve decision making. This was done, for example, by providing training on how to use the RAD method in an interdisciplinary fashion, conducting collaborative and comprehensive assessments and planning.

No significant changes have occurred in the staffing structure of the care management interdisciplinary teams. Since our 2001 report, the CMO contract added the member or consumer explicitly to the interdisciplinary team, which consisted of a social service coordinator (social worker) and an RN. All the counties are in compliance with this requirement. Under Family Care, RNs have an important role in assessing health needs, incorporating preventive measures, monitoring health, integrating social supports with medical needs, and coordinating

care with other medical providers. Together with the social worker, they work to best meet consumers' preferences and medical, psychological, and social needs.

The team may also include family members that the members elect and any providers who may be involved. However, it appears that consumers, families, and providers have yet to be fully integrated into the interdisciplinary team decision-making processes. Advocates indicated that consumers have limited involvement in the care planning processes. They felt that consumers merely signed-off on their care plans instead of actively participating in care planning.[11] Some providers also indicated that many consumers did not have a basic understanding of the program or that they were a part of the CMO. DHFS continues to monitor the CMOs' use of the member-centered plan, a fluid document which records client strengths, resources, skills, desired outcomes and steps to achieve them. DHFS reviews member-centered assessments and plans on a quarterly and annual basis. The review process includes reviewing a sample from each CMO to determine the quality of the collaborative assessment and planning process with the member, and the extent to which the member's preferences and desires appear in the written plan. DHFS identified a need to improve consumer involvement in care planning for some of the counties.

Similar to our 2001 update, many providers indicated that they were not involved in the care planning process. Clearly, the providers who were involved in the care planning process were the most informed of consumer preferences and the overall goals of the Family Care program. Providers of home care and daily living skills expressed the most interest in participating in the care planning process, including receiving a copy of the member-centered plan. A few of these providers stated the they "operated in a vacuum" and were "an afterthought." Durable medical equipment (DME) and disposable medical supply (DMS) providers did not have an interest in receiving plans.

C. Caseload Size and Structure

As reported in 2001, social worker caseloads have decreased under Family Care. Between May 2001 and May 2002, the CMOs continued to define a comfortable staffing level—one that would ensure individualized consumer attention for optimal service. Fond du Lac and Richland have met their caseload goals for all target populations, and Portage has met its goal for developmentally disabled members, as shown in *Exhibits VII-2* and *VII-3*.

The CMOs in Fond du Lac, La Crosse, and Milwaukee, increased caseload goals in the elderly and physical disabled populations from 2001 to 2002 (see *Exhibit VII-2)*. Increased familiarity and experience with the Family Care processes allowed them to make such changes. However, the goals have all remained between 35 and 45 individuals per social worker across counties. Portage was the only county to decrease its caseload goal from 45 to 36.

In 2002, actual caseloads ranged from 30 to 50 consumers for the elderly and physically disabled populations. From 2001 to 2002, actual caseloads increased in La Crosse and Portage, decreased in Fond du Lac and Richland, and remained the same in Milwaukee. In 2001, Richland and Portage were the only counties meeting caseload goals for older individuals and those with

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[11] The federal 1915 b/c waiver requires that a member sign the individualized service plan (ISP) any time it is changed.

physical disabilities, while in 2002, Richland and Fond du Lac were the only two CMOs meeting their caseload goals. Portage is no longer meeting its caseload goal because the CMO decreased the target from 45 to 36 members per social worker.

Exhibit VII-2
Social Worker (SW) Caseload for Elderly and
Physically Disabled Members, May 2001 and May 2002
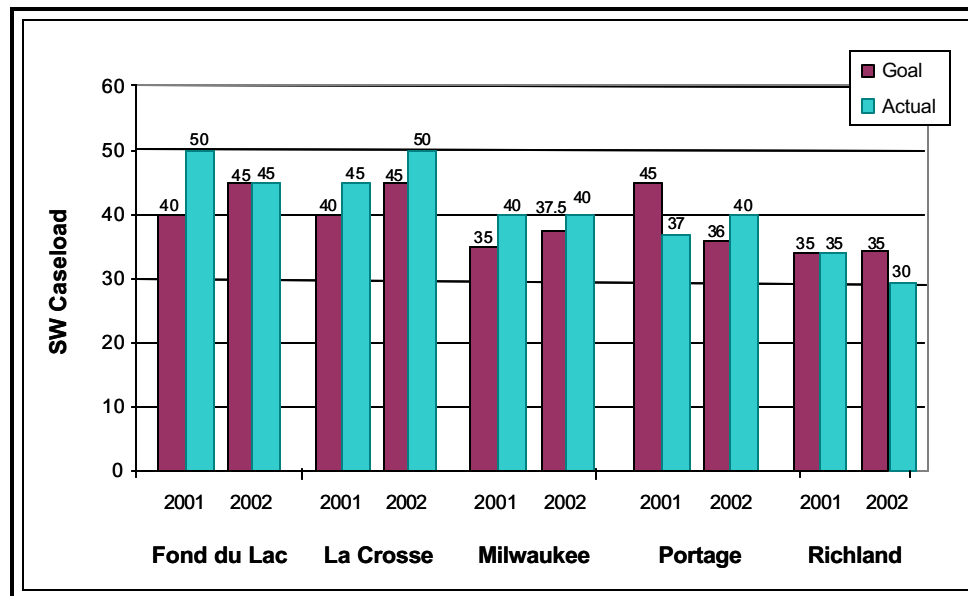
Source: Average caseloads reported by CMO staff in May 2001 and May 2002.

For the developmentally disabled population, the social worker caseload goal remained relatively unchanged from 2001 to 2002, with only Fond du Lac increasing its caseload goal from 40 to 45 (*Exhibit VII-3*). Actual caseloads for the DD population decreased in all counties except La Crosse.

Exhibit VII-3
Social Worker (SW) Caseload for
Developmentally Disabled Members, May 2001 and May 2002
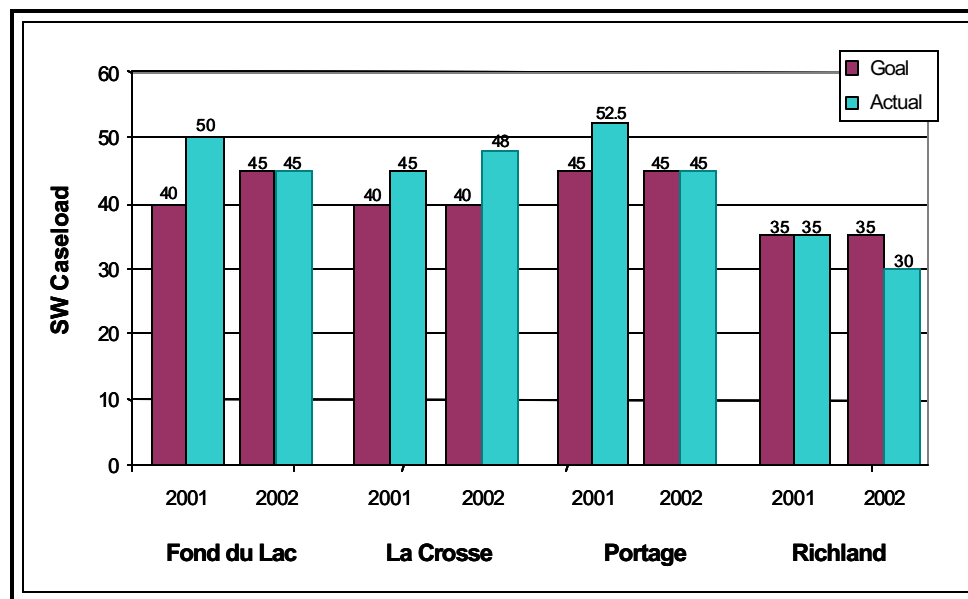
Source: Average caseloads reported by CMO staff in May 2001 and May 2002.

While in 2001 Richland was the only county meeting its caseload goal for the DD population, in 2002, all the counties except La Crosse were meeting their caseload goals for this population. The county board has authorized the CMO to hire additional staff.

Caseload composition varies from county to county. La Crosse and Portage social workers serve one specific target population while Fond du Lac and Richland social workers serve a mix of all target populations (see *Appendix F*). Several CMOs indicated that target group designation does not usually influence the intensity of care management needed. Rather, the level of medical complexity and presence of mental illness are the main determinants of caseload intensity. All of the CMOs noted a high prevalence of mental illness among their members. For example, Fond du Lac reported that 50% of their CMO members suffer from depression or other mental illness. The counties all reported the need to become better equipped to deal with mental health issues. As a result, the CMOs have held trainings on mental health issues, created special teams to work with individuals with mental illness, and collaborated with mental health professionals outside the CMO.

D.   The RAD Method: Balancing Cost and Consumer Preference

The CMOs use a DHFS-developed clinical tool, the Resource Allocation Decision (RAD) method, to balance consumer preference and cost. It is a three-step process which directs interdisciplinary teams to identify desired outcomes for the consumer, examine effective options to meet the outcome, and decide on the most cost-effective option.

DHFS and the CMOs invested heavily in training staff in the use of the RAD method over the past year. Last year, we reported that the CMOs seemed to be struggling with the concept of balancing consumer preference and cost despite receiving training in the method. Some county

representatives mentioned that requiring counties to be motivated by both these concerns was an impossible feat. For example, Portage County wrote a letter to DHFS expressing their confusion. DHFS responded by reinforcing the design of the Family Care model and encouraging the county to continue to understand and implement the use of the RAD method. DHFS has offered numerous trainings on the method to the individual counties and has also been available for case consultations. DHFS noted that the inclusion of CMO supervisors and management in the training was critical in increasing the support to care managers using the method. They also had CMO fiscal staff attend the trainings to ensure that they understood the philosophy and did not inappropriately influence care decisions. In addition, county staff conducted their own internal trainings on the method.

Evidence indicates that the RAD method appears to be more seriously considered in care planning than in May of 2001. County staff reported using the method in staff meetings in order to review difficult cases. All CMOs have procedures in place to document the use of the method. Also, consumer advocates we spoke with in May of 2002 heard complaints related to reductions in services. This is consistent with when the CMOs began to use the RAD method on a more consistent basis. That is, when the counties transitioned individuals from other waiver programs to Family Care, minimal, if any, changes were made in service plans due to the large volume of cases to be transitioned and the CMOs' lack of comfort or familiarity with the RAD method. As those transition cases began to have their annual re-certification and review of care plans, CMOs began to use the RAD method more frequently, which resulted in changing care plans and sometimes a reduction in services.

E.   Consistency of Interdisciplinary Teams vs. Individualized Consumer Focus

Discussions with CMO staff and advocates suggested that CMOs struggled to simultaneously honor consumer preference and provide consistent care to all members. One of the goals of care management under Family Care includes keeping decisions about care as close to the consumer level as possible. This requires that the interdisciplinary team understands the core issues facing the consumer and that the consumer plays a central role in care decisions. In addition to the long-term care benefit package, the CMO is responsible for developing service plans that include other services, such as treatments or supports, when they are more appropriate or likely to result in better outcomes for the individual than the services in the benefit package. For example, although massage therapy does not fall within the Family Care benefit package of services, La Crosse CMO purchased these services for some CMO members. Additionally, they have contracted with an Asian restaurant to provide meals that better meet the dietary preferences of Hmong members. However, as an agency responsible for an entire enrolled population, the CMO must also ensure fair and equitable service to its members. CMO staff must mediate care decisions and provide information about the most cost-effective ways to meet an individual consumer's needs.

1.   Pilot Strategies

The counties have adopted a variety of strategies to promote consistency across interdisciplinary teams. As a very large organization with many Care Management Units providing care management to members, Milwaukee faces particular challenges related to consistency. Milwaukee implemented team facilitators who meet with all of the interdisciplinary teams bi-weekly to consult and supervise team decision making-processes.

The team facilitator consulted on cases in which the primary team, consisting of a registered nurse (RN), social worker (SW), and member, needed further mediation. Milwaukee also developed several protocols for care management teams on such topics as "wound care" and "working with discharge planners."

The other counties have been less formal in their approach. The CMO manager in Portage interviewed all staff in the CMO to assess practices and determine consistency. As of May 2002, Portage planned to hire another supervisor to reduce supervisor caseload, create specific guidelines for the use of the RAD method and SDS option, and add questions about consistency to member and provider surveys. In La Crosse, only the CMO director conducted RAD method training for all new staff in an effort to consistently convey the information.

2. DHFS Monitoring

DHFS monitors consistency among care management teams through a formal review of county procedures. During the annual 2001 quality site visit, DHFS reviewed the CMOs' adherence to contract provisions around care decisions. In the CMO contract, any authorization decisions made outside of the interdisciplinary team must use regularly updated review criteria that are clearly documented and are based on reasonable evidence, or consensus among individuals involved to ensure consistency in decisions. DFHS closely monitored these procedures at the site visits to ensure that, in the process of promoting consistency among teams, individualized planning still remained central. For example, DHFS did not approve Fond du Lac's procedure for interdisciplinary team consistency, in which the management team granted prior authorization for items over $100, absent documented decision criteria. DHFS also urged La Crosse and Portage to institute a written plan to assure such consistency. Additionally, DHFS closely examined the role of the team facilitator in Milwaukee to ensure that consumer preference remained central.

3. Future Efforts

Future efforts to enhance the tracking and monitoring of care management activity will help ensure consistency. DHFS continues to urge CMOs to develop quality indicators for monitoring such consistency among care management teams. The Fond du Lac CMO has developed a data system for tracking vaccines given to members as a measure of the consistency with which teams address prevention. Portage plans to use the computerized member-centered plan as a way of tracking consistency. With a computerized documentation system, they could easily examine the consumer preferences identified across teams. DHFS also hopes to implement a certifiable care management course similar to those offered to staff who perform functional screens.

F. Prevention

A key concept of care management in Family Care involves valuing prevention as a means of ensuring better health of members and managing costs. During the past year, the CMOs had a greater opportunity to focus on prevention than previously because they had transitioned all waiver cases to Family Care. The following updates the CMOs' efforts to incorporate prevention into practice, including the more active role of the RN, the integration with acute and primary care, and specific prevention activities.

1. The Role of the RN

Since our 2001 report, RNs have been more heavily involved with prevention duties but are still impeded by high caseloads. As seen in *Exhibit VII-4,* RN caseloads ranged from 55 members in Richland to 120 members in Milwaukee in May 2002. Fond du Lac and Portage reduced RN caseloads and reported expansions of the RN role, including prevention and wellness tasks. None of the counties have met their caseload goals for RNs and the counties all reported that RNs could be more involved in prevention once they meet their caseloads goals. Milwaukee hopes to allow team nurses to conduct assessments for supportive home care and personal care provided by family or friends. Currently, in Milwaukee, if a consumer wants a family member or friend to provide care, one of two home care agencies, rather than the assigned care management team, must assess the consumer's specific needs to determine the number of hours needed.[12] Fond du Lac decreased their caseload goals for 2002 because they intend to use CMO nurses to deliver some skilled care as a more cost-effective method than contracting with agencies.

Exhibit VII-4
RN Caseloads for all Target Populations,
May 2001 and 2002
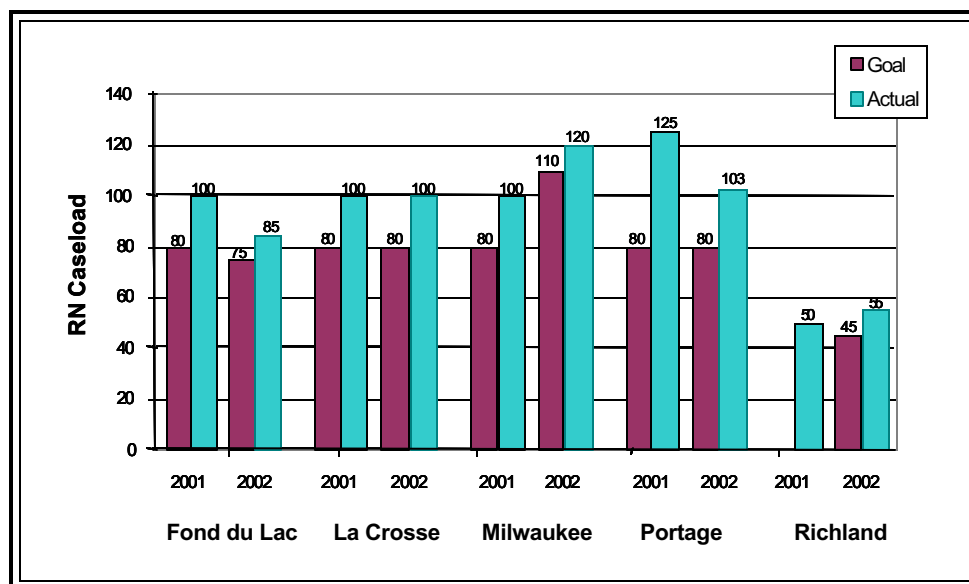
Source: Caseloads reported by CMO staff May 2001 and May 2002.
Note: Richland did not have a target for RNs in 2001.

The CMO staff felt that the addition of the RN ensured better quality care by providing a medical perspective in care planning and monitoring. In general, social workers viewed the RN as a valuable resource. However, some CMOs indicated that they encountered RN resistance to supervision from social workers. La Crosse and Milwaukee each appointed one RN supervisor to address this issue.

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[12] This assessment, as it is specific to supportive home care and personal care, does not replace the comprehensive assessment completed by the CMO team.

The providers we interviewed generally felt that the role of the RN in Family Care lacked clarity. This was particularly the case when both a RN from the CMO and a RN from an agency were involved in the care of a member. A few agencies who previously utilized RNs on staff reported that they no longer assign RNs for Family Care clients. In these cases, the CMO notified providers that the CMO would provide the nursing services for those clients as a cost-effective measure. On the other hand, some providers who did not traditionally staff RNs noted that the addition of the RN was a valuable resource for their agencies' service to Family Care members. Some nursing facilities, other residential providers, and home health agencies reported that they must continue to keep RNs due to federal requirements and this presented an issue of duplication in service. Very little coordination in care planning was reported between such providers and the CMO.

2. *Integration with Acute and Primary Care*

In the original re-design proposal, released by Secretary Leean in May of 1997, acute and primary care were included in the Family Care benefit package. But advocates, fearing an overly medical system, successfully limited the program to long-term care (LTC). Yet, coordination across acute, primary, and LTC service providers has become a necessary and important component of appropriate planning and service delivery under Family Care.

In recognizing the potential health benefits of integrated care for its consumers, CMOs have begun to develop procedures that facilitate communication between the acute and primary care providers. Efforts of the CMO interdisciplinary teams to integrate care varied across counties:

- Smaller counties, such as Portage and Richland, reported an easier time opening communication lines.

- The La Crosse CMO sent letters to physicians and has worked to educate discharge planners at hospitals.

- Milwaukee developed a Medicare and Medicaid consultant role to assist the teams in understanding the complexities of the two programs. They have also encouraged care management staff to be pro-active in interacting with, and introducing themselves to, hospital staff when members are admitted to the hospital, in order to coordinate care planning and transition back to the community.

- Portage has arranged to obtain discharge planning information from the local hospital via automated information systems.

Some CMOs indicated that they would like acute care providers to be more involved in the care planning process. Some counties have also offered trainings to hospital discharge planners. County staff reported that the addition of the RN to the interdisciplinary team also helped to engage the attention and cooperation of physicians. They indicated that educating primary care providers might help to reverse the view that institutional care offers the only solution for consumers in need of long-term care.

Several barriers exist to designing an integrated system where service providers work together to achieve the best outcomes for consumers. As mentioned above, in the case of home health services, nursing supervisory visits are a federal requirement for Medicaid, even if a CMO nurse follows the case. These visits, combined with the attention of the Family Care RN, often

duplicate effort. Nursing facilities must also conduct their own comprehensive assessments, duplicating the assessment by the CMO team. Further, CMO staff reported challenges in working with primary care physicians who have limited time and incentive to consult on cases. Also, some CMOs reported that nursing facilities do not want to serve the DD population for rehabilitation because of the requirement to have an active treatment plan.

3. *Specific Prevention Activities*

Specific prevention activities serve as another way CMOs can promote consumer preferences, reduce decline in functioning, and potentially lower costs to the system in the long run. The less impaired people are, the less likely they are to need services. Because of the CMOs' status as pre-paid health plans, each CMO county has developed prevention and wellness guidelines, at the direction of DHFS, to fulfill their Quality Assurance/Quality Improvement (QA/QI) project.

Fond du Lac identified preventive care as one of their quality target areas. Feedback from care management assistants who accompanied members to doctors appointments and the initial assessment process helped identify it as a target area. They intend to track measures according to the American Medical Association (AMA) Preventive Care Services Guidelines, outlining services such as screening, immunizations, preventive therapies, and medications. They will look at the state Medicaid data over time to assess the outcomes. They started a prevention/ wellness workgroup made up of RNs and SWs from the CMO. Fond du Lac also developed prevention guidelines surrounding the early identification and management of depression.

La Crosse developed prevention guidelines around spasticity for members with certain chronic conditions. Partners from the community, including medical specialists working with people who have cerebral palsy, physical therapy (PT), occupational therapy (OT), and speech therapy (ST) consultants, a local cerebral palsy outreach group and CMO members helped develop the guidelines. The guidelines include: identifying factors, training for SWs and RNs and other service professionals, and monitoring the effectiveness of the guidelines over time.

Milwaukee CMO has capitalized on the active role the Milwaukee Department of Aging has played in collaborating prevention activities with the larger community. They have received various grants to pursue prevention activities. They have also developed various guidelines with regard to prevention including: immunization information, heat alert information, wellness "tip of the week" emails to staff, medication information, and diabetes management. Their practice guideline centers on factors to consider in permanent placement.

Portage developed prevention guidelines for individuals suffering from congestive heart failure (CHF). The guidelines provide information, training and specific guidelines including information on managing the disease. Portage also included prevention and wellness as components of the ISP that the consumer, RN and SW identify and address.

Richland advertised and completed home safety assessments. They also conducted macular degeneration screens at all county congregate meal-sites. Blood pressure screens were also provided monthly at the meal-sites. The RC staff also created a health-related bulletin board in the public area of the Resource Center and a 2003 calendar to use as a health promotion tool.

G.   Self-directed Supports

The DHFS contract requires CMOs to offer a self-directed support option after two years of operation. Members who choose the option have the ability to select and manage services provided to them along a continuum of increasing control, from directing services to hiring and firing care workers. As of our 2001 update, Fond du Lac and Richland had yet to implement the option. Portage, La Crosse, and Milwaukee have offered the option since the CMO's beginning. Fond du Lac began the self-directed support option in October 2001, and Richland will offer the option in January 2003.

Fond du Lac, La Crosse, and Portage have similar models for the SDS option. They all allow members or caregivers to choose between a co-employment agency or a fiscal agent to direct care. The co-employment-agency acts as the employer for the individual care provider selected by the consumer. The fiscal agency model, on the other hand, allows the consumer to act as an employer, but includes an agency to handle fiscal concerns, such as payroll. Fond du Lac piloted the model with one consumer and now offers it to all members.

Exhibit VII-5 indicates that approximately 15% of CMO members have exercised some self-direction. As of May 2002, approximately 59 Family Care members in the Fond du Lac CMO, or 6% of its members, directed mostly personal and supportive home care. In La Crosse, 7%, or 75 CMO members, used the option to manage personal care and supportive home care; eventually, they hope to add supported employment as a self-directed support option. Until recently, La Crosse County had a grant-funded position for an SDS coordinator in their county long-term support unit, separate from the CMO, that helped start the option at the CMO. In Portage, 15%, or 74 CMO members, self-directed personal care and supportive home care. In the future, Portage also hopes to offer classes in self-advocacy to members.

Exhibit VII-5 shows that, as of May 2002, the elderly and physically disabled populations, as a combined group, comprised a larger proportion of the individuals choosing to self-direct care than the developmentally disabled population. In Fond du Lac and Portage, 53 and 74%, respectively, of individuals self-directing care were either elderly or physically disabled. Although, we did not receive these data by target population for LaCrosse, CMO staff reported that most of the individuals self-directing care were physically disabled or elderly, or their caregivers. We will continue to monitor these trends over time for our outcomes and cost-effectiveness evaluation.

Exhibit VII-5
CMO Members Self-directing Care as of May 2002

CMO	Elderly	Physically Disabled	Developmentally Disabled	Total	% of total CMO Enrollment
Fond du Lac	17 (29%)	14 (24%)	28 (47%)	59	6%
La Crosse	*	*	*	75	7%
Milwaukee	1200 independent providers [1] 10 using fiscal agent	N/A	N/A	1200	36%
Portage	30 (40%)	25 (34%)	19 (26%)	74	15%
Total	*	*	*	1408	15%

[1] Milwaukee employs 1,200 independent providers of members' choice. Family Care has marked no change because prior to Family Care, the county employed independent providers to provide 80% of all supportive home care.

Notes: According to the CMO contract, Richland does not have to offer the SDS option until January 2003. They currently have 13 CMO members using a fiscal agent to employ caregivers. * La Crosse reports majority self-directing care are elderly or physically disabled. Figures by target population were unavailable.

Milwaukee's model differs from the other counties because they designed the program with the philosophy that self-direction for older adults may not depend on assuming the employer role. Milwaukee offers self–directing services along the following continuum: developing personal outcomes or goals; requesting training in self advocacy; assessing available resources; being aware of cost of resources; choosing providers; and assessing safety and risk. Milwaukee noted that they have 2,000 people who have been selected by members to provide paid care as individual providers, a form of self-direction. Many of these non-traditional providers are family members. Milwaukee also plans to implement a meal and bus voucher system as another way to give consumers some direction over services. Additionally, the CMO has attempted to educate older adults about choice. For example, they are educating consumers on issues of control. They developed training in areas such as, how to talk to a physician or a supportive homecare worker; how to talk with family members about advance directives; and how to advocate for oneself. Milwaukee developed a booklet with the assistance of their SDS work group entitled "My Way," which serves as a guide for seniors to make long-term care decisions. The workbook style guide helps older adults record their preferences and values with regard to physical and mental health, financial issues, and spiritual beliefs and practices. It offers a framework for the older adult to discuss his or her care preferences with family and professionals.

Concerns remain with the implementation of the self-directed supports options. Fond du Lac noted that it has been difficult to develop the option concurrently with the Family Care model

because of the many requirements in developing the new program. Some counties' CMO staff expressed concern that allowing consumers to manage care, given the managed care model of Family Care, proved difficult to reconcile. They questioned the ability to fairly establish budget limits when service authorization for Family Care offers a different amount to each consumer, dependent on need, which differs from the COP and waiver programs in which all individuals were subject to the same maximum amount. As more members elect self-direction, La Crosse staff expressed concern over the potential amount of training time for the interdisciplinary teams. Additionally, it is difficult to assess if all members have been offered the option to self-direct their care. Thus, DHFS recommends that all the pilots have a procedure in place for the RC to alert the CMO to a member's potential interest in SDS.

The DHFS CMS Bridges to Work Grant will also be used for the enhancement of the self-directed supports program in each CMO and the development of a personal futures planning resource manual for use by each CMO.

H. Advocacy

Opportunities for advocacy in Family Care exist to offer assurance of a fair and equitable system that honors consumer rights. This is crucial within a managed care environment and DHFS and the counties have attempted to design a program which both promotes quality care and manages costs. During the past period, internal advocacy components continued to be developed, while formal, external advocacy decreased.

1. *Member Advocate*

The member advocate position, by contract, serves as an advocate for CMO members. Because this person must be someone outside the member's interdisciplinary team, he or she functions as a quality assurance mechanism to see that the consumer's preferences are honored. The roles of this position include: follow up with members at least two months after enrollment, alert members to advocacy options and answer questions; assist members with issues related to care management or service provision, including appeals and grievances, and assist with overall quality assurance at the CMO. The member advocate reports to management at the CMO.

CMO staff reported that the responsibilities of the advocate were initially difficult to implement, especially in terms of the requirement to contact new members within two months of enrollment. While the Milwaukee member advocate calls each new member, the Portage advocate sends letters to all members and randomly calls a sample of members. In La Crosse, the member advocate sends a letter to all new members. The Fond du Lac advocate plans to send letters as well. The Richland advocate does not contact members yet.

In March of 2001, three of the CMOs had the specific member advocate in place; Fond du Lac and Milwaukee did not. While Milwaukee CMO staff reported that they could not find qualified staff to fill the position, Fond du Lac did not attempt to fill the position until the independent advocate program was eliminated in October 2001. In March of 2002, all of the CMOs had at least a half-time member advocate, with the exception of La Crosse, whose member advocate served at one-quarter time.

2. *Complaints and Grievances*

Family Care consumers can use one of two avenues for filing a complaint or grievance– through the County or the State (*Exhibit VII-6*). Each RC and CMO has developed their own processes for consumers to raise complaints about the care received, as required by the 1915(b) waiver. The plans have all been approved by DHFS.

Exhibit VII-6
Complaint and Grievance Process in Family Care

Steps in Filing Complaints in Family Care	
County process* (Differs by county)	**State process**
1. Consumer or consumer advocate files complaint to RC or CMO staff. 2. RC or CMO staff educate consumer on all possible complaint and grievance processes (state and county) 3. Investigation by CMO or RC designated staff to attempt informal resolution. 4. Resolution within required timelines. 5. Notification of consumer.	1. Consumer or consumer advocate files complaint to DHFS or requests state fair hearing. 2. DHFS regional staff investigates situation to attempt informal resolution with RC and/or CMO staff 3. If not resolved, formal decision made by DHFS staff 4. If consumer wants to contest, requests a state fair hearing by Administrative Law Judge

Source: RC and CMO 2002 contracts.

The CMO contract required that CMOs: 1) educate CMO members about their complaint and grievance options within 60 days of joining the CMO; 2) appoint a member advocate or another staff member to assist members in filing grievances internally with the county; 3) offer a central person for consumers to contact during the process; 4) form a committee to review complaints and grievances with target population representation; and 5) acknowledge the consumer's request and estimate a resolution date (must be within 20 days). RCs have similar requirements with the exception of a required designated staff, and a committee. Additionally, they must resolve informal requests within three business days and formal requests within fourteen days of submission by a consumer or consumer advocate.

Consumers may also file a complaint directly with the State. The state process begins with the consumer, or consumer advocate, filing a complaint to DHFS or requesting a state fair hearing. Either state-level action will warrant an investigation by a DHFS regional staff person to attempt informal resolution with RC and/or CMO staff. If a solution is not reached informally, a formal decision will be made by a DHFS staff member. After this decision, or at any point during the process, the consumer has the right to contest the decision by requesting a state fair hearing. In addition to reviewing the individual county complaint and grievance plans, DHFS has also hosted training on the concepts of Family Care to the DHFS regional staff and the Administrative Law Judges hearing the cases.

The 1915(b) waiver requires that consumers have access to a variety of mechanisms through which to grieve which may have resulted in a complicated system that has not been

communicated well to program stakeholders. The State Long-Term Care Council has identified the complaints and grievance process as an area for investigation due to reports of its complexity and variation across counties. They have offered suggestions to DHFS and the counties to help clarify the processes. Advocates on the Council also suggested more prescriptive instructions in the CMO and RC contracts as a way of improving consistency across counties. Providers reported that they did not find the procedures any different from the previous system, if they were aware of the procedures at all.

3.   *Independent Advocacy*

Until October of 2001, when the Governor signed a biennial budget that eliminated funds for independent advocacy in Family Care, Wisconsin Coalition for Advocacy (WCA) conducted state-funded Family Care independent advocacy. The role of the independent advocate included providing an impartial entity to assist consumers with grievances, appeals, and fair hearings. It also included providing information and assistance, training, and technical support to individuals about how to obtain services and supports.

WCA compiled data on the number of complaints and grievances in which they assisted Family Care members. During the period from April 2000 to April 2001, 17 complaints were filed with DHFS. The complaints varied in nature, including: accessibility and quality of services, eligibility, disagreements over authorization of services, guardianship and protective placement, violation of consumer rights, and misunderstanding about choice of provider and choice to enroll. Ten were filed on behalf of elderly consumers, four on behalf of individuals with developmental disabilities, and three on behalf of individuals with physical disabilities.

WCA's role as independent advocate included education and advocacy surrounding Family Care. They created a consumer booklet which was given to all CMO members by the CMOs. In Milwaukee, during the contracted period of December 2000 to September 2001, WCA conducted outreach about consumer rights or individual assistance and/or training to 559 Family Care members and family members. They sent an introductory letter to 1,500 Family Care enrollees in Milwaukee regarding the availability of independent advocacy services. The agency assisted over 200 nursing-facility residents directly through information brochures and counseling. They also provided outreach about Family Care to 340 provider agencies and other advocates working with the Family Care target populations. During the contract period, the agency received 25-30 calls weekly regarding Family Care. As a result of the outreach, the agency handled approximately 45 cases each month of direct assistance to Family Care consumers.

Since the independent advocate's elimination, some advocacy organizations still provide limited advocacy to CMO members. Without state funding, those agencies do not have the resources to serve the entire CMO population. After state funding was eliminated, Milwaukee WCA ceased to provide outreach. However, they have coordinated a consortium of Milwaukee agencies, including WCA, SeniorLaw, Board on Aging and Long-Term Care, and Legal Aid. The group has met with the Milwaukee CMO to address advocacy issues, such as, the internal complaint and grievance process. In comparison to approximately 45 cases per month of direct advocacy to consumers during the nine-month contract, WCA has handled about 30 cases in the 10 months between September 2001 and May 2002. They have also only been able to provide information and referral to 50 consumers. Some attempts have been made by advocacy groups

across counties to offer training in disability sensitivity to the pilot counties. However, without the independent advocate, no formal mechanism exists for advocacy organizations to shape the development of the Family Care grievance and complaint process locally.

4.   Disability Benefit Specialist

The Disability Benefit Specialist (DBS) also serves as an advocate for individuals interacting with the RC. Their role includes providing advocacy for benefit programs on the following issues: eligibility, coverage/denials, terminations, overpayments, and explanation of notices. Pilot county staff that the DBS position has generally not been affected by the loss of the independent advocate. A position paper on the DBS role noted that the DBS should restrict advocacy to initial eligibility for Family Care and not subsume the responsibilities of the independent advocate listed above, to maintain their role as a short-term intervention.[13] The paper also stressed that the position should conduct systemic advocacy by using individual cases to identify programmatic changes needed for Family Care. As of November 2001, five of the eight RC counties serving individuals with disabilities employed a DBS. As of March 2002, all RCs had a DBS. Some of these counties ensured that the DBS was not involved in eligibility responsibilities to mitigate potential conflict of interest.

I.   Quality Assurance and Improvement

Quality constitutes a cornerstone of the Family Care program. During the past period, the counties remained engaged in defining, planning, and implementing quality improvement measures. The attention to quality in the Family Care model represents a change from the previous long-term care system. Though many of the counties felt that they were providing quality services previously, a greater emphasis through more formal mechanisms to improve quality at the consumer, provider, and organizational levels exists under Family Care.

1.   Partnership Between DHFS and the Counties

DHFS indicated that they want to be partners with the pilots in quality assurance, rather than an auditor monitoring paperwork, as in the previous system. Quality improvement implies an on-going effort to improve services. Since our 2001 report, DHFS has identified four areas in which they will continue to measure quality of the program: 1) LTC system objectives, 2) consumer outcome indicators, 3) Family Care system indicators, and 4) population health indicators. They remained heavily invested in the Multilevel Quality plan (outlined in our 2001 report) and provided feedback to the counties on their procedures related to quality. A large part of the plan involves providing feedback to CMOs via a quality site-review process. During the most recent review, they evaluated the QA/QI program, health, safety & welfare plans, provider network, self-directed support option, interdisciplinary teams, member transitions into and out of the CMO, and member-centered plans in each county. County staff mentioned that these reviews and subsequent feedback helped shape their quality improvement planning efforts.

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[13]   Abramson, B. (November, 2001). Disability Benefit Specialist Program: Summary of Issues and Recommendations. Prepared for Wisconsin Department of Health and Family Services, Division of Supportive Living (DSL), and Wisconsin Bureau of Aging and Long-Term Care Resources (BALTCR).

2. *Provider Accountability*

CMOs began to require increased provider accountability. With the creation of the CMO, counties can now hold providers accountable for quality service provision at the local level. Under the old system, very few monitoring activities accompanied a county's contract with local providers. The state Bureau of Quality Assurance (BQA) constituted the only systematic way of tracking provider quality through state licensing procedures. Milwaukee, La Crosse, and Portage have all now established good working relationships with BQA, wherein they share provider deficiencies they identify with the agency.

CMOs noted that involvement of care managers in all aspects of service provision serves as an effective means of quality control. Two specific examples illustrate such quality control. The CMO in Fond du Lac took corrective action with a particular residential provider. The provider had instances of caregiver abuse, medication errors, and staff training deficiencies. The CMO included a contract requirement with this provider to employ an assistant quality assurance staff person to act as a liaison among the agency, consumers, and guardians. Also, counties, such as Milwaukee and Fond du Lac, using the personal care option under the state plan, more closely monitored service provision. In these counties, prior to Family Care, no care managers were involved in the care of consumers receiving personal care under the state plan. Therefore, personal care providers had complete latitude to set the number of hours an individual could receive. Incentive existed for providers to set the number of hours higher to arrange more convenient work schedules for employees and to maximize Medicaid payment from each individual. CMOs report that under Family Care, the interdisciplinary team offers a more objective assessment of consumer need. County staff noted they spend funds more efficiently, which promotes more cost-effective services.

A statewide workgroup was formed to develop quality language to be used in the CMO provider contracts. DHFS has also offered the counties sample language on quality assurance. Each county incorporated its own methods into its provider processes. Milwaukee developed and implemented a quality indicator system for monitoring both individual providers and providers of a certain service type. The indicators are mapped to the expectations outlined in the contracts and important criteria discussed in a focus group with members. Milwaukee also has a provider/consumer liaison who communicates areas in need of improvement back to the CMO staff.

Portage has included specific quality expectations in the contracts with providers. Care managers, as the link between providers and consumers, monitored the expectations. They have taken corrective action against providers due to deficiencies identified through this process. Additionally, Portage required providers to complete an application packet with quality checks, and conducted an annual quality site visit to assess provider personnel files. La Crosse did not include language on quality in the contracts as of May 2002. They planned to include this language with residential providers first. Fond du Lac and Richland have begun to incorporate some of the suggested language provided by DHFS into provider contracts.

Interestingly, most of the providers we interviewed reported that there were no additional requirements or quality assurance standards under Family Care that affected the way they operated or delivered services. Further, some providers raised concerns regarding an increase in unlicensed independent providers with Family Care who might not be conducting criminal

background checks. The CMO is required by HFS 12, Wis. Adm. Code, to perform criminal background checks on anyone who is paid to provide services to a CMO member. The agency elected as an independent quality reviewer for DHFS will be reviewing these practices annually during quality site visits.

3. Member Outcomes

The member outcome interviews are beginning to shape quality initiatives at the county-level in the four CMOs established in 2000. DHFS continued to use the Member Outcome Tool, developed in partnership with the Council for Quality and Leadership (the Council), to evaluate quality in Family Care. The tool measures consumers' perception of outcomes and whether or not supports exist to achieve those outcomes in several areas: privacy, the ability to choose services, housing, safety, the degree to which members are respected, and experience continuity, and satisfaction with services.[14] The Department conducted the first round of member interviews between November 2000 and January 2001. They interviewed 355 randomly selected CMO members and the care managers serving them. The second round of interviews was conducted between May 2001 and November 2001; 492 randomly selected members and their care managers were interviewed. The third review will occur between December 2002 and April 2003.

DHFS cautions against drawing comparisons between results from the two rounds for several reasons. They noted that the interview process continues to evolve with changes in the way in which consumers were contacted to participate and the directions given to the care managers. Although the tool has been used by the Council to evaluate programs for individuals with disabilities, BALTCR and consumer representatives continue to adapt the tool for appropriate use with the elderly population in an attempt to validate the instrument. Additionally, DHFS noted that they have not yet developed benchmarks for each outcome. They believe that with the results from the application of the tool to other programs which have begun, such as, PACE, Partnership [15], and other waiver programs across the state, they will be able to establish some benchmarks.

DHFS stressed that, at this point, the primary value in the results of the outcome interviews was to provide a framework for quality improvement efforts at the CMO level. As the process continues, county staff will be able to use the results to track the success of their consumer-

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[14]   Please see http://www.dhfs.state.wi.us/LTCare/ResearchReports/CMOMemberOutcomes.htm for DHFS' full report on the Member Outcome Interviews.

[15]   Program for the All-Inclusive Care of the Elderly (PACE) and Partnership are other DHFS Medicaid managed care programs. The Partnership Program, serving older adults and adults with physical disabilities since 1996, currently operates in three Wisconsin counties: two sites in Dane County, one site in Milwaukee County, and one site in Eau Claire. As of August 2002, 1,303 individuals were enrolled. The program integrates all medical and long-term care services in a community-based setting. PACE was initiated in Milwaukee County in 1994 for individuals 55 and older at the nursing home level of care to provide on-site, comprehensive integrated medical and psychosocial services by a multi-disciplinary team. As of August 2002, there were 420 enrollees. Information from http://www.dhfs.state.wi.us/medicaid7/managed_care_summary_table.htm.

centered quality efforts. In addition to offering training to providers based on outcome results, counties have begun to make changes in the following ways:

Fond du Lac sought to improve outcomes around "people chose where and with whom to live." They reduced bed size at CBRFs to allow for members to have private rooms if they so desired. They successfully offered financial incentives to CBRFs to downsize, resulting in improved outcomes for 2001.[16]

Milwaukee's CMO performance improvement project included improving the appropriateness of placements in alternate care settings. "Members experience continuity and security" was one of the lower scores for Milwaukee on the first round of member outcomes. Through independent investigation, the CMO determined that only 3% of members in sub-acute residential care settings should have been there based on member care needs and other risk factors. The CMO developed clinical processes to ensure appropriate placement in the future. Milwaukee is also trying to involve providers in the interdisciplinary team during the re-certification, and reported that CBRFs and ADCs seem to appreciate the involvement.

La Crosse focused on the outcomes of "people are safe" and "people chose where and with whom to live," after reviewing results from the first round of member outcome interviews. They attempted to devise emergency plans, install smoke detectors for clients, and refine the assessment to examine safety issues. The CMO also educated care managers about some of the assumptions they may make in determining where a client might want to live. The La Crosse CMO quality improvement project "improving retention of personal care workers for people with physical disabilities" is intended to enable members to stay in their own homes longer.

Portage used consumer focus group information to design their first quality improvement project. The project focused on improving community integration opportunities for physically disabled members based on the consumer outcome "people participate in the life of the community."

Richland was not included in the first round of member interviews because the CMO began in January of 2001 after the first round of interviews was completed.

4. Data Collection and County Quality Indicators

DHFS encouraged the pilots to develop their own tracking systems related to monitoring the success of the quality initiatives. Counties are still in the process of building the necessary infrastructure. As mentioned previously, the member outcome tool will eventually function as a metric of quality assurance. Portage created a fifteen-hour-a-week IT position to assist with quality monitoring. Fond du Lac developed a system which will track quality indicators in the ISP. With the proper support and indicator development, automated ISPs may provide the data necessary for the other counties to track quality measures and eventually track outcomes.[17]

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[16] DHFS cautions against comparing 2001 and 2002 results due to continued development and testing of the tool.

[17] All of the counties, except Richland, have an automated ISP. Richland plans to automate the ISP by adapting the Portage ISP.

PART THREE:
CONCLUSIONS

VIII.   CONCLUSIONS

As we near the end of our observation of the Family Care program for the Wisconsin Legislature, in this section, we return to the core concepts and tenets of the Family Care model and discuss the program's successes and remaining challenges.

A.   Wisconsin's Implementation Model

Wisconsin's Family Care program constitutes one of the few state-level efforts to apply a capitated and managed model of care to the long-term care system. The choice of a managed care model as the method of organizing, arranging, coordinating, supervising, and financing long-term care service provision entails certain strategies, structures, processes, functions, and capabilities. Further, applying managed care to home and community-based services also requires a thorough understanding of the populations, services, and underlying philosophies associated with providing alternatives to institutionalization. The combination of limiting freedom of choice of providers, capitating payments for services, and promoting consumer focus for home and community-based services requires a balancing act of potentially conflicting goals on the part of the state, the resource centers, the care management organizations, and the consumers (*Exhibit VIII-1*).

Home and community-based systems strive to build from a base of equity, social justice and distributional fairness. At the core of the new managed care system are the infrastructure (access points, care management organizations, provider networks, IT systems), target populations, services included (acute and LTC, or carve outs, "specialty" services) and the capitated amounts paid. Family Care's person-centered planning approach needs to weigh ensuring health, safety and accountability against allowing consumers choice in determining when, where, how and from whom they prefer to receive services. At the fulcrum, it also must balance individual desires with available resources and desired outcomes (efficiency). Ensuring accountability and system integrity are the oversight roles of: 1) the state and external quality review organizations (EQRO) that monitor process and outcomes, and enforce regulations; and 2) individual consumers participating in and taking responsibility for decision making regarding their support plans and the managed care plan's governance, as well as vigilance against fraud and abuse.

In addition to balancing potentially competing goals of welfare, freedom and cost, another challenge for Family Care was the use of the Medicaid 1915(b) and 1915(c) waiver authority. The 1915(b) aspects of the Family Care initiative prevented the unified one-stop shopping for information and assistance and enrollment into the capitated care management organizations because CMS required a separation between the organization advising about an individual's choices and the managed care organization. Since the Resource Centers that facilitate eligibility determination and the care management organizations are both county government entities, CMS required a third party to play the role of enrollment broker. Also, the State must develop a strategy for complying with the CMS requirement to introduce competition in the next couple of years.

**Exhibit VIII-1
Balancing the Family Care Philosophy**
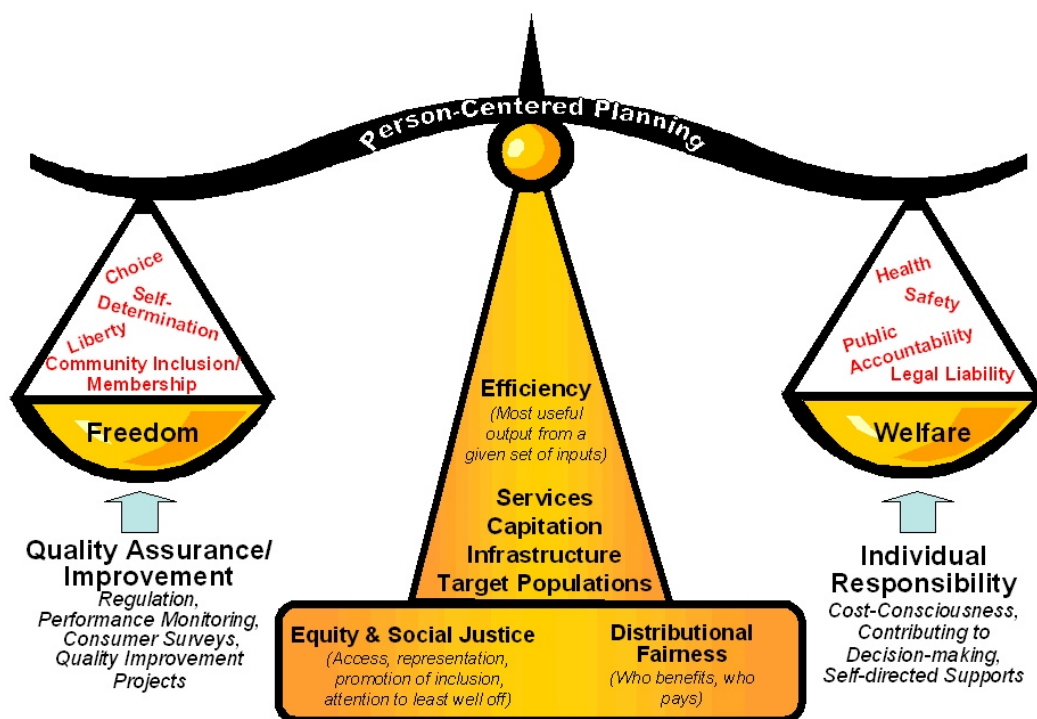
In the following sections, we discuss the four major tenets of the Family Care program: 1) **choice**; 2) access; 3) quality; and 4) cost-effectiveness. We conclude with a discussion of some of the major issues the program will face if it expands.

B.   Choice

Defining choice within the context of Family Care has been evolutionary and could be exercised in a number of ways:

* what services to receive

* who provides the services

* where to live and receive services

* how services are delivered, including when and individual preferences regarding aspects of service delivery (e.g., no smoking, Kosher menu).

In order to exercise choice, individuals need information regarding basic service availability and detailed information about those who might provide the services. The Resource Centers provide a foundation for allowing individuals of all income levels to make informed choices. The CMOs must struggle with some of the more delicate balancing between individual's preferences, safety considerations and cost. Given an unlimited budget, most choices could be accommodated, however, choice can be a difficult concept to implement when those involved have differing views of the limits of choice and available resources are constrained.

In the development of the Family Care program, the Department of Health and Family Services (DHFS) described choice in the following context:

> The primary goal of this effort to redesign the LTC system is to improve the quality of life of people who need supports. One important way to achieve that is by providing more choices for more people.[18]

Other parts of the same document went on to bound the options an individual could consider based on assessed need and reasonable cost:

> People who choose to enroll in Family Care will have more responsibility to collaborate in designing a cost effective service package, but will also have more flexible benefits, options and choices available to tailor the service package to their individual needs and preferences.[19] … Cost-effectiveness will be a consideration in developing service options, but care planning will not be entirely cost driven. … Individual values and preferences, quality, cost, and the ability to meet the individual's needs will all be considerations in development of a service/care plan, including living arrangement.[20]

The CMO contract and federal waiver rules explicitly stated some structural definitions of choice, such as CMO requirements to: offer a consumer choice between two care management teams, develop a self-directed support option, inform the member about the range of provider choice available to them even outside the CMO network, and purchase personal care, supportive home care, and chore services from any provider the consumers selects who meets the requirements of the CMO subcontract for the same service.

The application of choice has played out in different ways. In some cases, the emphasis on choice has meant creative solutions that meet the goals of the member and the CMO. For example, one CMO that needed to monitor the water retention of a member with concerns about individuals coming to her home for daily weighings negotiated for the member to measure her own ankle daily and to call the CMO if it exceeded a set size. Another CMO used the Resource Allocation Decision (RAD) method to decide against paying for a ceiling fan because there was no clear medical justification; however, the care manager arranged for another funding source to fulfill the member's desire.

The expectation for choice appeared to differ for the target populations. CMO staff noted that the target populations themselves had different definitions of choice. Milwaukee staff described older adults as usually grateful to receive any service and reluctant to complain lest they lose the service entirely. As a result, the CMO has worked with care managers to empower members to realize they have options. In the disability community, choice has been a cornerstone of advocacy. In this case, the CMO potentially faces requests that they cannot honor due to cost and network capacity constraints.

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[18]   Department of Health and Family Services, *Family Care: Redesigning Wisconsin's Long-term Care System*, July 31, 1998, page 3, at http://www.dhfs.state.wi.us/LTCare/History/8-98prop.pdf.

[19]   Ibid, page 13.

[20]   Ibid, page 15.

The initial articulations of choice downplayed cost considerations and emphasized the role of the member in the process. Some stakeholders heard the heavy emphasis on choice over the other considerations in the initial marketing of Family Care and have accused the CMOs of overly restricting members' options due to cost considerations. For example, several individuals who were in the waiver program prior to Family Care, in particular those who also received services from relatives or friends through the state plan personal care program, filed grievances concerning reductions in the amount of personal care services as a result of their first annual reassessment and care plan review. The CMO contends that the reductions are appropriate based on level of need and the total service package provided to the individuals. The CMO staff acknowledged that their strategy to minimize changes to care plans when individuals were initially rolled over to Family Care from the existing waiver may have sent the wrong message regarding how the program would ultimately operate.

An emerging issue has been the disenrollment of some individuals from Family Care because of their choice to stay in a nursing home. Some of the CMOs have developed care plans that differ from the member's and or their family's desire to stay in a nursing home. The CMOs argued that they can provide a package of services that would meet the member's level of care need in a less expensive setting than the nursing home. In these controversial instances, for the member to remain in the nursing home, the member disenrolled from Family Care and returned to the fee-for-service program where they could continue to receive Medicaid reimbursement for their stay. The program held true to the member's ability to exercise choice, even if it meant disenrolling. Nursing home representatives objected to the label of "voluntary disenrollment" to describe the situation where a resident returns to Medicaid fee-for-service to remain in the nursing home and accused the CMOs of skirting their financial responsibility to pay for nursing home care.

Providers endorsed the importance of having a choice among providers but some thought that choice was not being realized in Family Care. For example, some providers reported that the CMO selected based on the lowest bid, causing discontinuity for existing clients and concerns regarding the quality of care provided. Others felt that CMOs "placed" consumers with known providers who had an opening for more business rather than working with the member to develop new choices. The fact that some providers have begun to shift their marketing focus directly to the consumer, rather than, as in the past, the county contracting authority, seems to indicate an increased role for consumers.

In response to these issues, DHFS' goals statement has now evolved to reflect both the choice and resource aspects of the program and the challenge presented in *Exhibit VIII-1*:

> The redesigned system will provide individuals and families with meaningful choices of supports, services, providers, and residential settings, as long as such care or support is necessary, meets an adequate level of quality, is cost-effective, is consistent with the individual's values and preferences, and can be provided within available resources. [21]

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[21]   http://www.dhfs.state.wi.us/LTCare/History/VISION.HTM last revised 7-29-02 and accessed 9-20-02.

State staff also emphasized the need to educate advocates, providers, county staff and consumers about what choice means in Family Care. They plan to conduct education through RAD method training, consultation with the LTC Councils, ongoing communication with advocates and state LTC Council reports and meetings. DHFS will also continue to collect consumer outcomes as a means of monitoring choice.

In the future, Family Care faces several issues related to choice:

- **Loss of the independent advocate -** Advocates for the disability community, in particular, indicated that without an independent advocate, members lack an important voice for expressing their choices and ensuring the program's responsiveness. They lamented that, without a dedicated function, they lacked the necessary time and resources to be able to devote a proactive focus on Family Care members. To address several consumer involvement issues, we suggest that stakeholders consider a multi-function, consumer-oriented position that encompasses the activities of the independent advocate, enrollment consultant and staff support for the County LTC council.

- **Full realization of a self-directed supports option** - The ultimate manifestation of self-directed supports occurs when the consumer receives a budget allocation to be spent as desired. If pursued, the CMOs must take on the difficult task of devising a method for setting budgets consistently, fairly, and adequately, without exceeding available resources.

- **CMS requirement for CMO competition** -Federal rules under 1915(b) also require competition among managed care organizations to foster efficiency and better service. Wisconsin requested and gained CMS permission to initially make awards to the counties without competition. In exchange for permission to sole source, Wisconsin agreed to a CMS condition to institute competition after the initial four years of operation. DHFS staff have begun to consider their options related to instituting competition. Most stakeholders expressed strong preferences for the care management organization functions to remain in public entities. Recently, Michigan, which has a 1915(b)/(c) combination waiver for its mental health, substance abuse and developmental disabilities services, successfully argued to CMS that the unique nature of supportive services, the vulnerable population targeted and the local public administration that combines several funding streams and coordinates with other community health and human services systems makes a competitive model both inefficient and counter-productive.[22] Interestingly, Michigan officials did not think the same arguments were applicable to services for the elderly. DHFS will need to think strategically about its goals for the program and weigh the pros and cons of alternative arrangements for meeting those goals. In their deliberations, DHFS staff may want to consider the following:

  ➢ Minimum membership – For efficient operations, there needs to be sufficient enrollment to support the fixed costs required to deliver services. In addition, there needs to be enough covered lives to mitigate the risk of high-cost cases. DHFS may need to explore whether there should be a minimum expected enrollment threshold

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[22] Department of Community Health, State of Michigan, *Competition for Management of Publicly-Funded Specialty Services*, 1999.

for an area to support one CMO and another threshold for an area to viably support two or more CMOs.

➢ Qualifications and past experience of the organization – In considering the potential to expand the program to other counties, DHFS has begun to approach the process more like any other procurement. This means that they are considering an organization's administrative capacity and devising ways to assess readiness to function as a risk-bearing entity.

➢ Commitment to public policy and regulatory management – The CMOs function not only as managed care entities, but also as managers of public policy responsible for numerous protective, procedural, clinical and fiduciary regulations and as stewards for the major program tenets of choice, access, quality, and cost-effectiveness. DHFS will need to assess whether organizations other than public entities will be able to fulfill these commitments in an efficient manner.

➢ Overhead to benefit requirements – If a business case can be made, allowing wider competition means that for-profit organizations may respond to competitive solicitations. With for-profit entities come concerns that the profit motive may override other program goals. Arizona has successfully used competitive procurement for risk-based long-term care services for over a decade, resulting in a mix of county-based and private plans. Michigan chose to give existing public entities the first opportunity to document their readiness before opening up to competition. To counter profit motive concerns, DHFS may want to consider allowing a maximum overhead percentage or developing some form of loss ratio measure (benefit expenditures over revenues) and measures to monitor the adequacy of care management.

➢ Fostering innovation – Competition can be a mechanism to foster innovation by requiring competing organizations to come up with creative approaches to distinguish themselves from the competition. DHFS may want to consider mechanisms to structure any competition or other method of procurement so that organizations will be encouraged to be innovative.

C.   Access

As indicated earlier, individuals in need of long-term care services can access a wealth of information through the Resource Centers. The presence of the CMOs with guaranteed entitlement in Fond du Lac, La Crosse, Milwaukee, Portage and Richland has meant the elimination of wait lists and the ability to serve even more individuals. For many services, the CMOs have successfully expanded the number of providers available and also recruited new providers for services not previously available under the Medicaid program (e.g., some forms of transportation). CMO network managers identified selected services, particularly accessible housing, community-based residential facilities, and supported employment, that they would like to see further expanded. Some providers expressed dissatisfaction with the small number of referrals received under Family Care.

In the future, Family Care faces several issues related to access:

- **Increased enrollment** – As Family Care enrollment continues to expand, the CMOs face the challenge of hiring and training additional staff, while maintaining a consistent culture and application of care management principles. This will require the continuation of ongoing initial training as well as refresher courses for not only care managers, but fiscal and management staff.

- **Selective Contracting** – As of Spring 2002, the CMOs had narrowed the number of contracted providers in only a few instances. As the CMOs gather additional information about provider performance and member satisfaction, they may face the politically sensitive task of excluding some traditional providers from their networks. CMOs will need to ensure that decision processes are well-documented and that standardized provider appeals procedures are in place.

- **Expanding the use of non-traditional providers** – The CMOs have just begun to explore alternative providers and encourage existing providers to offer new and/or more responsive services. In order to meet the full range of member needs, CMOs will need to continue these efforts, especially in rural areas where the pool of traditional providers has been limited. This may also require creative contracting arrangements between the CMOs and providers.

D. Quality

The ideal quality standard for long-term care services has yet to be developed. The nature of the services, a mix of social supports and custodial care, coupled with the goal of allowing individuals to make their own choices, make traditional standards based solely on the clinical experience and opinions of professionals or experts inappropriate. Geron concludes that "the standards for long-term care that have been promulgated often have little to do with quality in the areas of care considered most important to consumers."[23] As discussed earlier, Family Care relies on a consumer-centered approach that includes process measures, such as CMO contract compliance and quality site reviews, but more heavily relies on consumer-defined outcomes captured by the Member Outcome Tool. DHFS has refined the process measures over the course of the program and continues to develop benchmarks for the outcome measures. The counties have begun to buy into a systematic approach to quality and the groundwork related to basic research techniques for monitoring quality has been laid.

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[23] Geron, Scott M. (2001) "The Quality of Consumer-Directed Long-Term Care," *Generations*, Vol. 24, No. 3.

In the future, Family Care faces several issues related to quality:

- **Transitioning quality assurance/improvement to a contracted organization** – As of July, in accordance with CMS requirements related to the 1915(b) waiver, DHFS contracted with MetaStar to serve as Family Care's external quality review organization (EQRO). MetaStar will assume many of the activities that DHFS staff had previously conducted with the assistance of other contractors. This shift may require different roles for some DHFS staff, and new relationships that county staff will have to develop, and will require continued effective and frequent communication.

- **Benchmarking the Member Outcome Tool results** – DHFS has conducted two rounds of member outcome interviews with Family Care members and one round each with Partnership members, PACE enrollees, and "regular" 1915(c) waiver recipients. State staff discourage the comparison of the Family Care Round I and II interviews because they implemented some process changes in the second round. Staff do hope to use the data collected to develop benchmarks eventually. Comparing the Family Care results to the others could be particularly difficult given the differences in the populations and the many environmental factors that cannot be considered. DHFS will need to continue to take care in presenting results and may want to consider developing mechanisms for case mix adjusting results.

- **Continuing education** – Implicit in the continuous quality improvement approach adopted by DHFS is the need for continuing education of DHFS, EQRO and county staff regarding the goals and measures. In addition to these entities, consumers, families, and providers will also need continuing education to both further the program goals and manage expectations.

- **Financial incentives for meeting quality goals** – DHFS may want to consider instituting financial incentives in the CMO and/or RC contracts to encourage them to meet or exceed established targets. Nationally and in Wisconsin, financial incentives related to quality have been successfully used with other Medicaid managed care organizations. Minnesota is developing plans to include financial incentives as part of it Minnesota Senior Health Options (MSHO) program managed care plans that provide both acute and long-term care services.

E.   Cost-Effectiveness

Defining cost-effectiveness can be difficult. Issues related to "how to measure costs?", "cost to whom?", "how to quantify benefits," and "compared to what?" emerge. Cost-effectiveness analysis (CEA) is one of the techniques of economic evaluation designed to compare the costs and benefits of a healthcare intervention.[24] The choice of technique depends on the nature of the benefits specified. In CEA, the benefits are expressed in non-monetary terms related to health effects, such as life-years gained or symptom free days, whereas in cost–utility analysis they are expressed as quality-adjusted life-years (QALYs) and in cost–benefit analysis in monetary terms. As with all economic evaluation techniques, the aim of CEA is to maximize the level of benefits – health effects – relative to the resources available.

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[24]   Sloan F (ed). Valuing Health Care: Costs, benefits and effectiveness of pharmaceutical and other medical technologies. Cambridge: Cambridge University Press, 1996.

What constitutes a cost? In economics, the notion of cost is based on the value that would be gained from using resources elsewhere – referred to as the opportunity cost. In other words, resources used in one program are not available for use in other programs, and, as a result, the benefits that would have been derived have been sacrificed. It is usual, in practice, to assume that the price paid reflects the opportunity cost and to adopt a pragmatic approach to costing and use market prices wherever possible. In Family Care, the "cost" per member is set through the program payment methodology and does not truly reflect price determined by the market. The capitated amounts also do not include the start-up and other costs, such as DHFS staff, associated with the program. In addition, for some services, such as nursing home care, costs are not available at the individual level because Wisconsin's Medicaid payment rates do not vary within a nursing home.

Within the context of Family Care, the entity that incurs the cost also becomes important. From the State's perspective, the state general revenue and county costs are of greater import than the federal Medicaid match, Medicare and member cost-share expenditures. To the extent that the state and counties are able to shift spending to Medicaid, which has a 58.6% match from the federal government, the more they are able to reduce their own obligations or serve more individuals for the same amount of spending. However, if the program is to be fairly evaluated, to the extent possible, all of the costs would be taken into consideration.

Can benefits be quantified? A particular challenge for the Family Care program is quantifying the program's benefits. Medicaid and Community Options Program (COP) administrative data primarily reflect use and cost measures for before and after the implementation of Family Care. The functional screen information is not available in electronic form prior to Family Care and screenings are usually performed only annually. As a result, it is not possible to develop measures of days of improved functioning, only whether functioning improved, stayed the same or declined. Due to the limited nature of the data, it is difficult to translate these data into measures of benefits. In addition, the evolving nature of the member outcome tool means that these more direct measures of program benefits cannot yet be tracked over time and as a result do not yet offer a measure of benefits gained.

To what should costs and benefits be compared? The legislation authorizing Family Care and the analyses The Lewin Group has undertaken required a comparison to nursing home costs. DHFS staff have argued that the 1915(c) waiver program in the remainder of the state would be the most appropriate comparison. We have pursued a methodology that focuses on specific counties selected for their similarity regarding measurable characteristics of their long-term care systems and the remainder of the state for the period prior to and after Family Care for the purposes of our next report.

In the future, Family Care faces several issues related to cost-effectiveness:

- **Measuring cost-effectiveness over the long term** – DHFS and the Legislature will want to continue to measure the program's costs and outcomes. The issues outlined above will likely continue and, in addition, as the system continues to transform, it could get more difficult to standardize costs prior to and subsequent to the program. Given the uncertainty, DHFS may need to pursue different methods in order to triangulate results.

- **Instituting a functionally-based payment system** - As DHFS moves to incorporate information from the functional screens into its payment methodology, staff will have to: 1) continue to rely on self-reported data from the CMOs regarding service use and costs until transactions can be directly reported and audited; 2) contend with the incentives for the CMOs that conduct their own recertifications to report higher needs for members on the functional screen in order to receive a higher payment; and 3) continue to assess whether the functional screen adequately captures functional need, particularly for aspects related to mental health. The Department and its actuaries continue to break new ground in the payment for long-term care services.

F.   Expanding Family Care

Wisconsin, like most other states, faced a budget shortfall as it entered state fiscal year 2003. As a result, Family Care did not expand to any new counties. In October 2001, Governor McCallum indicated that he would await the result of this independent evaluation prior to making further decisions regarding the future of Family Care. In addition, counties not implementing Family Care have begun to question the relatively high level of state funding flowing to the current Family Care counties while they face reductions in services. Although, while there is currently no discussion about pilot counties reverting back to the pre-Family Care system, it is notable that CMO staff unanimously expressed a preference for Family Care over the old system. It is in this environment that DHFS has begun to plan for the possibility of additional CMO counties.

Aside from political considerations, the major issues for DHFS include the scope, configuration and timing of any expansions, along with technical assistance that would need to be provided.

Scope - The scope could range from one additional county, as was initially planned, to the rest of the entire state (another 67 counties). If Family Care is expanded to multiple counties, issues of timing and the ability to meet the technical assistance needs of the new counties become important considerations.

Configuration - The configuration could continue to be county-based, or like Michigan, DHFS may determine that the organizational economies of scale warrant a minimum number of covered lives, which would argue for a more regional approach for counties with smaller populations. In its recent solicitation for contracting organizations for its 1915(b)/(c) combination waiver, Michigan required a minimum of 20,000 Medicaid beneficiaries in their catchment area, of which a fraction might be expected to access covered services. Another consideration will be whether the State will continue to contract exclusively with county governments or allow other organizations to become CMOs. DHFS is also exploring whether partnership arrangements with providers or other organizations might meet CMS competition requirements, as well as play to the counties' strengths, primarily clinical functions, and shore-up areas in which they are weaker, primarily operational and fiscal systems. Milwaukee's CMO operates in this manner with Keylink Solutions for the fiscal operations related to claims payment, and contracts with private entities for additional Care Management Units (CMUs). Virchow Krause, a management consulting firm, has helped DHFS explore these issues.

Timing – The experience of the pilot counties suggests a gradual phase-in and possibly staggered roll-out of additional CMO counties. This may help reduce the level of technical assistance required.

Technical Assistance - DHFS has taken advantage of the knowledge gained from implementing the pilot program to develop protocols and other aspects of the program for use in the rest of the State even without the full, capitated payment model. The web-based functional screen is being used in non-Family Care counties. The Resource Allocation Decision (RAD) method was being introduced to supervisors in the waiver counties, and the Bureaus of Developmental Disability Services, and Aging and Long-Term Care Resources, planned to train care managers in the Fall of 2002. DHFS conducted member outcome interviews with waiver recipients in the Summer of 2002. These early efforts should ease any transitions to Family Care.

If the State continues to sole-source with local public entities that had population and HCBS experience to act as the managed care organizations, this will still require the build-up of managed care expertise and infrastructure at the public entities. DHFS will still need to provide technical assistance so that local governments can learn how to implement the mechanisms necessary to become managed care organizations in terms of the operational, clinical and fiscal management. In recognizing this, DHFS has begun to consider the infrastructure elements that it may require of counties prior to implementing Family Care. For example, having the necessary information technology in place should accelerate the implementation process. DHFS has drafted a readiness assessment to aid in evaluating any future Family Care care management organizations because one of the lessons of the pilot was that the basic infrastructure needs to function smoothly in order to devote the necessary resources to organizational culture and philosophical changes.

Keys to the pilots success that would be important to foster in any expansion include:

- **Commitment** – The state and the county staff have demonstrated a high level of personal investment and pride in the program. They are committed to its success and do not even consider the possibility of reverting back to the old system because they see the advantages of the new system. It is this commitment that motivated the continuous learning process and spirit of cooperation. The current CMO staff and DHFS support the expansion of Family Care because they think it will provide other counties the opportunity to improve their long-term care systems.

- **Cooperation** – All of the parties involved have been willing to work through problems and cooperate to build the new program. Not everyone agrees on everything, but cooperation is evident in: 1) the work groups established by DHFS where counties share information and bring up issues with the state staff; 2) the governing bodies, LTC councils and work groups established at the state and county level to advise on operations and policy; 3) the inter-departmental cooperation between DHFS and the Department of Workforce Development at the state level, and the RCs, CMOs and the Economic Support Units at the county level, to resolve the eligibility processes; and 4) the advocacy groups' efforts to improve the program and keep everyone focused on the member.

- **Trust** – State staff had to trust the competency of county staff to implement the program. County staff had to trust that the state staff would support them and work with them. Members had to trust that they would continue to receive high quality, appropriate services. The pilots tread in uncharted territory. During one of our site visits, a CMO director commented, "We didn't know what we didn't know." As a result, all parties had to have sufficient trust and willingness to make mistakes and learn from them without finger pointing.

APPENDIX A
FIDELITY MEASURE

The chart below displays a prototype fidelity measure for Family Care for the five counties with CMOs. The fidelity measure matrix presents the baseline assessment of Family Care implementation by county for each of the core domains and program components. The measure includes components under the Family Care core domains, as well as sample **ranges** for some components. All observations are as of May 2001 and May 2002.

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

The **sample ranges,** however, reflect a dynamic definition that has been and will continue to be refined with input from the Department and the Family Care pilot counties. Only some components have sample ranges. For example, "CMO, RC, and ES Relationship" does not contain a range and "Staffing" has the range "Have staff in all required roles → Staffing level sufficient to carry out functions." The definitions or ranges associated with the other components were derived empirically from information collected from each of the pilot programs. As the evaluation continues with the impact evaluation, we will monitor the counties in these areas.

Some areas added since the 2001 update contain an "N/A", indicating that Lewin did not assess that component in 2001. Also, "N/A" may appear in areas where Lewin did not have sufficient information to make an assessment for that area. For example, Lewin could not assess the degree to which providers were participating in the care planning process across counties from the limited provider interviews. Some areas remain blank because data from the outcome/cost benefit study will enable comment on those ranges. Some of these components are required elements of the Family Care contract, while others have emerged as critical components in the course of program implementation. Required components are defined as specified in the Family Care contract. "N/A" indicates that Lewin did not assess that component.

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Exhibit A-1
Fidelity Measure for Family Care: Current Status of Family Care County Implementation in May 2001 and May 2002

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]		Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
		2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
System Structure													
CMO, RC and ES Relationship	Eligibility and enrollment plan between CMO and RC, ESU and EC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Resource Center contact made within timeline (October 2000-March 2001)[2]	Y	Y	63%		94%		43%		95%		57%	
	Set meeting time for ES, CMO and RC or availability to meet when problems arise			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Degree of involvement of ES from the beginning of implementation – ES workers devoted solely to FC eligibility determination – information sharing between ES and RC staff			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Re-certification policies in place and approved by DHFS			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Web-based functional screen			N	Y	N	Y	N	Y	N	Y	N	Y
Staffing Level	**Range: Have staff in all required roles ® Staffing level sufficient to carry out functions**												
	All positions filled			Y	Y	Y	Y	Y	N	Y	Y	Y	Y
	Freedom to hire new staff independent of the county board or agreement worked out for Family Care			N/A	N	N/A	Y	N/A	N[3]	N/A	N	N/A	N
	RC contacts per FTEs (Feb 2001 and March 2002 contacts used; March 2001 and 2002 FTEs used)			24	26	30	29	69	60	151	96	21	24
	CMO functions – caseload goals met for all target populations			N	Y	N	N	N	N	N	N	Y	Y

1. Based on the 2001 and 2002 RC and CMO contracts

2. DHFS no longer reporting this information in Quarterly Activity or Monthly Monitoring Reports.

3. Milwaukee does not need County Board approval to add contracted care management units.

Exhibit A-1, Continued
Fidelity Measure for Family Care: Current Status of Family Care County Implementation in May 2001 and May 2002

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]		Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
		2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
System Structure (continued)													
IT System	**Range: IT development plans ® Fully developed IT system supporting functions of RC and CMO.**												
	I and R outcomes			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Functional Screen			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Assessment			Y	Y	N	N	Y	Y	N	N	N	N
	Case Notes			Y	Y	N	N	Y	Y	N	N	N	N
	ISP and outcomes			Y	Y	Y	Y	Y	Y	Y	Y	N	N
	Prior authorization			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Billing Internal			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Provider Claims Processing			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Governance													
RC and CMO Separation	Establishment of separate governing board with no overlap in membership	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Role of Governing Bodies	Established with correct make-up→ integral in CMO and RC operations	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outreach													
Targeting	**Range: Slightly under contact goals ® Exceeding contact goals, innovative strategies to reach target populations**												
	Exceeding contact goals	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PAC Referrals	Receiving referrals from facilities according to PAC plan > referrals are appropriate[2]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Outreach to institutional residents		Y	N	Y	N	Y	N	Y	N	Y	N	N
	Actively engaged in prevention activities	Y	Y	N	Y	N	Y	N	Y	N	Y	N	Y
Service Access													
Functional Screen	Consumers screened within 14 days of contact[4]	Y	Y	96%		95%		100%		100%		100%	N/A
Type of Information Provided by RC	Broad range of services			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

[4]   DHFS no longer reporting this information in Quarterly Activity or Monthly Monitoring Reports.

Exhibit A-1, Continued
Fidelity Measure for Family Care: Current Status of Family Care County Implementation in May 2001 and May 2002

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]		Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
		2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
Service Access (continued)													
Format of Provider Information at RC	**Range: Paper brochures ® Searchable database ® Consumer searchable**												
	Consumer searchable listing on the website			Y	Y	N	Y	N	N	N	N	N	N
	Waiting list eliminated			Y	Y	Y	Y	N	Y	Y	Y	N	N
	Entitlement reached			N	Y	N	Y	N	N	N	Y	N	N
	Delayed enrollment instituted			Y	N	Y	N	N	Y	N	N	Y	Y
Enrollment Rate	% increase from March 2001 to March 2002			30		28		180		34		50	
	Enrollment reached a stable state			N		N		N		N		N	
Consumer Unmet Needs	Pilot identified consumer unmet needs → addressed unmet needs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prior Authorization	Procedures established, procedures followed and understood by providers (verbal, written)			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community Alternatives Developed and Supported	County has options available for all target populations[5]	Y	Y										
	Institutional relocations occurring			Y	Y	Y	Y	Y	Y	Y	Y	not tracking	
	Number of institutional relocations since beginning of CMO			5	6	34	42	20	0	3	13	not tracking	
CMO Provider Network	**Range: CMO meets quality requirements in provider contracts. ® Provider network meets consumer needs**												
	Number of providers under contract with the CMO			195	241	258	287	N/A	N/A	132	179	301	118
	Quality language beginning in provider contracts			Y	Y	N	N	Y	Y	Y	Y	N	Y
	Full-time provider network staff			Y	Y	N	N	Y	Y	Y	Y	Y	Y
	Provider training in place			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Care Management													
Composition of CM Team	**Range: County developed goal. ® Followed through with goal. ® Evaluation of effectiveness of composition**												
	Teams in place			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RN to Consumer Ratio	At least one RN per 80 consumers			N	N	N	N	N	N	N	N	Y	Y

[5]   Will be assessed in the outcome evaluation.

Exhibit A-1, Continued
Fidelity Measure for Family Care: Current Status of Family Care County Implementation in May 2001 and May 2002

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]		Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
		2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
Care Management (continued)													
RN Responsibility	**Range: Assessment/ consultation ® Prevention ® Coordination of nursing with other Interdisciplinary Team (IDT) members**												
	Role moving beyond assessment			Y	Y	N/A	Y	N/A	Y	Y	Y	N	Y
RAD Method	RAD training given to all CMs → documented use by all CMs												
	Training and documentation of use			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consumer Participation in Care Planning	Ability to participate in the care plan communicated to the consumer by the CMO → Use of the member centered plan to identify preferences and outcomes	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	y
Provider Participation in Care Planning	Providers receiving prior authorization, receiving ISP → helping to create ISP			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Relationship to Acute and Primary Care	Collaboration w/ acute primary care meeting w/ local hospital staff information sharing occurs			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prevention	Prevention activities occurring	Y	Y	N/A	Y	N/A	Y	N/A	Y	N/A	Y	N/A	N
Quality													
Quality Plan	Plan created and approved by DHFS – moving forward on agenda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Internal Advocacy	Member handbook developed	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Full-time member relations coordinator	N	N	N	N	N	N	N	Y	N	N	Y	N

Exhibit A-1, Continued
Fidelity Measure for Family Care: Current Status of Family Care County Implementation in May 2001 and May 2002

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]		Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
		2001	2002	2001	2002	2001	2002	2001	2002	2001	2002	2001	2002
Consumer Direction													
Degree of Consumer Involvement	**Range: Limited involvement of consumers. ® Extensive input from consumers into day-to-day operation (e.g. Self-Directed Support Option committees)**												
	Number of committees with consumer involvement other than the LLTCC and governing bodies			N/A	2	N/A	1	N/A	4	N/A	3	N/A	2
Consumer Choice Supported	Degree to which consumers have choices about their care → scores higher than 60% for all choice related outcome on Member Outcome Tool across all target populations			N	N	N	N	N	N	N	N	N/A	N/A
Self-Directed Support Option	Self-directed support option available → documented use of the SDS Option developed according to standards	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N
	SDS committee with consumer representation			N/A	Y	N/A	N	N/A	N	N/A	N	N/A	N
Local LTC Council	LTC Council formed and meeting regularly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Independent Advocacy	Local agency provides advocacy independent of the county			N/A	Y	N/A	Y	N/A	Y	N/A	N	N/A	Y
	State funded Independent Advocate in place[6]			Y	N	Y	N	Y	N	Y	N	Y	N
Capitation													
Pilot Viability	**Range: Pilot county ability to manage the rates ® Factors such as adequacy of rate set by DHFS, management of services. ® Track adjustments in the rate.**												
	CMO assumes full risk			Y	Y	N	N	N	N	Y	Y	Y	Y
	CMO does not rely on county funds			Y	Y	N	N	Y	Y	Y	Y	Y	Y

[6] Funding for independent advocate was not included in 2001-2003 state budget.

APPENDIX B
SITE VISIT INTERVIEW PARTICIPANTS

I.   ENROLLMENT CONSULTANTS

Southeastern Wisconsin Area Agency on Aging (SEWAAA)

Jenny Bielefeldt	La Crosse, Richland, Portage
John Schnabl	Milwaukee, Fond du Lac

II.   COUNTIES FULLY IMPLEMENTING FAMILY CARE

A.   Fond du Lac

1.   *County Staff*

Maggie McCullough	CMO Director
Deborah Rathermel	Network Developer
Kay Krause	Deputy Director
Michelle Dunn	Case Manager
Vonni Dunn	Case Manager
Connie Atkinson	Case Manager
Stacey Burton	Case Manager
Julie Schmer	Case Manager
Deb Kurek	RN Case Manager
Larry Debbert	Member Relations Coordinator
Sandy Tryon	Resource Center, Supervisor
Mary Neuman	(SSS - phone at ADRC/support tasks for unit)
Mary Koplitz	Social Worker - I & A/choice counseling/DSS
Mary Schlautman	Social Worker
Linda Berg	Social Worker - recerts/ ongoing cases
Cheryl Retterhagen	Social Worker
Cheri Luelca	Social Worker

2.   *LTC Council*

4 Consumer representatives

2 Provider representatives

3.   *Advocates* (Telephone Interview)

Options for Independent Living

Tom Diedrich	Executive Director

B.   La Crosse

1.   *County Staff*

Dean Ruppert	HSD Operations Manager
Peggy Herbeck	Supervisor
Sigrid Dooley	RN, Nurse Consultant, Screen Lead
Mary Faherty	LTS Manager
Nancy Schmidt	Network Developer/ QA/ Complaint and Grievance
Dave Janney	Elderly Supervisor - Social Worker
Kaila Brynt	PD Supervisor
Joe Byrnes	Finance
Celia Fluehager	DD Supervisor

2.   *LTC Council*

3 Consumer representatives

3.   *Advocates*

Great Rivers Independent Living Services

Kathie Knoble-Iverson	Executive Director
Michelle Olson	Assistant Director
Cheryl Ottens	Benefits Coordinator
Steve Johnson	Independent Living Specialist

C.   Milwaukee

1.   *County Staff*

Stephanie Sue Stein	Director Milwaukee County Department on Aging
Chester Kuzminski	Resource Center Manager
Gail Cheatham	QI Coordinator
Lilian Alford	RC Supervisor
Michelle Lameka	Elderlink Coordinator
Arlene Murray	Program Coordinator
Meg Gleeson	CMO Project Manager
Cathy Eschete	CMO Training Coordinator
Carol Miller	Program Coordinator/ Supervisor
Nora Gomez	Quality Improvement Coordinator

George Searing	Assistant Director, Fiscal and Support Services
Adrienne Kiff	Provider/Member Liason
MaryAnne Filo	RN Nurse Educator/ Trainer
Mark Lucoff	Contract Administrator

2. *LTC Council*

3 Consumer representatives

2 Provider representatives

3. *Advocates*

Leonila Vega	Wisconsin Coalition for Advocacy
Paula Lorant	Legal Aid Society
Pat Towers	Commission on Aging
Tom Hlavacek	National Association of Protection & Advocacy Systems
Claudia Stine	Board on Aging and Long-term Care
Donna Thompson-Schneider	SeniorLAW

D. Portage

1. *County Staff*

Janet Zander	Director
Dana Cyra	Resource Services Director
Jim Canales	CMO Contact
Evelyn Heikenen	Family Care Systems Analyst
Randy Bestul	Network Development Manager
Jessica Schmidt	Quality Assurance/ Member Relations
Lucy Runnells	Financial Manager
Linda Weitz	Supervisor DD Unit

2. *Consumer and Provider Representatives*

4 Consumer representatives

3 Provider representatives

E. Richland

1. County Staff

Kim Enders	Resource Center Supervisor
Marianne Stanek	Resource Center
Sharyn Knudson	RC Specialist
Teri Buros	Manager
Becky Cupp	Long Term Support Supervisor
Robin Smelcer	Provider Network Developer
Linda Overbeek	Administrative Assistant LTS Unit
Russell Lutz	Consultant - State Bureau of Information Systems

2. LTC Council

1 Consumer representative

1 Provider representative

III. REPRESENTATIVES OF THE LEGISLATURE

Senator Rodney Moen Chair, Senate Committee on Health, Utilities, Veterans and Military Affairs

Ryan Natzke for Senator Mark Meyer, Chair, Committee on Universities, Housing, and Government Operations

Kevin Moore for Representative Kitty Rhoades, Chair, Assembly Committee on Aging and Long-Term Care

IV. FAMILY CARE STATE STAFF

Chuck Wilhelm	Director, Office of Strategic Finance
Judith Frye	Director, Center for Delivery Systems Development
Monica Deignan	Family Care Project Manager
Karen McKim	Quality and Research Manager
Ruthanne Landsness	Policy Monitor and Grant Specialist
Alice Mirk	RC/CMO Implementation and Technical Assistance Manager
Angie Morgan	Family Care Quality Consultant
Bruce Wasserstrom	Program and Policy Analyst
Tom Lawless	Rate setting and Research Consultant

Dana Parpart	BIS staff supervisor
Greg Robbins	Family Care Administrative Manager

V. STATE LTC COUNCIL

Carol Eschner	Interfaith, provider representative
Lorraine Barniskis	Council Staff
Beth Christie	Wisconsin Assisted Living Association (WALA)
George Potaracke	Ombudsman

VI. SURVIVAL COALITION

Jennifer Ondrejka	WI Council on Developmental Disabilities
Maureen Ryan	WI Coalition of Independent Living Centers
Michael Blumenfeld	Jewish Coalition, Partnership, Cerebral Palsy
Lynn Breedlove	WI Coalition for Advocacy

VII. WISCONSIN COALITION OF AGING GROUPS

Tom Frazier	WI Coalition of Aging Groups
Jason Kay	AARP Public Policy

VIII. PROVIDER COALITION

John Sauer	Wisconsin Association of Homes and Services for the Aging (WAHSA)
Tom Ramsey	WAHSA
Tom Moore	Wisconsin Health Care Association (WHCA)
Michael Bargs	Meadowmere/ Mitchell Manor
Jean Gasings	Franciscan Villa
Kristen Huber	Fond du Lac Lutheran Home
Sandra Randall	Villa Loretto
Mari Betz Borek	Fond du Lac Lutheran Home
Betsy Vanheesen	Fond du Lac Lutheran Home
John Hager	Friendship Village
Marge Herden	Silver Spring Health and Rehabilitation
Sue Blackwell	South Shore Manor
Bob Conlow	Beverly Health Care

Barbara Moore	Community Care Organization
Lynn Vogt	St. Ann's Home
Kathy Ciante	Pine Valley Health Care and Rehabilitation
Tom Rand	Bethany St. Joseph
Ann M. Echstern	Bethany Lutheran Homes
Tom Rislow	Bethany Lutheran Homes
Linda Krause	Saint John's Home of Milwaukee
Frank Reuser	Saint John's Home of Milwaukee

APPENDIX C
SITE VISIT PROTOCOLS

APPENDIX C

Table of Contents

Site visit Protocol for Evaluation of Wisconsin Family Care Program

Care Management Organization Staff

County:

Date:

Respondents:

Overview

Please note the major turning points in the development of the Family Care model in your county since May 2001 (e.g., rate changes, contract changes).

I.   SYSTEM DESCRIPTION

A.   Administrative Structure

- Please discuss any **significant** changes, if any, in the administrative structure of the CMO since May 2001.

- Please describe your relationship with the county board. What has been helpful in obtaining their support? What strategies have not been successful (e.g., contract renewal, staffing, funding)?

B.   Relationship with the RC, ES and Enrollment Consultant

- Please describe what information is provided from the RC and the enrollment consultant for each consumer? How do you receive the client's decision to enroll in the CMO from the enrollment consultant (e.g. paper, phone, fax)? Please comment on the quality of the information.

- What guidance did DHFS provide around the enrollment consultant?

- How has the addition of the enrollment consultant affected communication between the RC and CMO?

- Please describe how the re-certification process has proceeded. How could the process be improved?

- Please discuss the costs/benefits of the physical location of the ES staff and the enrollment consultant.

C. Information Technology (IT) System Development

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

- What are the costs involved in your IT system for 2001? Were there any costs that you did not anticipate?

- Please comment on the degree to which IT system issues have been or could be shared with other counties.

- Please comment on the degree to which the following areas are computerized:

    ➢ Shared access between the RC and CMO (Y/N/planned)

    ➢ Functional Screen (Y/N/planned)

    ➢ Assessment (Y/N/planned)

    ➢ Case Notes (Y/N/planned)

    ➢ Client documents on the internet or intranet (Y/N/planned)

    ➢ ISP and outcomes (Y/N/planned)

    ➢ Wellness inventory (Y/N/planned)

    ➢ Prior authorization (Y/N/planned)

    ➢ Billing (Y/N/planned)

    ➢ Provider claims processing (Y/N/planned)

    ➢ Claims lag reports (Y/N/planned)

    ➢ Tracking capability (Y/N/planned)

    ➢ Refund reversal (Y/N/planned)

    ➢ Time and Expense Reporting (Y/N/planned)

    ➢ Coordination of benefits reporting (Y/N/planned)

    ➢ Considering HIPAA regulations (Y/N/planned)

    ➢ IT staff position (Y/N/planned)

    ➢ Integrating with acute care (Y/N/planned) What confidentiality issues exist here?

    ➢ Any others of significance (Y/N/planned)

D. Relationship with the State and Federal Government

- Does current federal law restrict your programs' operations?

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

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

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

- In what areas could you use additional staff?

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

- Please describe patterns of staff turnover since the beginning of FC.

II.   FUNDING

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

- Please describe the impact of higher enrollment than projected on your budget.

III.   GOVERNANCE

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

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

- Please describe the role of the enrollment consultant. How did the CMO Governing Committee contribute to the plan? How have consumers been affected? How has your county attempted to ease the burden on consumers? How could the process work better?

IV.   ENROLLMENT

- Please comment on the timeliness and accuracy of eligibility determination. Probe: What do you feel are the strengths and weaknesses of the new web-based LTC functional screen?

- Please comment on the state's partial freeze on non-MA enrollment.

- Do you have a delayed enrollment plan at this time? When did the plan go into effect? And why?

- Do you anticipate your enrollment will reach a steady state?

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

- Given the lag time in getting enrollment dates entered into the CARES system and thus to the Medicaid MMIS system, have you noted any problems in reimbursement?

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

V.   ACCESS TO SERVICES

- Please describe your capacity to handle FC as entitlement. What barriers, if any still exist? (refer to Attachment 2)

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

- In what areas do members have unmet needs?

- Which services do members use the most?

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

- Describe any changes in your provider network.

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

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

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

- What methods are the most effective in strengthening the provider network?

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

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

- In what areas has the CMO offered training to providers? What training are providers requesting?

- What issues still remain surrounding prior authorization?

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

VI.   CARE MANAGEMENT AND CARE PLANNING

- What is the composition of the interdisciplinary teams? Has this changed since May 2001? What has worked best? (Please compare to Attachment 1)

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

- Please fill-in your caseload size below.

	Elderly/PD		DD	
	Current	Target	Current	Target
RN				
SW				

- Do the populations continue to differ in the intensity of care management needed?

- How frequently does the interdisciplinary team meet?

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

- Have you encountered any difficulty hiring RNs?

- How are the caseloads distributed among care managers? How do you assess when a care manager has an unmanageable caseload with regard to size or intensity?

- Is the RAD method used by all care managers?

- Has the RAD method tool lead to more appropriate service use?

- Do care managers document when they use the method?

- Please describe the training that has been provided to care managers on the RAD method.

- What provider information is made available to the care managers for care planning? Probe: format of information, spreadsheet, etc.

- To what extent are providers involved in care planning? Is there an effort or need to increase involvement?

- To what extent does the CMO coordinate with acute care providers in care planning?

- In what ways are members and their families involved in the care planning and monitoring processes? Do you have a method to document such involvement? Does this differ by target population?

- Are the state established timelines for completing the individualized service plan (ISP) and comprehensive assessment appropriate and reasonable?

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

- To what degree are your interdisciplinary teams equipped to deal with individuals with mental illness? In what ways has Family Care forced you to examine mental health issues more?

VII. CONSUMER DIRECTION

- What aspects of consumer direction are supported by the CMO?

- Were there any contract requirements with regard to consumer direction that were difficult to meet? Please explain.

- Are members required to call the CMO when they have a problem with a provider or do they contact the provider directly?

- Please comment on your process to date with regard to your self-directed support (SDS) option plan. How many members are using the option?

- About how many individuals are using independent care providers? How are providers paid (e.g., fiscal intermediary, agency)? Is this option only open to individuals using the SDS option? If so, do you have plans to extend the individual provider option to other members?

- What training has been provided to staff and members/families on the option? What training has been effective?

- What services can members self-direct? Are there plans to expand those service options?

- What committees have you formed to support the SDS option?

- Please explain your plans for back-up for individual providers.

- What barriers to consumer direction exist in your county? In Family Care in general?

- Have choices expanded for consumers? How have you sought consumer input on consumer direction?

VIII. QUALITY

- When was your quality plan approved by the Department? If this process were to be repeated, what improvements would you suggest?

- Have you been able to meet the established timeline in the plan? Why or why not?

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

- What new goals did the CMO governing board set based on last year's quality results?

- Do you have a CMO member advocate in place?

- What have been the results of any attempts to survey CMO members beyond the member outcome assessment?

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

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

- Please comment on provider's awareness of policies and procedures regarding Family Care. Have you experienced any difficulty surrounding provider concerns?

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

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

- Have quality indicators been included in provider contracts?

- Are there any providers with whom you have decided not to contract? Please explain.

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

- What barriers to quality exist in Family Care?

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

- Do you feel there are sufficient avenues for advocacy for members?

- What operations or procedures has the CMO changed in response to the member outcome results? Or DHFS quality site reviews?

IX.   CAPITATION

- Please comment on the adequacy of the new capitation amounts determined by the state which account for some percentage of functional status.

- How did the adjustments for administrative costs affect your county?

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

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

- How have you dealt with high cost cases?

- How have you managed the risk (e.g., state insurance option, other county-level options) ?

X.   SYSTEM LEVEL QUESTIONS

- What are the most innovative aspects of the long-term care system in this county that distinguish you from other counties?

- Is there interest and support for Family Care in your county?

- Do you feel that Family Care allows for innovation in service delivery and funding? Describe examples.

- What would a county considering Family Care need to have as far as resources and support?

- How has the CMO evolved into an effective model since the beginning of Family Care?

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

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

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

- What suggestions do you have for other counties considering FC?

- Do you have a vision of how state-wide expansion would work?

- What do you want to communicate to the Governor about the Family Care program?

Exhibit C-1
CMO Care Management Team Configurations May 2001
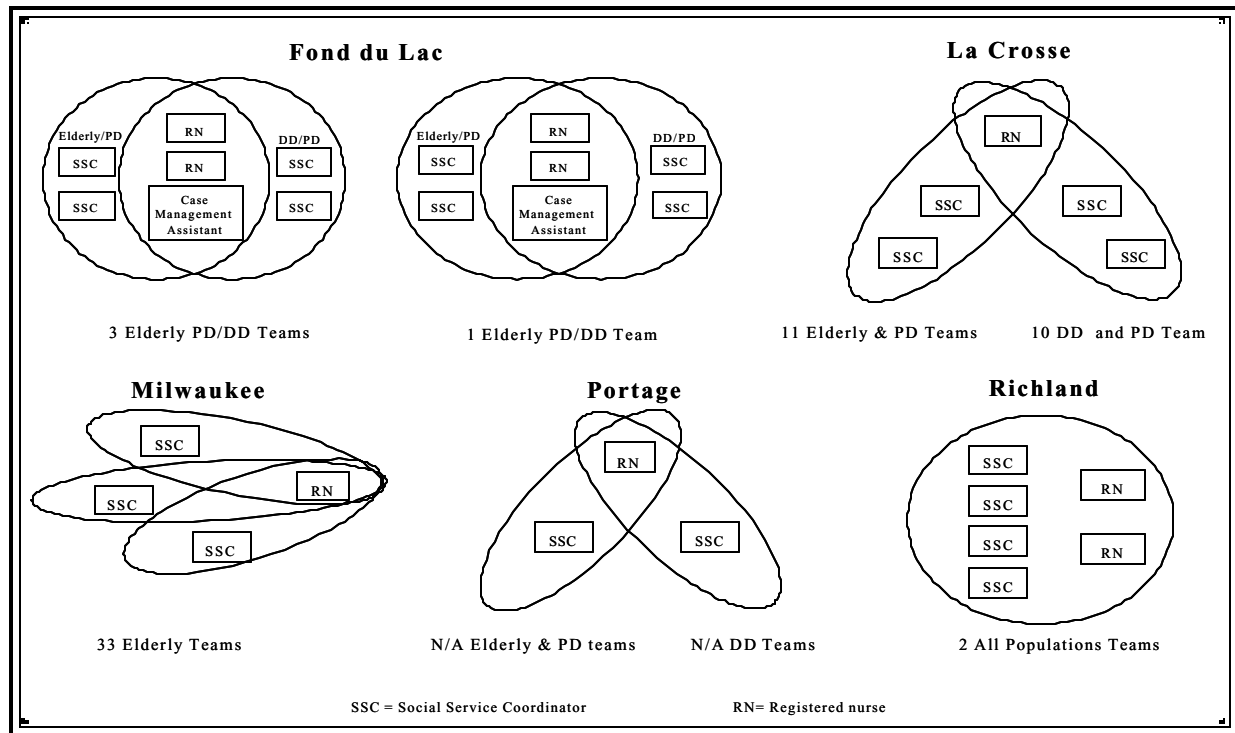
Note: Portage has not yet formalized its team arrangements. Nurses are neither population, nor Social Service Coordinator specific.

Exhibit C- 2
Number of Providers Under Contract with the CMO,
by Type of Service

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

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

Site visit Protocol for Evaluation of Wisconsin Family Care Program

Resource Center Staff

County:

Date:

Respondents:

Overview

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

I. SYSTEM DESCRIPTION

A. Administrative Structure

- Please discuss any significant changes in the administrative structure of the RC since May 2001.

- Please describe your relationship with the county board. What has been helpful in obtaining their support? What strategies have not been successful (e.g., contract renewal, staffing, funding)?

B. Information Technology (IT) System Development

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

C. Relationship with the State and Federal Government

- Does current federal law restrict your programs' operations?

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

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

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

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

- Where could you use additional staff?

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

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

II.   FUNDING

- What additional funding did the RC receive beyond the contract with DHFS? Probe: source, dates received, adequacy

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

III.   GOVERNANCE

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

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

- What guidance did DHFS provide around the enrollment consultant?

- Please describe the role of the enrollment consultant. How have consumers been affected? How has your county attempted to ease the burden on consumers? How could the process work better?

- Has the addition of the enrollment consultant affected communication between the RC and CMO? Are there confidentiality issues that exist in the information transfer?

IV.   OUTREACH

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

- Have you had sufficient funding to conduct the outreach necessary?

- What patterns have you observed, if any, with outreach efforts and your contact numbers?

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

- Which populations have been difficult to reach? Which populations, if any, are not making use of the Resource Center?

- Please provide an update on your progress with resident outreach.

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

- Please provide a description the current PAC referral process.

- From which agencies do you receive the most PAC referrals? The least?

- What have been effective strategies for ensuring appropriate PAC referrals? Is the penalty being enforced for noncompliance?

- Please describe any improvements in the PAC referral process.

V.   ENROLLMENT

- What are the strengths and weaknesses of the new functional screen? Has it changed the time it takes to complete the functional screen?

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

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

VI.   ACCESS TO SERVICES

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

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

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

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

VII.   CONSUMER DIRECTION

- How does the RC incorporate consumer-direction? For example, does the structure and atmosphere of the RC promote consumer choice and independence?

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

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

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

VIII. QUALITY

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

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

- Please describe the main components of your quality plan. Please describe your focused quality improvement project.

- Please describe prevention efforts. How are you tracking the success of prevention efforts? Do you have any results?

- What have been the results of your efforts to obtain consumer feedback on the RC?

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

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

- What barriers to quality exist in Family Care?

IX. SYSTEM LEVEL QUESTIONS

- What are the most innovative aspects of the long-term care system in this county that distinguish you from other counties?

- Is there interest and support for Family Care in your county?

- Do you feel that Family Care allows for innovation in service delivery and funding? Describe examples.

- What would a county considering Family Care need to have as far as resources and support?

- How has the RC evolved into an effective model since the beginning of Family Care?

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

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

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

- What suggestions do you have for other counties considering FC?

- Do you have a vision of how state-wide expansion would work?

- What do you want to communicate to the Governor about the Family Care program?

Exhibit C-3
Number of Providers Known by the RC,
by Type of Service

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

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

Site visit Protocol for Evaluation of Wisconsin Family Care Program

County Long-Term Care Council Representatives

County:

Date:

Respondents:

I.   BACKGROUND

A.   Consumer and Provider Representatives

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

B.   LTC Council Members

- Please comment on the development of the LTC Council.

- How often does the Council meet?

- How are the meetings run? Who facilitates?

- Please describe the responsibilities of the Council.

- Do you feel you have an important role in guiding the LTC system in your county? Please provide examples of your impact on the system.

II.   SYSTEM DESCRIPTION

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

- How well do you think Family Care has met those goals?

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

III.   ELIGIBILITY

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

- Please comment on prior authorization rules under Family Care.

IV.   CARE MANAGEMENT AND SERVICE PLANNING

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

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

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

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

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

V.   SERVICES

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

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

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

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

- In what areas are consumers experiencing unmet need?

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

VI.   CONSUMER DIRECTION

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

- Does the consumer make/initiate changes to the care plan?

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

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

- Please comment on your awareness of the advocacy in your county.

VII.   REIMBURSEMENT (PROVIDERS)

• Please comment on the adequacy of reimbursement rates under Family Care.

VIII.   QUALITY ASSURANCE

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

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

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

• Please describe any changes in the contracts process with regard to quality assurance? Are there any provisions that are difficult to meet or problematic?

• What external monitoring do providers receive from the CMO, if any?

IX.   CONCLUSIONS

• What are the most innovative aspects of the long-term care system in this county that distinguish you from other counties?

• Is there interest and support for Family Care in your county?

• Do you feel that Family Care allows for innovation in service delivery and funding? Describe examples.

• What would a county considering Family Care need to have as far as resources and support?

• How has the CMO evolved into an effective model since the beginning of Family Care?

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

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

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

• What suggestions do you have for other counties considering FC?

• Do you have a vision of how state-wide expansion would work?

• What do you want to communicate to the Governor about the Family Care program?

APPENDIX D

PROVIDER TELEPHONE INTERVIEW PROTOCOL

**June 2002 Provider
Family Care Telephone Interview Guide**

I.   PROVIDER INVOLVEMENT IN FAMILY CARE PROGRAM

- In addition to *<county>*, do you serve Family Care clients in any other county? If so, do you have a contract with that CMO?

- What services are you contracted to provide members under Family Care?

- Approximately how many Family Care members do you serve and what populations?

- What proportion of your clients in Family Care are existing clients and how many are new referrals?

II.   SYSTEM DESCRIPTION

- Describe the communication between your agency and county and/or state officials regarding policy and procedures associated with Family Care.

- Was training and education provided on the Family Care procedures and policies? If so, what was the nature and adequacy of the training?

- How well is Family Care meeting overall goals for transforming the LTC system?

III.   SERVICES

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

- Are you providing any additional services under Family Care that you did not provide under the previous system?

- Have you increased your capacity in certain service areas as a result of becoming a Family Care provider (e.g., hired more staff, technology changes)? If so, how and why?

- Does your agency receive the member's plan of care from the CMO?

- Please describe the coordination, if any, between the CMO assessment and care planning procedures and the procedures of your agency (e.g., what staff from your agency and what staff from the CMO are involved in coordinating the client's service plan? do you receive verbal and/or written authorization? what is the coordination like for ongoing care—does the CMO inform you of changes to a member's care plan?).

- Are there limitations in how you deliver services under Family Care?

IV.   CONSUMER DIRECTION

- How involved are consumers in the care planning process?

- To what extent do consumers have choice under Family Care?

- Does the CMO make requests as to the type/day/hours of service that the consumer has requested? If so, are you able to meet those requests?

- Does the consumer make/initiate changes to your service plan?

- Please comment on the accuracy of the information that the Resource Center makes available to consumers about your services.

- Are you familiar with the self-directed support option under Family Care?

V. REIMBURSEMENT

- Please comment on the current negotiated rates versus the rates paid by the county under the previous system.

- Describe the prior authorization process. How well does the process function? Do you have any suggestions for improvement?

- Please comment on the timeliness of claims processing and payment (i.e., how long is the billing cycle from the time you submit a claim to the time you are reimbursed).

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

VI. QUALITY ASSURANCE

- How responsive is the CMO/Care Manager if there are any concerns (e.g., billing, consumer care)?

- Do you think quality assurance under Family Care is adequate? Is the contract clear with regard to quality assurance requirements? Are there any provisions that are difficult to meet or problematic?

- Are you familiar with the grievance process under Family Care? Has your agency had experience using it? How adequate is the grievance process for consumers?

VII. CONCLUSION

- Do you see your agency continuing to participate in Family Care in the future?

- Has the number of Family Care referrals to your agency been what you expected?

- Do you feel there is increased competition now?

- Other comments_____ .

APPENDIX E

ACRONYMS AND GLOSSARY OF TERMS

ACRONYMS

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

ALF   **Assisted Living Facilities:** Three types of residential assisted living facilities are subject to regulation. Community-based residential facilities serve 5 or more adults; adult family homes may serve up to three or four adults; residential care apartment complexes serve five or more adults in independent units.

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

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

BALTCR   **Bureau of Aging and Long-Term Care Resources:** A unit within the Wisconsin Department of Health and Family Services designated for planning, coordinating, funding and evaluating state and federal programs for older adults.

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

CBRF   **Community-Based Residential Facility:** A place in which five or more unrelated adults live and where they receive care, treatment, or services, but not nursing care on any permanent basis, in addition to room and board. CBRFs are licensed by DHFS under ch. HFS 83 rules. [25]

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

CHF	**Congestive Heart failure:** a condition in which the heart is unable to maintain an adequate circulation of blood in the bodily tissues or to pump out the venous blood returned to it by the veins causing the buildup of fluid accumulating in the lungs and around the heart.
CIP	**Community Integration Program:**

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

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

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

CMO	**Care Management Organization:** Entity that provides or arranges for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. The CMO must coordinate care across different delivery systems (including primary health care, long term care [LTC], and social services) and funding sources (including Medicaid fee-for-service and other commercial health insurance, Medicare, and funding sources for vocational and social services).
CMS	**Centers for Medicare & Medicaid Services** (formerly HCFA): The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).
CMUs	**Care Management Units:** Milwaukee CMO contracts with CMUs, private agencies, to serve as care managers with CMO members.
COP-W	**Community Options Program Waiver:** In January of 1987, Wisconsin received approval of the COP-Waiver request from the federal government. The waiver permits the use of federal Medicaid funds to finance services provided to eligible persons in the community, as an institutional alternative.
COP	**Community Options Program:** A DHFS financed, county-administered program to support individuals who desire to remain in the community setting. The program involves assessing the need of Medical Assistance eligible persons faced with nursing home placement and assisting them via a range of available supportive services in the community, care planning and management, and paying for gap-filling supportive services to make continued or new community residence possible.
CSDRB	**Community Services Deficit Reduction Benefit**: A program under which counties, tribes, and local health departments are able to claim the federal matching dollars to cover approximately 60% of their deficits for certain Medicaid-covered services. These public agencies are responsible for

providing the non-federal matching dollars (approximately 40% of total costs) with local funds.[26]

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

DHCF   **Division of Health Care Financing**: Responsible for administering the Medical Assistance (Medicaid), Chronic Disease Aids, WisconCare, Health Insurance Risk Sharing Program (HIRSP) and General Relief programs.[27]

DHFS   **Department of Health and Family Services:** Wisconsin State Department of Health and Family Services, began July 1, 1996 and oversees Medicaid and other health programs and social service programs.[28]

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

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

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

DSL   **Division of Supportive Living:** The division within DHFS which manages programs involving mental health, substance abuse, developmental disability, as well as aging and long-term support programs.

DWD   **Department of Workforce Development:** Directs the Eligibility process for the following programs:

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

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

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

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

[28]   Definition from http://www.dhfs.state.wi.us/aboutdhfs/BiennialReport9799

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

FDD   **Facility for the Developmentally Disabled:** A type of nursing home primarily for developmentally disabled persons. State centers for developmentally disabled persons are FDDs. Licensed under ch. HFS 134 rules.[29]

FFES   **Functional and Financial Eligibility Screen:** A tool developed by DHFS and used by trained Resource Center staff to determine functional and financial eligibility for Family Care conducted.

HCBS   **Home and Community-Based Services:** Alternatives to nursing home care that provide services to people living in the community. With further developments in community supports and technological advances, there is an increased opportunity for individuals at many levels of disability to be effectively served in the community.

HIPAA   **Health Insurance Portability and Accountability Act of 1996:** The act offers improved portability and continuity of health insurance coverage and regulations to guarantee patients rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information.

I & A   **Information and Assistance:** Service provided by the Resource Centers using a telephone number that is toll-free to all callers in its service area. Information provided is related to aging, physical and developmental disabilities, chronic illness and long-term care, including referrals to and assistance in accessing services.

IADL   **Instrumental Activities of Daily Living:** Refers to tasks required to maintain an independent household. Activities include such tasks as meal preparation, light housework, using the telephone, arranging and using transportation and the ability to be functional at a job site.

ICF   **Intermediate Care Facility:** A federal Title XIX term for Medical Assistance reimbursement purposes to a lower level of nursing care than that provided in a skilled nursing facility (SNF).

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

ICF-MR	**Intermediate Care Facilities for Individuals with Mental Retardation:** An ICF serving only or mainly mentally retarded residents providing active treatment for residents, and certified under 42 Code of Federal Regulations (CFR) 435 and 442. In Wisconsin, these are called facilities for the developmentally disabled (FDDs).
ISP	**Individual Service Plan:** A plan of care developed by the CMO and the Family Care member. It is based on a comprehensive assessment of the individual and reflects the individual's values and preferences for care.
IT	**Information Technology:** IT refers to information and businesses regarding computers, software, telecommunications products and services, as well as, Internet and online services.
LAB	**Legislative Audit Bureau:** A non-partisan legislative service agency created to assist the Legislature in maintaining effective oversight of state operations. The Bureau conducts objective audits and evaluations of state agency operations to ensure financial transactions have been made in a legal and proper manner and to determine whether programs are administered effectively, efficiently, and in accordance with the policies of the Legislature and the Governor. The LAB is the agency administering the contract to The Lewin Group for the independent evaluation of Family Care.[30]
LOC	**Level of Care:** The level at which an individual screens functionally eligible for Family Care, either comprehensive or intermediate.
LTC	**Long-Term Care:** A range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self-care. Services may be continuous or intermittent but are delivered for sustained periods to individuals who have a demonstrated need, usually measured by some index of functional incapacity.
MA Card	**Medical Assistance Card:** Card provided by Wisconsin Medicaid and covers a broad range of health care services, including home health and nursing facility care as well as the Personal Care option.
MA	**Medical Assistance:** Wisconsin's term for the Medicaid (Title XIX) program which pays for necessary health care services for persons whose financial resources are not adequate to provide for their health care needs.
MOU	**Memorandum of Understanding:** Document clearly defining respective responsibilities of multiple entities.
MCO	**Managed Care Organization:** Any system that manages healthcare delivery to control costs.

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

MCP   **Member-Centered Plan:** The plan developed by the CMO staff and the Family Care member which outlines the member's preferences and personal outcomes. The plan should inform the Individualized Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.

MR/DD   **Mentally Retarded/Developmentally Disabled**

                 Mentally Retarded: Individual with subnormal intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following: (1) maturation, (2) learning, (3) social adjustment.

                 Developmentally Disabled: Disorder in which there is a delay in development based on that expected for a given age level or stage of development. These impairments or disabilities originate before age 18, may be expected to continue indefinitely, and constitute a substantial impairment.[31]

PAC   **Pre-Admission Consultation:** Consultations designed to inform individuals of available long-term care options and counsel them regarding their options before making permanent decisions on their LTC. It is also an opportunity to determine if they are eligible for family care.

PD   **Physical Disability:** A physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person.

RAD   **Resource Allocation Decision method:** Developed as a tool for the care management team to determine how best to use resources and serves to identify individual outcomes and derive cost-effective options to meet these outcomes.

RAP   **Resource Allocation Program:** Under ch. 150, Wisconsin Statutes, ch. HSS 122, and Wis. Adm. Code, the program of adjusting caps on nursing home and FDD beds, distributing newly available beds, and prior review of capital expenditures of nursing homes and facilities for the developmentally disabled (FDDs). [32]

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

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

RC   **Resource Center:** Entity offering a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers that are available in the local communities. The RCs also provide counseling about long-term care options and eligibility determination for the Family Care benefit and serve as a clearing-house of information designed to assist service personnel working with populations in need of long-term care services.

RCAC   **Residential Care Apartment Complex:** A type of assisted living facility (1997 Wisconsin Act 13 amended statutes to change official name to Residential Care Apartment Complex).

RFP   **Request for Proposal:** Document that solicits proposals from outside parties in a competitive bidding process.

RN   **Registered Nurse:** A graduate trained nurse who has been licensed by a state authority after qualifying for registration.

SNF   **Skilled Nursing Facility:** A federal Titles XVIII and XIX certification term and state licensing term for long-term care facilities that provide care to residents who no longer need the type of care and treatment provided in a hospital but do require some medical attention and continuous skilled nursing observation.

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

WHCA   **Wisconsin Health Care Association:** A non-profit organization representing 250 primarily for-profit nursing homes.

WAHSA   **Wisconsin Association of Homes and Services for the Aging:** A non-profit organization with 190 not-for-profit members principally serving the elderly and disabled, including nursing home facilities for the developmentally disabled, community-based residential facilities, independent living facilities and community service agencies.

GLOSSARY

Direct Services	Services provided directly to people by agency staff rather than purchased by the agency from an outside provider.
Indirect Services	Services to people provided by DHFS through various public and private agencies under contract.
Nursing Home	A facility that provides 24 hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care. Nursing homes are licensed by DHFS under ch. HFS 132 rules (Health and Family Services).
Options Counseling	RCs offer consultation and advice about the options available to meet an individual's long-term care needs. This consultation will include discussion of the factors to consider when making long-term care decisions. Resource centers will offer pre-admission consultation to all individuals with long-term care needs entering nursing facilities, community-based residential facilities, adult family homes and residential care apartment complexes to provide objective information about the cost-effective options available to them. This service is also available to other people with long-term care needs who request it.[33]
Personal Care	Refers to assistance with activities of daily living such as eating, dressing, bathing and walking.
Selective Contracting	The process by which CMOs will begin to include quality requirements as part of the contracts process with providers.
Supportive Home Care	Care provided to elderly and disabled persons residing in their own homes; consists of assistance with daily living needs, including household care and personal care.
Community Aids	Community Aids provides core funding to counties for basic community services to people with developmental and other disabilities and other needs. When the Community Aids system was established in 1974, the state used a combination of state and federal dollars to provide approximately 90% of the funding for county-run human services. Counties had to provide a "match" of approximately 10 % in order to capture funding. Over time, the amounts contributed by some counties has grown larger than 10 %.

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[33] Definition from Family Care web-site at http://www.dhfs.state.wi.us/LTCare/Generalinfo/RCs.htm

APPENDIX F

RC AND CMO STAFFING

Exhibit F-1
Resource Center Staffing, Full-Time Equivalent Positions
March 2001 and March 2002

RC Position	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02
Agency Director													0.25	0.25		0.30		
RC Manager	1.00	1.00	0.57	0.57	1.50	1.50	0.75	1.00	1.00	1.00	1.00	1.00	0.75	0.68	0.50	1.00	1.00a	1.00a
Supervisor								1.00			4.25	5.25						
I and A	2.25	3.25	0.50ª	0.50	4.10	5.18	1.75	2.00	6.00	7.00	9.00	10.00	3.75ª			1.50a 2.00a	.50	.50
Screener (non RN)	4.25	2.50	0.50	0.50	6.10	5.95	4.50	6.00	5.00	5.00	25.00	25.00		3.00			0.50	0.50
Screener (RN)					1.00	1.00	1.00	1.00	1.00	2.00	1.00	1.00		1.00	0.25			
Nurse	0.30	0.30													0.25	0.50		0.20
Disability Benefit Specialist	0.25	0.75	0.45	0.70	1.00	1.00	0.50	1.00		1.00	c		0.25	1.00		0.60	0.25	0.50
Support Staff			0.50	0.50						1.60		3.50	0.58	0.68	0.50	1.00		
Quality Coordinator											1.00	1.00						
Enrollment/Brief Services											3.00	13.00						
Outreach Specialist						1.00					1.00	2.00						
Social Service Specialist	3.75	3.25									10.00	5.00						
Case Manager					0.05ᵇ	0.05												
Total	11.80	11.05	2.52	2.77	13.75	15.68	8.50	12.00	13.00	17.60	55.25	66.75	5.58	6.61	3.00	5.40	2.25	2.70

[a] These individuals also perform screening.

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

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

Note: Kenosha's numbers from 2001 were updated from 2001 report to correct errors.

Source: Resource Center 1st Quarter 2001 Reports provided to The Lewin Group by DHFS and correspondence with county staff.

Exhibit F-2   CMO Staffing, Full-Time Equivalent Positions
March 2001 and March 2002

CMO Position	Fond du Lac		La Crosse		Milwaukee		Portage		Richland	
	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02	3/01	3/02
Administration										
CMO Manager	1.00	1.00	0.80	0.85	1.30	1.30	1.00	1.00	1.08	1.08
Administrative Assistant						3.50			1.00	1.00
Sub-total	1.00	1.00	0.80	0.85	1.30	4.80	1.00	1.00	2.08	2.08
Fiscal										
Asst. Director (financial)	0.75[a]		1.00	1.00	0.50	0.50	1.00	1.00	0.50	0.50
Analyst		3.20			0.50	0.50				
Accountant					0.50	0.50			1.00	2.00
Budget Analyst					0.30	0.30				
Business Support	7.00[a]	9.00		4.00		3.00	4.50	7.00	1.00	
Sub-total	7.75	12.20	1.00	5.00	1.80	4.80	5.50	8.00	2.50	2.50
Provider Network										
Contracts Specialist/ Coordinator	1.50	1.50	0.50	0.50	6.00	7.00	1.00	1.00	1.00	1.00
Quality										
QI Coordinator	1.00	1.00	0.25	0.25	1.00	1.00	1.00	0.50		
IT System										
IT Worker	0.25[a]	0.25	[b]	[b]	1.50	1.50	0.30	0.34	0.20	0.20
Training										
Training Coordinator					4.00	5.00				
Care Management										
Member Advocate		0.50	0.25	0.25		1.00	0.50	0.50	1.00	0.50
Team Supervisor			2.00	2.00	3.00	3.85		2.00		1.00
Supervisor (RN background)				1.00		5.00				
Nurse	7.50	8.50	8.00	11.00		34.85	3.00	6.00	2.00	5.00
DD CM	7.00	17.00	8.00	9.00	NA	NA	5.50	5.00	8.00	7.10
Elderly/PD CM	9.00		10.00	15.00	101.00 [c]	75.04	7.50	9.00		
Service Aide	4.00	4.00								
Sub-total	27.50	30.00	26.00	38.00	104.00	119.74	16.50	22.50	11.00	13.60
Total	39.00	45.95	30.80	44.85	119.60	143.84	25.30	33.34	16.78	19.38

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

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

[c]   This number includes RNs.

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

Source: Care Management Organization 1st Quarter 2001 and 2002 Reports provided to The Lewin Group by DHFS.

APPENDIX G

DISABILITY BENEFIT SPECIALIST JOB DESCRIPTION

DISABILITY BENEFIT SPECIALIST

The Disability Benefit Specialist is a highly specialized position. Benefit specialists are continually trained and monitored by attorneys knowledgeable in elderly or disability law. The specialist can consult with this legal back-up to determine appropriate interpretation of the law. The disability benefit specialist has three main functions that differentiate their duties from that of a case manager or social worker experienced with the target populations. The functions are as follows:

1. Information about available benefits;
2. Assistance to apply for benefits; and
3. Advocacy for appealing benefits denial.

Qualifications:

- Bachelor's degree in human service field
- Previous direct or related experience (1 year)
- Flexibility in scheduling
- Access to reliable transportation with required insurance coverage for daily use
- Well developed oral and written communication skills
- Ability to work in a team setting
- Ability to assist individuals to coordinate effective personal planning and assist individuals in following through with the plan

Job Skills:

- Provide technical assistance to consumers about how to access benefits
- Assist in organizing and verifying both financial and non-financial data to apply for benefits
- Assist individuals in coordinating effective personal planning and assist individuals in following through with the plan
- Provide accurate and current information about the following benefits:

  Medicare
  Medicare supplement insurance
  Supplemental Security Income (SSI)
  Social Security
  Medical Assistance
  Consumer problems
  Age discrimination in employment[34]
  Homestead Tax Credit
  Housing problems
  Supportive home services

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[34] Abramson, B. (November, 2001). Disability Benefit Specialist Program: Summary of Issues and Recommendations. Prepared for Wisconsin Department of Health and Family Services (DHFS), Wisconsin Division of Supportive Living (DSL), and Wisconsin Bureau of Aging and Long-Term Care Resources (BALTCR). Noted that employment related issues, because they are part of the long-term employment benefit counselors work, should not be part of the role of the DBS in Family Care who primarily should work with clients on a short-term basis.

Food Stamps
Veteran's Administration benefits
General Relief
Other legal and benefit problems

- Consult with legal back-up to determine appropriate interpretation of law or regulation and appropriate action to assist in resolution of concerns
- Refer to legal back-up for consideration of representation in judicial proceeding
- Initiate investigations to gather needed factual information to pursue advocacy duties
- Provide information on consumer rights, complaint, grievance and appeals processes
- Provide advice and assistance in preparing and filing complaints, grievances, and appeals at the local and state levels, as well as beyond
- Provide representation for consumers, as needed in administrative hearings, as well as in other formal or informal grievance set-ups
- Provide technical assistance in completing reporting activities and appeal procedures on behalf of the individuals who have been denied benefits
- Negotiate on behalf of individuals with service providers, or the District regarding disputes over long-term care services
- Make appropriate referrals for employment and other disability related counseling and services
- Identify concerns and problems of people with disabilities and related system level issues, as appropriate, and present that information to appropriate entities
- Provide consumer and volunteer training and technical assistance to develop self and family advocacy