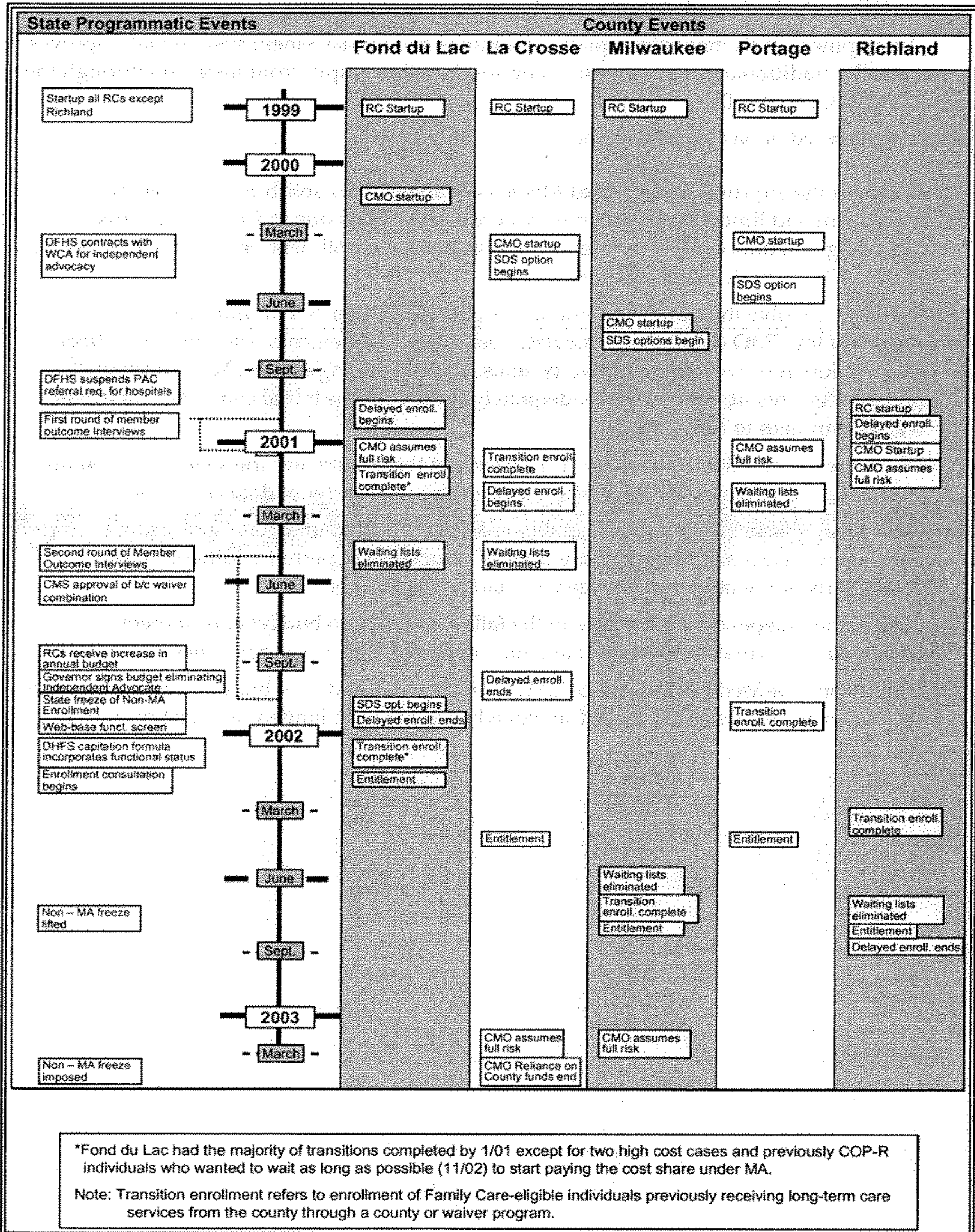
**Exhibit IV-1**
**Family Care Timeline**




*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.



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- Increased consumer involvement through a self-directed supports option at the CMOs, active participation of consumers in the care management process, governing boards for the RCs and CMOs, and state and local long-term care councils.
- Development of an innovative quality assurance and improvement system that improves upon the traditional process measures by seeking direct input from members through the Member Outcome Tool.

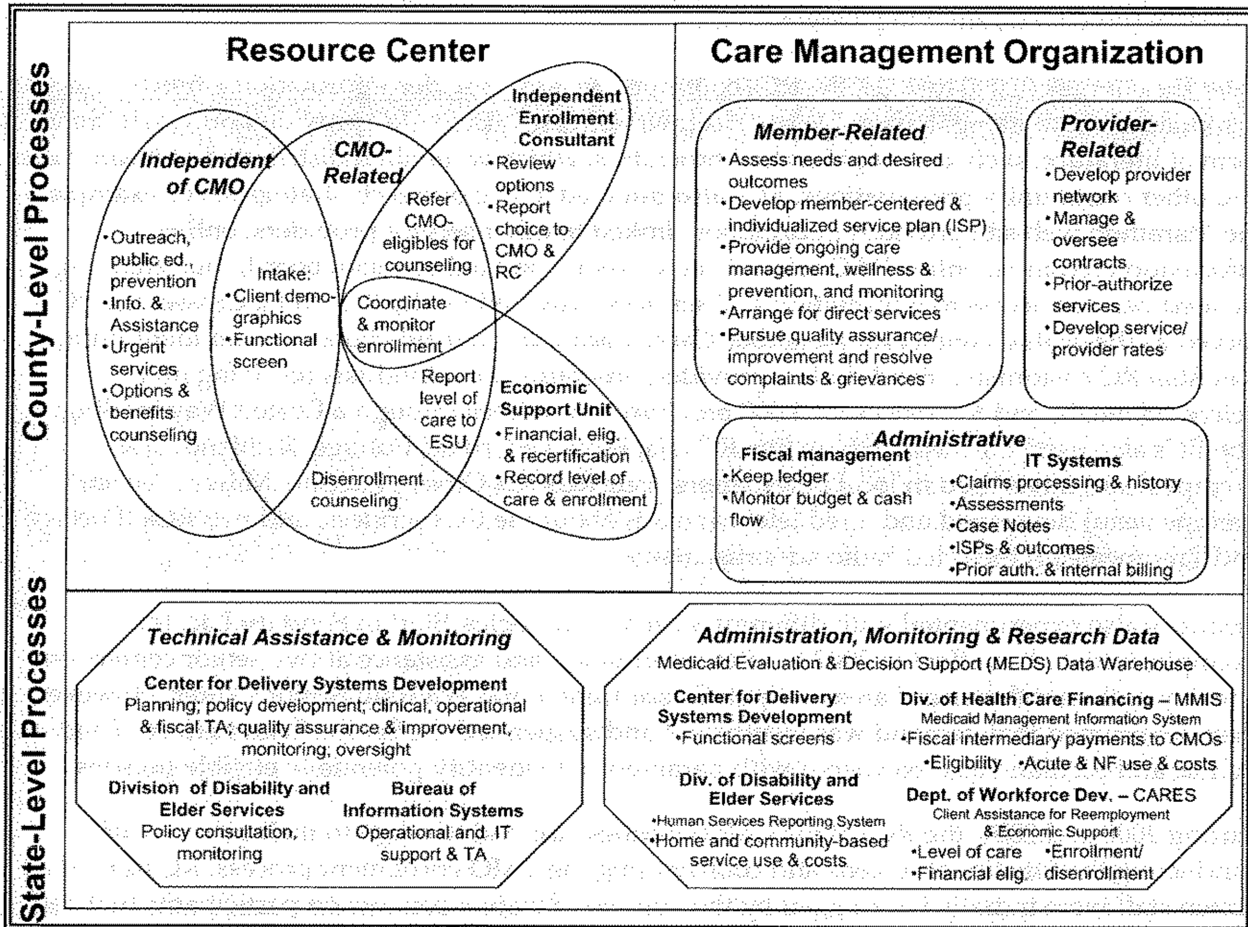
Issues encountered of particular note include:

- Delays in the approval of the initial Medicaid waivers to establish the mandatory enrollment and limit the allowable providers to the CMOs due to federal concerns regarding potential conflict of interest involved in the enrollment process because the RCs and CMOs are both county entities.
- Failure to involve the staff of Economic Support Units, which determine financial eligibility for CMO enrollment, calculate cost-share requirements, and enter enrollment information into the administrative systems, in the planning of the CMO enrollment process. As a result, ESUs were inadequately staffed for the initial conversion of existing waiver enrollees to the CMOs.
- Disparate information technology (IT) systems at the county and the state level, making automation of some functions difficult and electronic transfer of data cumbersome.
- CMO struggles to hire ahead of member enrollment due to uncertainty regarding enrollment trends and some County Boards' reluctance to permit additional staff, particularly while other county agencies had hiring freezes.
- Loss of the independent advocates in the fall of 2001 due to budget cuts, thereby eliminating a formal, independent avenue to address CMO member issues and grievances.
- Freezes on non-Medical Assistance CMO enrollment also due to budget situations which restricts new enrollment to those functionally eligible with limited financial resources.

# V. INFRASTRUCTURE DEVELOPMENT

As indicated in the ***Program Overview*** section, in order to establish the Family Care program, several new organizations and processes needed to be established. ***Exhibit V-1***, an adaptation of a DHFS framework, depicts 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. 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.

**Exhibit V-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.

In order to carry out these processes in Family Care, infrastructure had to be developed. In this section, we highlight the infrastructure development over the last three years by focusing on major events and issues related to: Resource Centers, the CMO enrollment process, Care Management Organizations, and Information Technology systems.

## A. Resource Centers

With the exception of Richland, all of the Resources Centers had been operating at least one year prior to the start of the evaluation period. 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[6], and tracking demographic information about callers. Pilot county staff had extensive experience in these areas prior to Family Care. During the initial start-up of the RCs, staff focused on establishing initial outreach and information materials and distribution points and activities for the materials. RCs provided consumers with basic information about long-term care providers in their area including: the name of the business, the type of service offered, its location, and phone number. Most RCs initially did not have a contact name and direct telephone number for most providers and there was substantial variance in the amount of additional information available (brochures, smoking allowed, etc).

Over the course of 2000 to 2003, the RCs continued to add provider information, often automating and making it available to consumers directly. 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. RCs also pursued active outreach strategies. For example, the Marathon web-site provides information, linked to other service providers, online information requests, online PAC referral, a chat room, and a discussion board, thus enabling isolated persons access to information and services provided by the RC. In La Crosse, the RC served as the central contact for Neighbor Care, a program that aids businesses in identifying potential RC customers. Fond du Lac provided brochures to individuals receiving home-delivered meals, and Kenosha sent 5,000 brochures to retirees through a United Way mailing. The RCs also used the media where five RCs (Jackson, La Crosse, Portage, Richland, and Trempealeau) advertised in local newspapers, four RCs (La Crosse, Jackson, Milwaukee and Trempealeau) developed and aired television ads about the RCs services, and two RCs (Portage and Trempealeau) included radio advertisements.

Counties also experimented 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. However, they determined that demand was insufficient and suspended the Senior Center effort. Fond du Lac and Richland also partnered with paramedics to identify potentially eligible persons.

During 2000 and 2001, the RCs in the CMO counties also had to adapt to their new role of conducting the functional screens and coordinating the CMO enrollment process. RC functional screen staff were initially backlogged by the volume of waiver conversion participants that had

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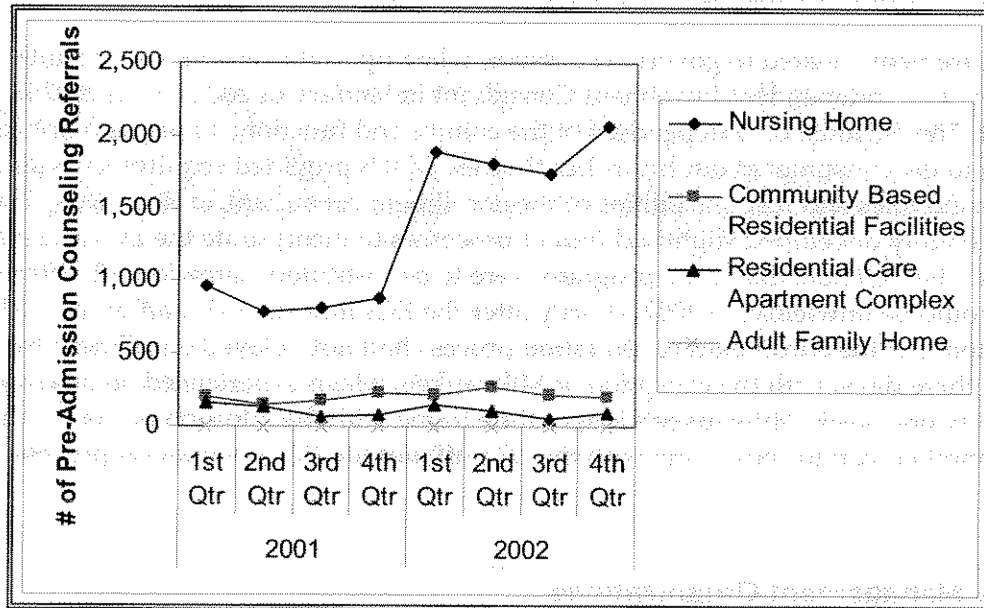
6 Options counseling differs from enrollment counseling provided by the ECs. See definition of "options counseling" in ***Appendix D: Acronyms and Glossary of Terms***.

to be screened. Aggressive outreach efforts were halted by some RCs due to the overwhelming staff resources needed to respond to functional screen requests. During this period, RC staff in CMO counties raised concerns about their ability to provide sufficient attention to RC functions other than CMO intake. This prompted some CMO counties to shift the responsibility for the annual re-certification screens to the CMOs. By 2002, the RCs reported less difficulty completing screens in a timely fashion due to reduced workload from a combination of factors that varied across county, including increased staffing, responsibilities shifted to the CMOs, and reduced volume.

During the same CMO start-up period, in addition to functional screen workload, the CMO county RCs implemented mandatory pre-admission consultation (PAC) referrals from hospitals, nursing homes, and community-based residential facilities (CBRFs). The RCs reported being overwhelmed by the number of referrals to which they had to respond, primarily from the hospitals. The RCs reported that the majority of the hospital referrals were inappropriate, in that the individuals being referred did not have a long-term care need of 90 days or more. In response, DHFS' suspended the requirement for mandatory referrals from hospitals only in the fall of 2000.

*Exhibit V-2* shows a significant increase in PAC 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, the state Bureau of Quality Assurance (BQA) began enforcing the rule by asking facilities about PAC during site-reviews. Milwaukee dominated the increase in PAC referrals from nursing homes.

**Exhibit V-2**
**Quarterly PAC Referrals, by Facility Source,**
**First Quarter 2001 to Fourth Quarter 2002**




**Source:** DHFS Quarterly Family Care Activity report, 4th Quarter 2001 and 2002.

More recently, during the six months following full entitlement in accordance with s. 46.283 (4)(e), Wis. Stats., pilot county RCs conducted outreach to inform residents of long-term care facilities about Family Care and assisted them in applying for the Family Care CMO 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 began even before the county reached entitlement in August 2002. Richland is currently conducting their outreach. 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.

## B. CMO Enrollment Process

The CMO enrollment process became progressively more complicated during the course of Family Care's implementation. The original plan was to develop one-stop shopping through the RCs, keeping things as simple as possible for the consumers. Practical and policy considerations prevented a true one-stop shop. The RCs provide information about the CMO, its benefits and alternatives to CMO membership, and determine functional eligibility. However, local Economic Support Units need to determine financial eligibility and any cost-share amounts. Federal requirements instituted an Independent Enrollment Consultant.

Initially, ESUs did not participate in the development of the Family Care enrollment process. Once the oversight was identified, the CMO counties established regular meeting times with their ESUs to work on issues surrounding the enrollment process. All counties now have ES workers specializing in Family Care-related eligibility to increase productivity and improve communication; Fond du Lac county offices two ES workers dedicated to CMO enrollment. However, as of May 2003, despite the addition of an ESU supervisor, Milwaukee continued to experience problems in obtaining timely eligibility determination through the ESU.

Federal requirements related to governance issues, taken up in the next section, resulted in the introduction of an Independent Enrolment Consultant in January of 2002 (April 2002 in Milwaukee). The EC must be independent of the county and functions to provide unbiased information to the consumer about his or her choices. DHFS provided requirements and guidance on the roles and responsibilities of the enrollment consultant, and the RCs, ESUs, and ECs in each county developed slightly different processes to incorporate the ECs and complete enrollments. The ECs note that if the program were to be instituted statewide, 72 different processes would be unwieldy. In 2002, shortly after the ECs first started, staff in the CMO counties noted that the enrollment consultation process had not delayed enrollment by more than two or three days, with the exception of Milwaukee, which experienced an increase of approximately one week. Milwaukee's longer time frame with the addition of the ECs had more to do with another step to coordinate with the ES staff, not the EC consultation process.

## C. Care Management Organizations

DHFS' decision to contract with counties to serve as Care Management Organizations (CMOs) required the state and the counties to work together to build managed care expertise and

infrastructure at the counties. Essentially, county government agencies had to learn how to become managed care organizations in terms of the operational, clinical and fiscal management. While the counties had ample experience with the clinical aspects under the prior system, 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 business practices, staffing, and information technology (IT) to carry out all of the processes. The evolution of IT, care management, and provider networks at the CMOs are taken up in subsequent sections.

Prior-authorization provides an example of evolving business practices. Initially, prior authorization procedures for services delivered by providers under the Family Care benefit were time intensive for both the CMO care managers, who authorized services, and the providers, who delivered the services. CMOs struggled to develop a consistent and timely process to ensure that providers receive authorization before delivering services (i.e., prior authorization procedures). However, over time these processes became more routine or adapted to become less cumbersome. For example, prior authorization for small durable medical equipment or disposable medical supplies (DME/DMS), such as cottonballs and gauze pads, exceeded the monetary costs for these items. In an attempt to streamline the process, Portage used the service plan to pre-authorize these types of items and the interdisciplinary team reviews the authorization every six months. Other counties provided a monthly allowance for such purchases.

The CMOs have experienced some difficulty staffing ahead of enrollment and retaining experienced staff as a result of county politics and collective bargaining agreements. The relationship between the local Family Care agencies and the county boards had an impact on 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.

Issues with unions in Milwaukee and Fond du Lac had an impact on the staffing composition during 2001 and 2002. 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 which constitute over half of the total care management teams in Milwaukee. 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. As they grow, the CMOs continue to specialize positions. The Milwaukee CMO recently added a fiscal

analyst to process member obligations based on the cost-share calculations and La Crosse added a quality assurance position in the past year.

## D. Information Technology

IT system development is central to building an effective program in the Family Care model, particularly for the CMOs. Without basic, nearly real-time information about the members and their service use and costs, CMOs may find it difficult to manage the capitated payments and coordinate care. Integration of the core CMO functions permits the generation of management reports that can assist staff in understanding the consequences of decisions. The ability of counties to share information electronically among the RC, ES, EC, and the CMO might also create efficiencies since electronic transmission of information generally reduces the need for re-keying of information.

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. The use of different systems makes instituting new automation requirements (such as those mandated by the Health Insurance Purchase and Portability Act (HIPPA)) and integration across systems challenging. ***Exhibit V-3*** shows the current status of automation and integration of the major functions for the RCs and CMOs.

The main RC functions, information and referral, outcome tracking, and conducting functional screens, have all been computerized. The Resource Centers either added to information and referral software they had in place prior to Family Care or purchased software from vendors designed specifically for this activity. The state provided the functional screen software application because it generates the level-of-care determination required for the MA waiver eligibility, which must be applied uniformly across the state. The 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.

More variation in information technology exists at the CMO level with different systems and different degrees of integration across the systems. The systems listed in ***Exhibit V-3*** are not required to be integrated, although there are some advantages to being able to tie them together for reporting, planning, and management functions. Each of the CMOs has taken their own approach to IT, some choosing to build their own systems, some contracting out major functions, and others purchasing existing software packages and adapting the applications as necessary.

**Exhibit V-3**
**Development of County Information Technology Systems, May 2003 Status**

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

**Note:** I&R is "Information and Referral" and ISPs are "Individual Service Plans."

**Source:** DHFS provided information and site visit interviews.

All of the clinical processes in Milwaukee and Fond du Lac are computerized with the exception of prevention and outreach activities. Milwaukee also integrated most of its clinical functions. La Crosse computerized their Individual Service Plan (ISP)[7] and is considering adopting Milwaukee's Web-based system for assessments and case notes; however, in May 2003, an office move was expected to delay any IT updates. Portage computerized its ISP, but the CMO continues to test the assessment, case notes, and outcome functions, and the plan is to have them all integrated. Richland has adapted components of the Portage system for fiscal functions and still plans to automate both the assessment and the Member-Centered Plan but progress has been delayed due to lack of sufficient staff time. All of the counties have operational and fiscal procedures computerized with the exception of La Crosse. La Crosse is still in the planning stages of automating claims processing.

The counties' diverse approaches to IT systems have presented challenges for both the counties and the state. The state provided funds within the counties' start-up grants for IT development. To build their respective systems, the counties allocated more than $1 million of these state start-up funds, plus some of their own funds. In addition, state IT staff served as consultants to the counties. The counties' different approaches to developing their systems has resulted in a different customized system for each county, which reduces potential economies of scale that could be achieved with greater sharing of common systems. This also means that each CMO has different capabilities regarding the integration of its IT functions and, thus, management of the CMO's finances.

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

The current IT challenges for the CMOs are the switch to an electronic submission of encounter data and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. Encounter data are records of individual health care services provided to CMO members. This information is currently manually entered into HSRS. The switch to electronic encounter reporting will occur in two phases. As of May 2003, the DHFS and the CMOs had completed Phase I, which essentially mimicked the current HSRS manual process in an electronic format. Phase II will incorporate more stringent guidelines regarding data requirements as well as logical edits and a "feedback loop".

On the HIPAA front, DHFS has made considerable efforts assisting the pilot counties in preparation for compliance with the Act's requirements. The Act offers improved portability and continuity of health insurance coverage and regulations to guarantee patient rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information. DHFS health programs and the CMOs, which operate as health

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7 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 Individual Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.

plans, must comply with HIPAA privacy (effective April 14, 2003), security, and transaction rules (effective October 16, 2003). The Bureau of Information Systems offered technical assistance of approximately .5 to 1 FTE staff to the counties to help them become HIPAA compliant. In May 2003, Portage, Fond du Lac, Milwaukee, and Richland reported that they experienced strain on staff due to the increased time obtaining records for members as well as training on HIPAA rules, especially in the months leading up to April 14, 2003. The Human Service Department in La Crosse County provided most of the preparation for HIPAA alleviating the burden from RC and CMO staff directly.

An ongoing issue for the counties is the maintenance and upkeep of their systems. IT systems require annual resource commitments to maintain both the hardware and software. In 2002, the counties contended that these types of costs were not adequately accounted for in the capitated rates. In 2003, the CMO capitated rates included 12 percent for administrative functions and other non-benefit expenses.

# VI. GOVERNANCE

For Family Care, governance encompasses conflict of interest issues and consumer participation in the development of the Family Care model that is, in part, manifested in governing boards and advisory bodies. As discussed in the ***Program Overview*** section, each RC and CMO has a separate governing board and each CMO county has a Local Long-term Care Council and the DHFS supports a State Long Term Care Council.

## A. Conflict of Interest

Two conflict of interest of interest issues arose during the evaluation period: 1) the separation of enrollment and service provision; and 2) the recertification functional screens. At the beginning of the program, in approving the b/c waiver combination, the Centers for Medicare and Medicaid Services (CMS) raised concerns about the potential for conflict of interest as a result of the same entity (the county) being ultimately responsible for intake, enrollment, and service delivery. Specifically, as a result of the capitated rate, the CMO has a financial interest in who is eligible and at what rate. If the county controls both the CMO and the RC, and the CMO faced a shortfall in funds, the county could pressure the RC to unduly influence individuals to enroll in the CMO if their costs were expected to be less than the capitated rate or not to enroll if costs would be expected to be higher than the capitated rate.

In response to these concerns, DHFS originally required that CMOs and RCs to have separate governing boards. However, since the RC and CMO governing boards are advisory to the county boards and the RC and CMO also 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 a CMO.

In 2002, stakeholders had reservations about the effect of the enrollment consultant (EC) on consumers who must now be channeled through yet another person before receiving 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.

In our 2002 Implementation Report, The Lewin Group raised concerns about conflict of interest related to the annual recertification process. The Economic Support Units complete annual recertification of financial eligibility in all counties. The original plan was for the RCs to conduct all functional screens for recertification. However, as noted earlier, in some counties, Fond du Lac, Milwaukee, and Richland, CMOs assumed this responsibility. In these counties, CMO conduct of recertification functional screens relieved RCs with limited staff of this duty, capitalized on the CMO's long-term relationship with the client, offering maximum continuity for the consumer, and provided the potential to more accurately assess the individual based on continuing contact versus a snapshot 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. In addition, each CMO complies with requirements for on-going testing for inter-rater reliability for the CMO, as well as the RC, screeners. Also, in Richland, the RC now reviews re-certification completed by the CMO if the level of care changes.

## B. 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 Bodies; and
- CMO and RC Committees.

The State Long-Term Care 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, former DHFS Secretary Phyllis Dube´ 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 s. 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.

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.

Although the LLTCCs offer an avenue of consumer participation, some advocates expressed concern 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 statutory definition of consumer representative reads, "….[O]lder persons or persons with physical or developmental disabilities or their immediate family members or other representatives", s. 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 may not make an appropriate consumer representative.

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 examined effective strategies of involving consumers in the Family Care program. Through the grant, DHFS contracted for the development of: 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 direct education and consultation on-site.

As of the end of 2001, all the RCs and CMOs had met contractual obligations in establishing separate governing boards comprising one-fourth consumer representation. RC boards provided oversight on the development of a mission statement for the Center, determined relevant structures, policies, and procedures of the Resource Center consistent with state requirements and guidelines, identified unmet needs, and proposed plans to address unmet needs. 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, with the exception of Richland, did not assist with the development of the plan. In addition to the separation plans, staff from most CMOs reported presenting other program policies and procedures to the CMO board for review.

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 had consumers involved in the Self-Directed Support Option (SDS) committee and a Community-Based Residential Facility (CBRF) variance and will be starting a member grievance committee. As of May of 2003, Portage re-instated a SDS workgroup with consumer membership.

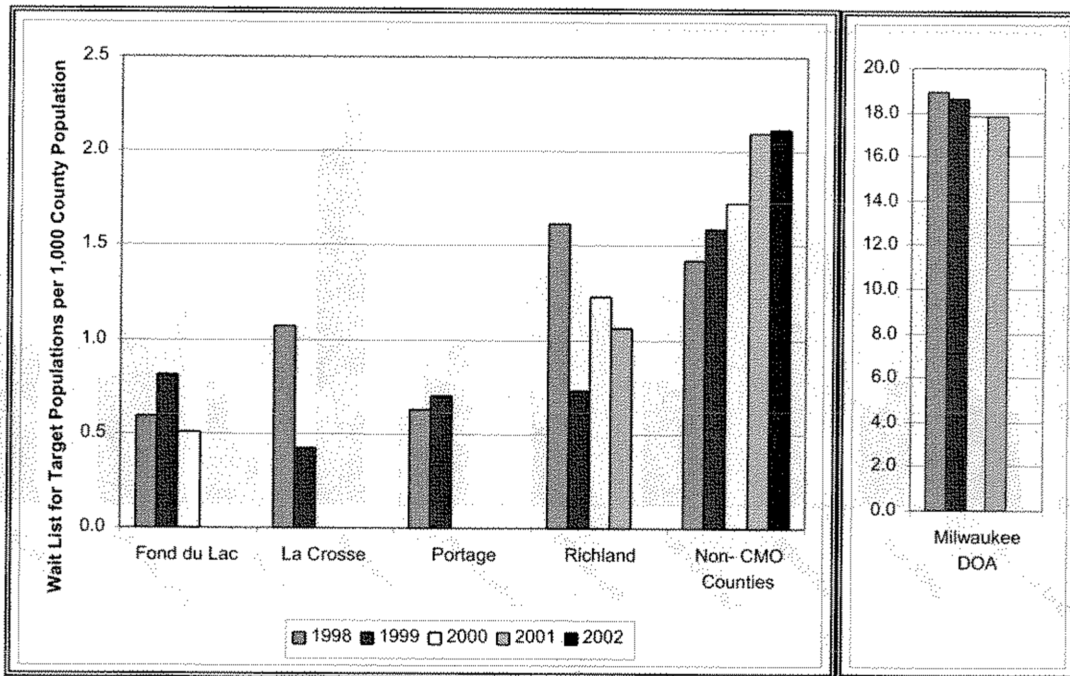
# VII. ACCESS TO SERVICES AND INFORMATION

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 over 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 continue to experience increasing enrollment into Family Care, with different rates of enrollment among the elderly, physically disabled, and developmentally disabled populations.

## A. Elimination of Wait Lists

As of the end of 2002, as shown in Exhibit VII-I, the wait lists in the CMO counties were eliminated while the wait list in the non-CMO counties continued to climb. No wait lists means that individuals applying for services begin receiving them soon after they become a CMO enrollee.

**Exhibit VII-1**
**Wait List for Target Population per 1,000 County Population**
**December 31, 1998 - 2002**




**Note:** The non-CMO counties include individuals under age 60, while the scale for Milwaukee only includes individuals age 60 and over. The estimates for non-CMO counties and the CMO counties other than Milwaukee prior to the elimination of the wait list include children with physical disabilities or developmental disabilities.

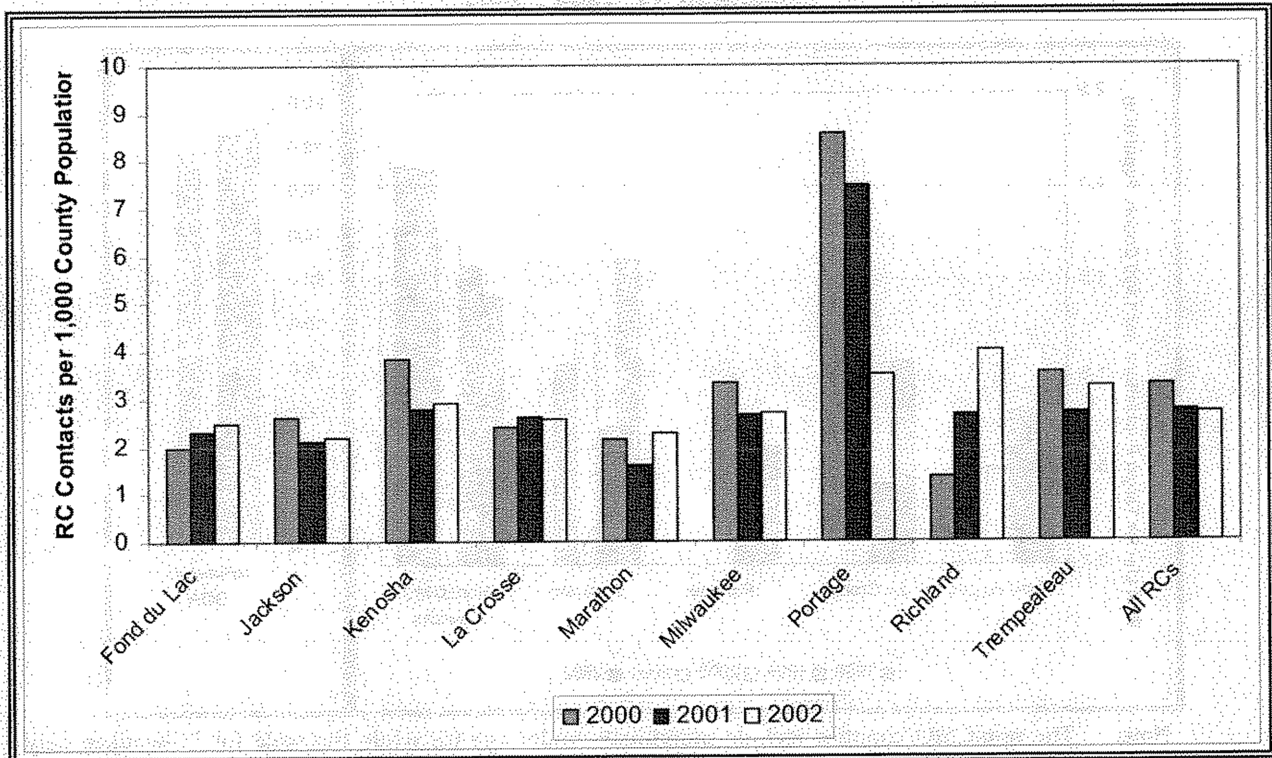
**Source:** The Lewin Group calculations based on DHFS provided wait list data.

## B. Information and Outreach Activities

As noted earlier, Aging and Disability Resource Centers (RC) play a critical role for long-term care information and service seekers. Among the nine counties with RCs, all provide information, assistance and options counseling, while the five CMO counties are also involved in outreach and intake related to the CMO benefit.

Examining the average monthly RC contacts per 1,000 people in the counties provides an indication of the effectiveness of overall outreach. ***Exhibit VII-2*** shows that the average RC contacts per month for all of the RCs fluctuated over time with five of the nine RCs reporting the highest number of contacts per 1,000 county population in 2000 and all but Portage showing stability or increases between 2001 and 2002. Some of the fluctuation may represent reporting refinements over time as the RCs improved and standardized their tracking of contacts. For example, the apparent large decline in contacts in Portage resulted from the county adopting DHFS' convention for reporting that excludes pre-admission consultation referrals, whereas prior to 2002, they had included these as contacts. Richland's increase in contacts over time reflects its RC's later start-up (November 2000), compared to all the other RCs that had been operation for at least a year prior to 2000.

**Exhibit VII-2**
**Average Monthly Resource Center Contacts per 1,000 County Population**




**Note:** Milwaukee's Resource Center focuses on individuals age 60 and older; however, the denominator used for county population includes all ages.

**Source:** The Lewin Group analysis of DHFS data from the Family Care Activity Reports, December 2001, February 2002 and March 2002.

Resource Centers were designed to reach the general public and not just individuals seeking publicly-funded services. ***Exhibit VII-3*** indicates the primary outreach areas for the RCs and some of the more notable outreach activities were summarized in the ***Infrastructure Development*** section. 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.

**Exhibit VII-3**
**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.

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, an indication of the breadth of the population using the RCs is that a minority of the contact outcomes focused on access to the COP, HCBS waiver, and CMO benefits. On average 15.3 percent of all of the RC's contacts were referred for a functional screen to assess eligibility for these benefits from October to December 2002, compared to 13.2 percent for the same period in 2001.[8] Also, in the last quarter of 2002, 178 or approximately one percent of RC contacts were referred to private long-term care services and this percentage has been fairly consistent over time.[9]

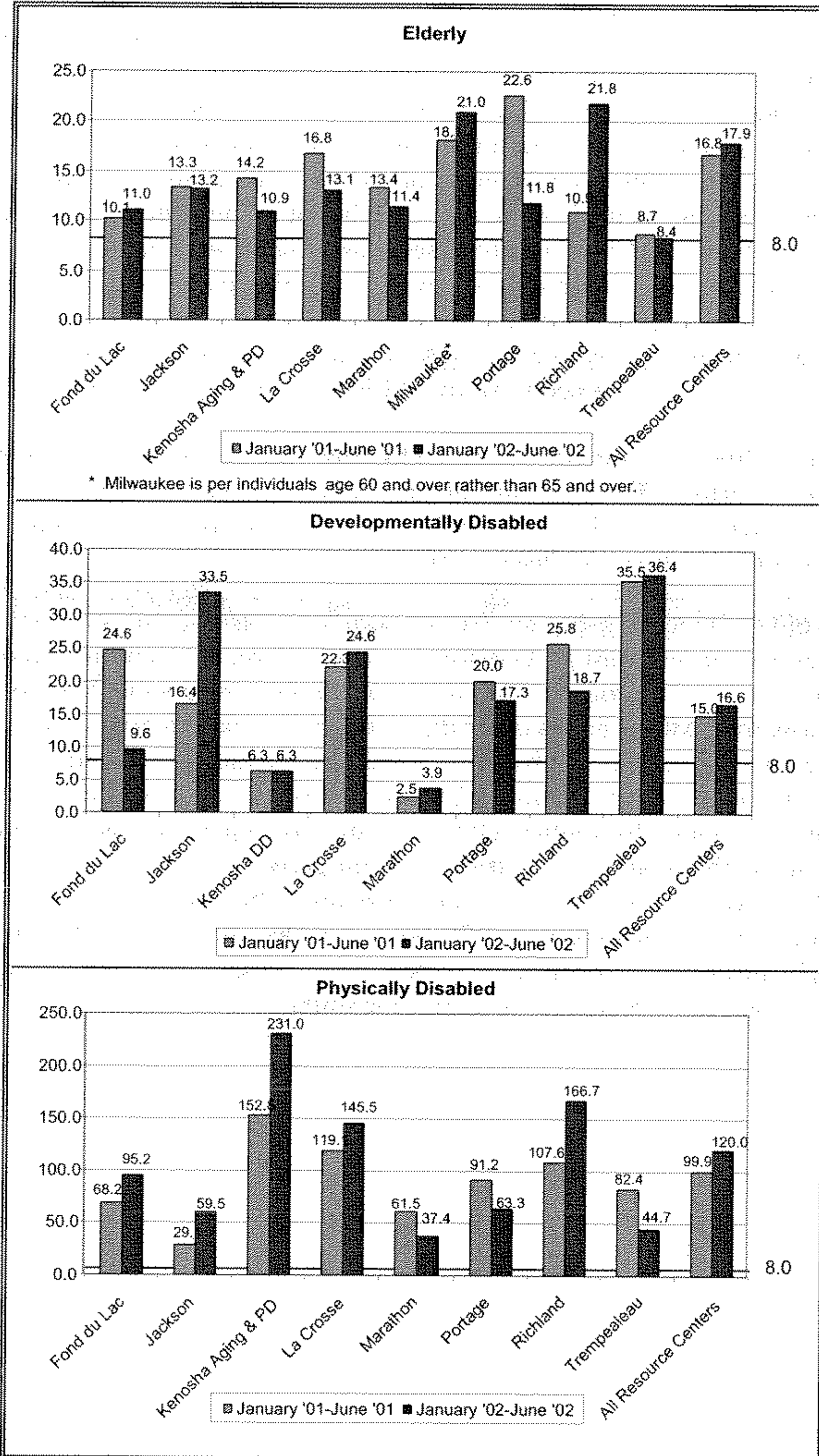
Over the course of program implementation, the Resource Centers have generally met or exceeded the DHFS established contract goal of eight contacts per 1,000 target population each month. As presented in ***Exhibit VII-4***, with the exception of Kenosha and Marathon for the DD population, during the first half of 2001 and 2002, all of the RCs met their goals of eight contacts per 1,000 target population. The lower contacts in these two counties may be due in part to the denominator used for the calculations. No direct measure of the number of individuals with developmental disabilities by county exists. Therefore, DHFS used a proxy of the percentage per 1,000 population based on a national average which may not accurately reflect a particular county's population in need. Also worth noting is the lack of the use of media as an outreach avenue in Marathon and the relatively limited use of media in Kenosha in comparison to the other counties with Resource Centers.

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 in 2002 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 in 2002 was among the PD population, ranging from 37.4 in Marathon to 231.0 in Kenosha.

8 From Quarterly Family Care Activity Report: For periods ending December 2001 and December 2002.

9 From Quarterly Family Care Activity Report: For periods ending December 2002.

## Exhibit VII-4
## RC Contacts per 1,000 per Month
## (January to June, 2001 and 2002)




**Source:** DHFS provided data based on County Resource Center reports.

## C. CMO Enrollment Activity

CMO enrollment continued to increase through the end of 2002. Generally, the CMOs enrolled existing Community Options Program (COP) and waiver program consumers during an initial enrollment phase during the first six to 12 months of operations followed by new enrollees, primarily from the wait lists, until the wait lists were eliminated in Spring 2001 for Fond du Lac, La Crosse and Portage and Summer 2002 for Milwaukee[10] and Richland. According to Family Care statutory language, CMOs must reach full entitlement after two years of operation. In order for CMO county 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. All five CMOs reached full entitlement during 2002.

As shown in ***Exhibit VII-5***, enrollment continued to grow in each county, with smaller percentage increases during 2002 and with Milwaukee continuing to experience the largest absolute and percentage increase. Possible implications of these trends are discussed in the ***Outcome and Cost-Effectiveness Analyses*** section.

The composition of CMO membership has shifted somewhat since their inception. During the initial transition of waiver program participants to Family Care, the composition of Family Care members mirrored the waiver programs. While the absolute numbers in all of the target groups continue to increase, the CMO counties other than Milwaukee experienced a faster rate of growth for younger individuals with physical disabilities. Excluding Milwaukee, 47 percent of CMO enrollees were elderly as of December 2002 compared to 46 percent in December 2000; 31 percent had developmentally disabilities (DD) compared to 35 percent; and 21 percent were younger individuals with physical disabilities (PD) compared to 19 percent (see ***Exhibit VII-6***). By including Milwaukee's primarily elderly membership in the total count of CMO enrollees, the proportion of elderly enrollees jumps to 76 percent in December 2002. The proportion of elderly members in all CMOs may continue to increase as targeted outreach to nursing facilities advances and the program responds to demographic shifts.

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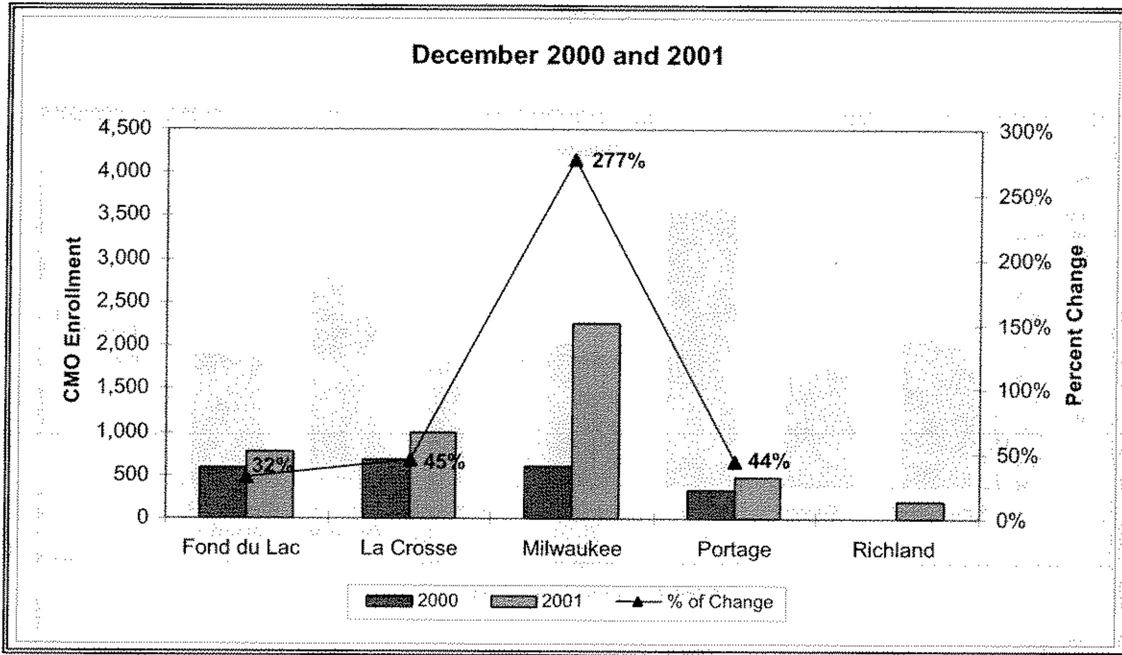
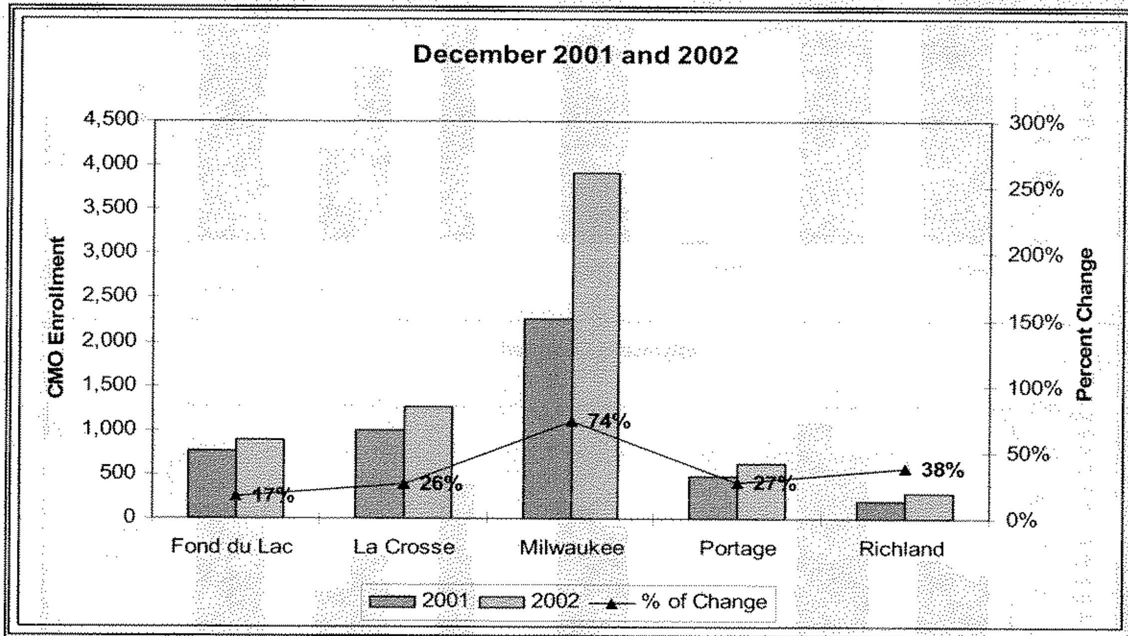
10 Milwaukee was an exception in that existing enrollees and the wait list were processed in parallel over a two-year period.

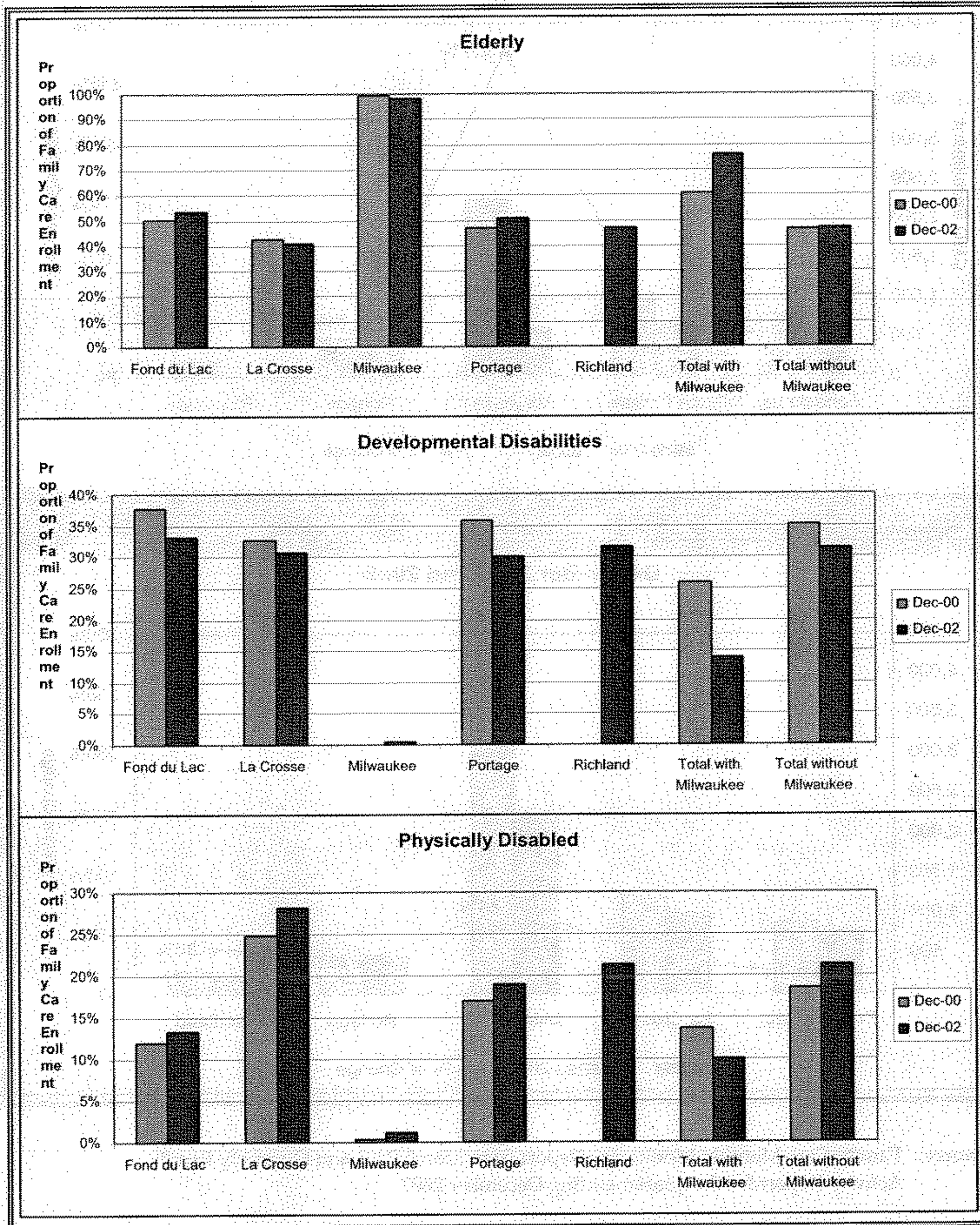
**Exhibit VII-5**
**Trends in Annual CMO Enrollment**




**Source:** Family Care Monthly Monitoring Report from March 2001 and Quarterly Family Activity Report for the quarter ending December 2002.

**Exhibit VII-6**
**Enrollees by Target Population as of December 31, 2000 and 2002**




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

### 1. Delayed Enrollment

As seen earlier in the timeline shown in ***Exhibit IV-1*** at the beginning of the Program Progress section, 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 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.

### CMO Disenrollment

A common measure of potential dissatisfaction with managed care is voluntary disenrollment rates. ***Exhibit VII-7*** shows that 348 or 9.9% of CMO members who were members on June 30, 2001 had disenrolled by June 30, 2002, primarily, and not unexpectedly with a frail and often older population, because they died. Portage had the highest rate of overall disenrollment with 14.0% 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.

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.[11] 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.

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

**Exhibit VII-7**
**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.

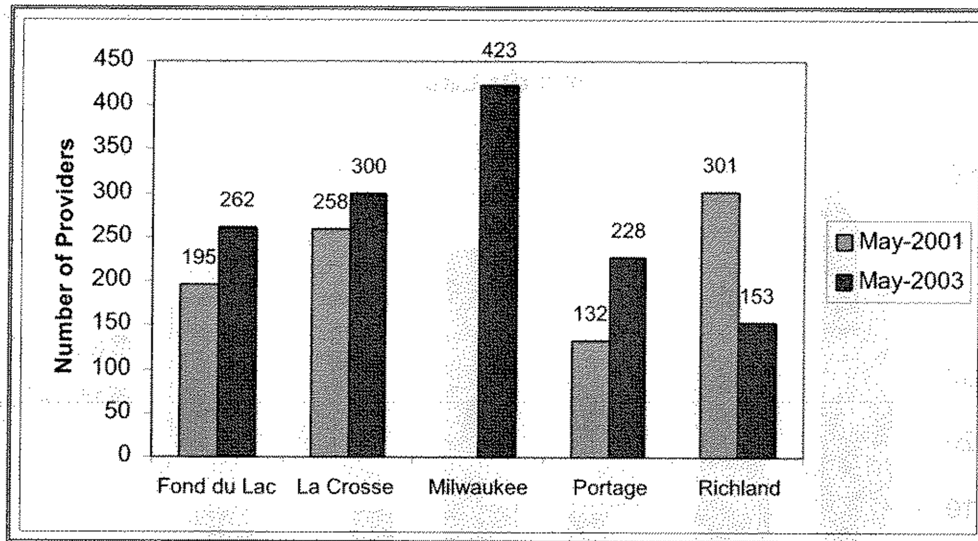
Among members as of June 30, 2001, 2.2%, or 76, chose to return to fee-for-service and forfeit services available through the waiver. These individuals were still able to access Medicaid-funded personal care services under the state plan or nursing facility care. Nursing facility representatives have claimed that Family Care members have been disenrolled when they indicate that they want to remain in the nursing home. A joint survey conducted in 2002 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 these types of disenrollment constitute more than an anomaly, it would have implications for the program's ability to be cost-effective.

## D. Service Availability

CMOs make providers available to their members 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 34%, 16%, and 73% respectively, from May 2001 to May 2003 (see ***Exhibit VII-8*** and ***Appendix E***). Accurate change over time could not be calculated for Milwaukee and Richland due to the methods used for data collection and provider contracting practices.

**Exhibit VII-8**
**Number of Providers Contracting with the CMO, 2001 and 2003**



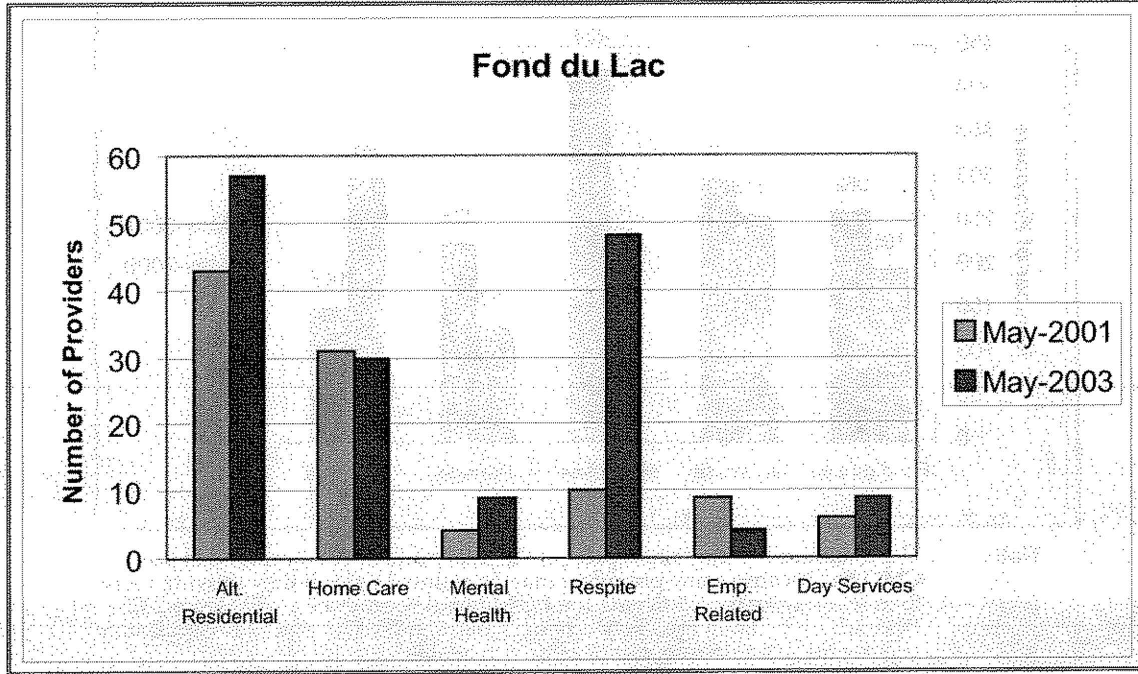

**Note:** The total number may not represent the total number of contracts that the CMO has because some providers may be counted twice if they provide more than one service type. Information for Milwaukee was not available for 2001. Declines in Richland are likely due to changes in CMO provider network staff and not the actual number of providers available.

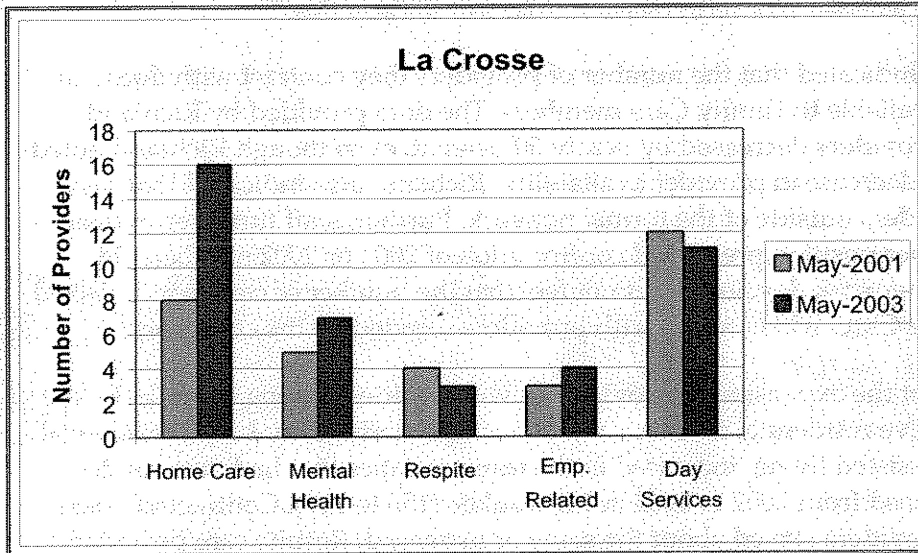
**Source:** Data provided to Lewin by counties in May 2001 and May 2003.

Milwaukee and Richland indicated that the number of providers they contract with does not fully reflect the options available to Family Care members. The data provided by Richland suggests the number of providers decreased by nearly 50 percent, even though Richland noted they did not experience a decrease in provider availability. Richland also indicated that they obtain services with providers outside of the formal network. Further, staff turnover in their provider network developer position prevented confirmation of 2001 or 2002 numbers. 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.

***Exhibit VII-9*** indicates that the expansion of provider networks varied among counties by the type of provider. Alternative residential facilities, which include community-based residential, adult family homes and assisted living, increased in the three counties that had data for 2001 and 2003. They also increased from 2002 to 2003 in Milwaukee (156 to 197). Contracted home care and mental health providers stayed about the same or increased. Respite care providers increased in both Fond du Lac and Portage. However, in 2003, the La Crosse CMO had to develop a new home health provider contract when their previous primary provider would no longer serve Medicaid long term care cases citing inadequate reimbursement and a desire to focus on severe acute cases.

**Exhibit VII-9**
**Number of Providers Contracting with the CMO for Selected Services, 2001 and 2003**



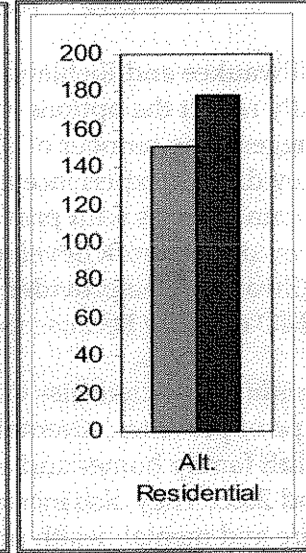
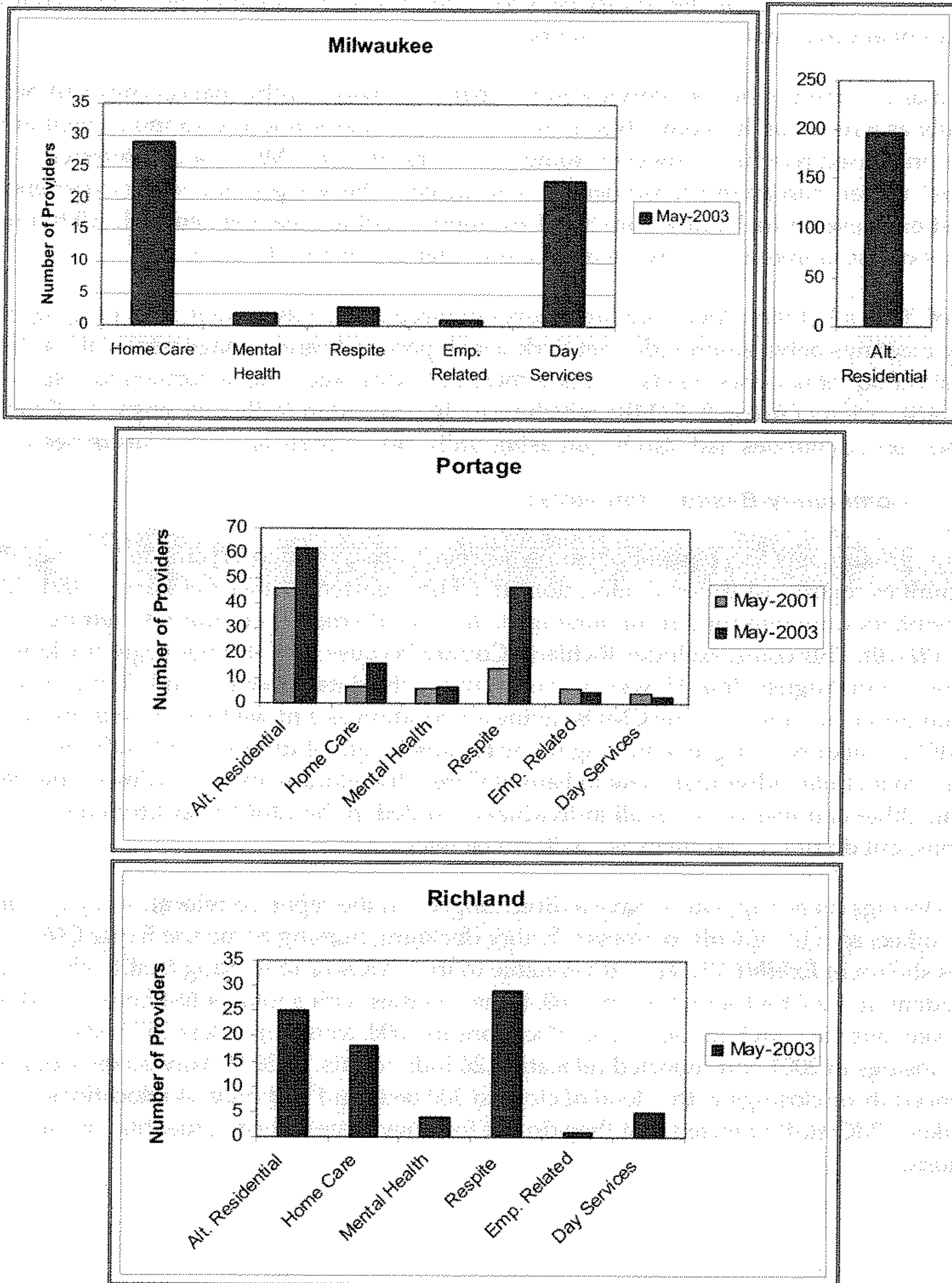



**Exhibit VII-9 (cont.)**
**Number of Providers Contracting with the CMO for Selected Services, 2001and 2003**




**Note:** Information for Milwaukee was not available for 2001. 2001 information for Richland not presented due to lack of comparability to information reported for 2003.

**Source:** Data provided by counties in May 2001 and May 2003.

Despite the general trend of expanding the number of providers in the network, some decreases in providers also occurred. For example, employment providers of related services in Fond du Lac decreased from nine to four providers. The CMO 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.

In 2002, 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.

In May of 2003, all of the CMOs had procedures in place to identify unmet need ranging from monthly meetings between provider network developers and care management staff and on-going lists of out of network needs, to a task force in Milwaukee County formed to respond to loss of certification of many ICF/MRs which recently resulted in facility closings. La Crosse and Fond du Lac counties had also begun using utilization reports to project future need.

### 1. Community-Based Alternatives

In 2002, approximately five percent of Family Care members resided in nursing facilities. The CMO counties report institutional relocations to DHFS quarterly. Since the start of 2001, 252 CMO members were relocated from nursing facilities to alternative community settings (see ***Exhibit VII-10***). 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 all individuals enrolled in the CMO as institutional diversions, but do not report them as institutional relocations.

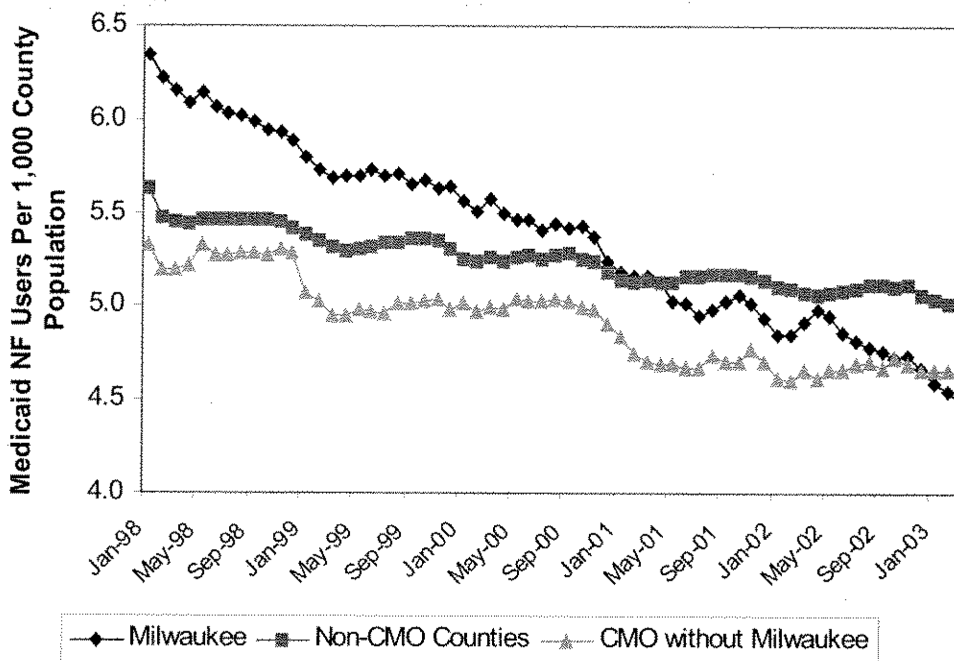
Facility closings do not appear to have a direct impact on the reported relocations, particularly in Milwaukee, so it is difficult to assess whether declining nursing home use in the CMO counties shown in ***Exhibit VII-11*** is attributable to the CMOs or to nursing facility closings independent of the CMO activities. 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. In 2002, Milwaukee County experienced three closings with a total of close to 300 beds and had only 34 relocations. Milwaukee CMO staff reported that they do not feel they have recorded the total number of relocations.

**Exhibit VII-10**
**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 |
| | Apr - Jun | 2 | 30 | 11 | unknown | 43 |
| | Jul - Sep | 5 | 18 | 16 | 1 | 40 |
| | Oct - Dec | 2 | 12 | 7 | 3 | 24 |
| 2003 | Jan - Mar | 2 | 12 | 5 | 3 | 22 |
| **Total** | | **22** | **148** | **59** | **23** | **252** |

**Source:** CMO Quarterly Narrative Reports and correspondence with pilot county staff.
**Note:** As of May 2003, Richland had not begun to track relocations.

**Exhibit VII-11**
**Medicaid Nursing Facility Use per 1,000 County Population**




**Source:** The Lewin Group calculations based data from the Department of Health and Family Services Medicaid statistics found at http://www.dhfs.state.wi.us/Medicaid1/caseload/intro.htm and 2000 Decennial Census population estimates.

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 2002 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.

# VIII. CARE MANAGEMENT, CONSUMER DIRECTION, AND QUALITY

The care management, consumer direction, and quality components of the Family Care model all significantly altered prevailing practices prior to the establishment of the CMOs. The CMOs adopted an entirely new culture of care management practice that demanded the formation of care management interdisciplinary teams to carry out new practices and monitoring of caseload size and structure. The DHFS and CMO counties also instituted formal mechanisms for consumers to direct their own care and influence the program through advocacy. Finally, the Family Care pilots adapted to the new requirements of the quality initiatives described in the ***Program Overview*** section. While all of the counties have moved beyond the initial start-up phase, the process of realizing the full intention of the Family Care model will be a continual one.

## A. Care Management

At first, the CMO counties faced the multiple challenges of expanding the number of people they served, expanding the scope of services they provided, adapting to new practices, such as including an RN on each care management team, and adapting to new information systems. During this initial implementation period, care managers had a number of extra burdens placed on their time, such as enrolling current clients in Family Care and learning new information systems and forms. At the same time, they were trying to develop expertise in providing services previously financed through the Medical Assistance Card. In addition, many workers were newly hired and, as a result, had limited institutional knowledge.

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

In order to implement the revised care management approach, CMOs reduced caseloads for social workers, relative to pre-Family Care levels. The average caseload size of about 30 to 50 is smaller than caseloads prior to Family Care. In the COP program in Milwaukee, caseloads were as high as 60 individuals per care manager and they now average 40 to 45. The pilot counties noted a significant reduction in the caseload size for social service coordinators caring for the DD population as compared to pre-Family Care arrangements. Portage reported that caseloads for the DD population averaged between 70-80 prior to Family Care and now run about 40 to 45.

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

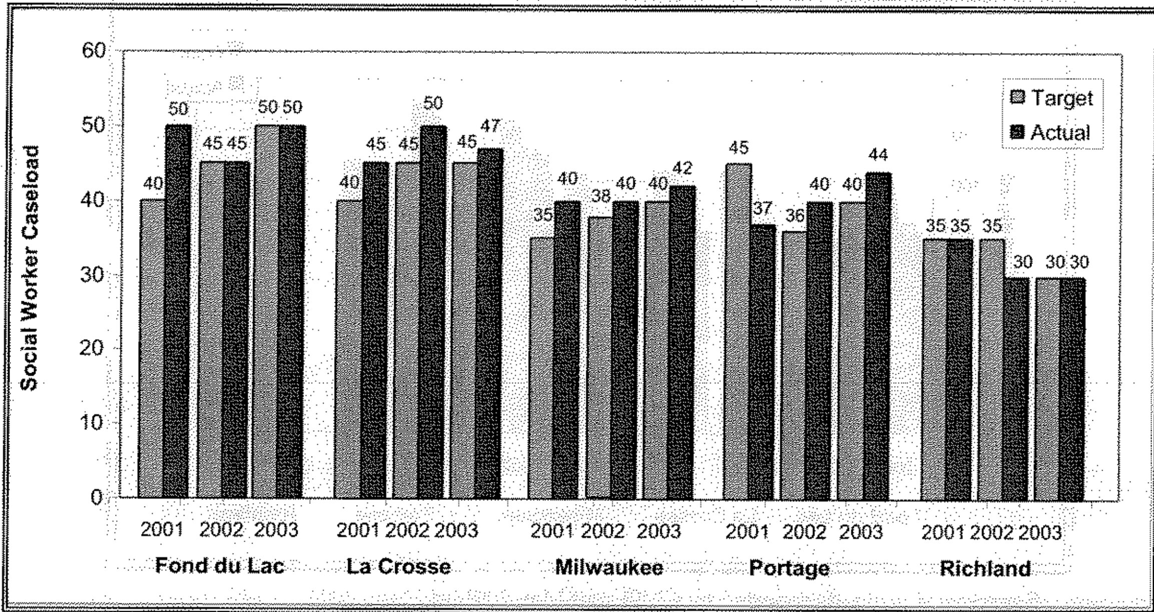
| Old System/ Case Management | Family Care / Care Management |
|---|---|
| Service focused | Outcome focused |
| Primarily considers social and functional needs and finances | Considers the whole person, including preferences and physical health |
| Care decisions made at management level | Care decisions 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.

***Exhibits VIII-2* and *VIII-3*** indicate that caseload targets have adjusted as the CMOs gained more experience and the actual caseloads achieved changed over time with the ability to staff. More recently, some of the counties had specialized beyond/within target population. Milwaukee added a dementia team and a Spanish speaking team, while La Crosse created a mental health unit.

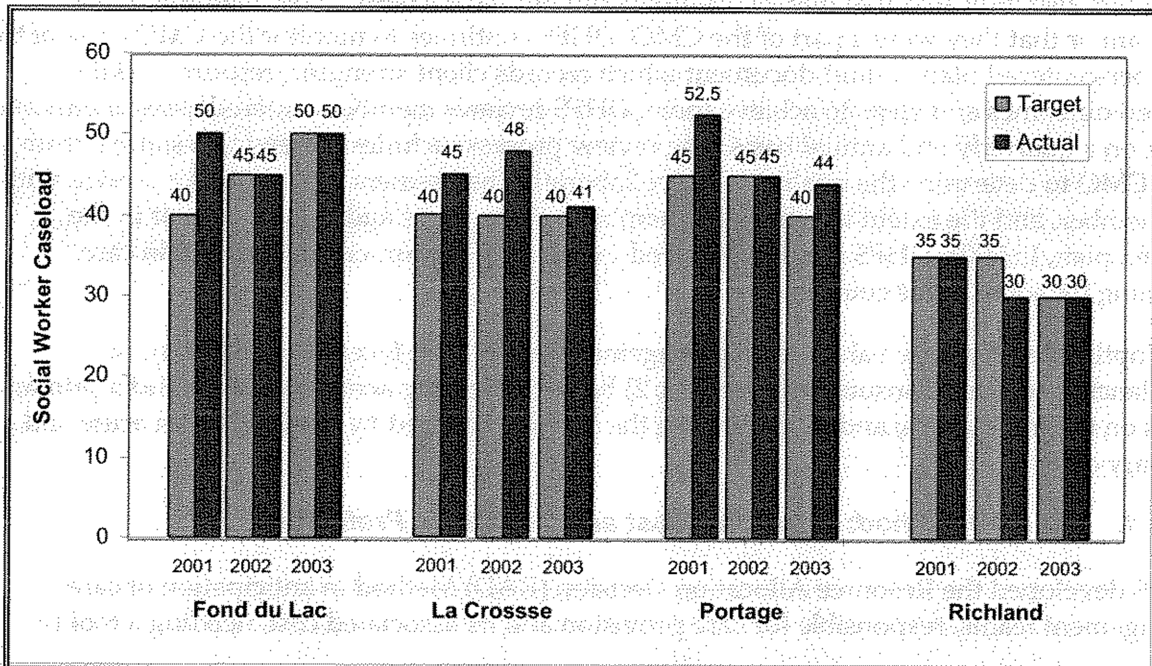
Under Family Care, RNs have an important role on the interdisciplinary teams assessing health needs, incorporating preventive measures, monitoring health, integrating social supports with medical needs, and coordinating care with other medical providers. Together with the social worker, they work to best meet consumers' preferences and medical, psychological, and social needs. The 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 and, as a result, appointed a RN supervisor. Also, the CMOs have had a difficult time hiring enough RNs to lower their caseloads to the targets they established (***Exhibit VIII-4***). In 2003, Portage received County Board approval to hire ahead of enrollment, making it possible for the CMO to finally meet its goal of 80 members per RN.

**Exhibit VIII-2**
**Social Worker Caseload for Elderly and Physically Disabled Members, May 2001, 2002, and 2003**



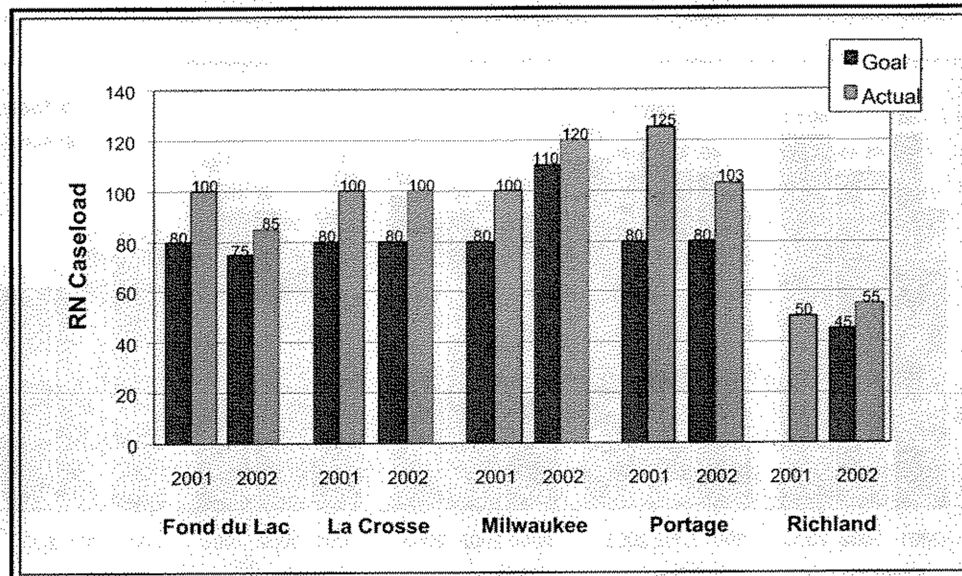

**Source:** Average caseloads reported by CMO staff in May 2001, May 2002, and May 2003.

**Exhibit VIII-3**
**Social Worker (SW) Caseload for Developmentally Disabled Members, May 2001, 2002, 2003**




**Source:** Average caseloads reported by CMO staff in May 2001, May 2002, and May 2003.

**Exhibit VIII-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 care management teams are still working on fully integrating consumers, families, and providers 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.[12] 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. In 2002, DHFS identified a need to improve consumer involvement in care planning for some of the counties.

In adopting Family Care values, care management teams have faced three challenges: 1) balancing cost and consumer preference; 2) balancing equity across members and a primary focus on the individuals; and 3) integrating the services covered by the CMO with acute and primary care.

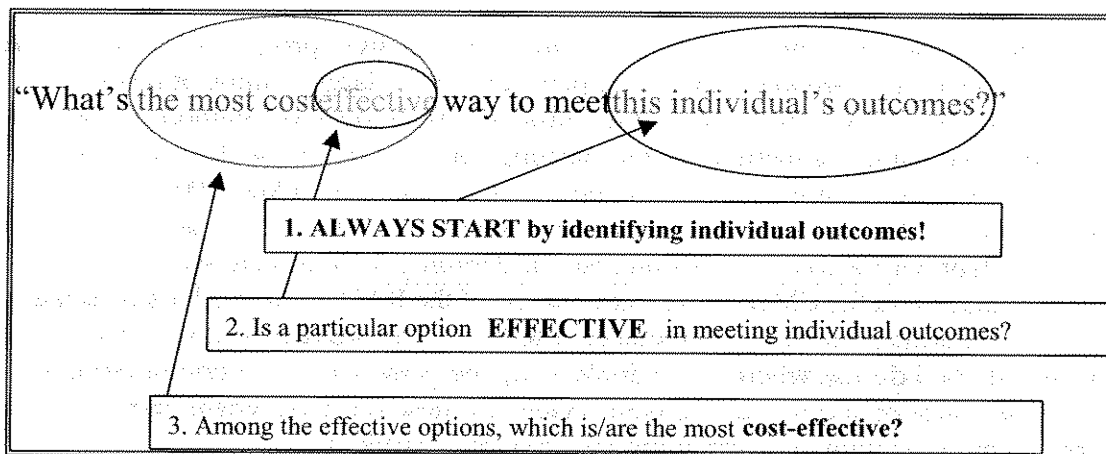
### *1. The RAD Method: Balancing Cost and Consumer Preference*

DHFS developed the Resource Allocation Decision (RAD) Method in anticipation of care management teams, responsible for care provision and its associated cost, needing a tool to

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

guide them in determining how best to use resources. The process 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 (***Exhibit VIII-5***).

**Exhibit VIII-5**
**The DHFS Resource Allocation Decision (RAD) Method**




**Source:** DHFS.

It provides logic for the care management team to follow when making service decisions. The RAD steps include:

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

Following initial training in 2000 and 2001, care managers generally thought the tool would be useful, but had little experience with it in the field. During 2002, DHFS and the CMOs invested heavily in training staff in the use of the RAD method. Despite this training, we reported in 2002 that the CMOs seemed to be struggling with the concept of balancing consumer preference and cost. 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. Currently, DHFS has begun introducing the RAD method to non-Family Care counties.

Initially, as 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. Subsequently, CMO staff reported using the method in staff meetings in order to review difficult cases and all CMOs had procedures in place to document the use of the method. In May 2002, consumer advocates interviewed indicated hearing complaints related to reductions in services. This timing is consistent with waiver conversion cases undergoing their annual re-certification and review of care plans and the CMOs more frequent use of the RAD method which resulted in changing care plans and sometimes reductions in services. This was especially true in Milwaukee and Fond du Lac where individuals using the personal care option under the state plan were newly subject to care management review for these services, where previously providers had more latitude in determining the amount of services.

### 2. Equitable Care Plans 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 the interdisciplinary teams to understand the core issues facing the consumer and that the consumer play 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, the 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.

The CMOs 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 faced 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. More recently, the CMO contracted with Community Care for the Elderly (the PACE and Partnership contractor) to assist the CMO administrative staff in providing oversight, training, and quality assurance. Milwaukee also developed several

protocols for care management teams on such topics as "wound care" and "working with discharge planners." During 2003, La Crosse's quality monitoring and improvement focused on case management timeliness and consistency.

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. Portage hired an additional supervisor to reduce supervisor caseload, created specific guidelines for the use of the RAD method and SDS option, and added 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.

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. The 2003 quality site visits will be conducted in the summer.

### 3. 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 remains a necessary and important component of appropriate planning and service delivery under Family Care.

Several barriers exist to designing an integrated system where service providers work together to achieve the best outcomes for consumers. 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.

Despite these barriers, CMOs recognized the potential health benefits of integrated care for their consumers and developed 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 Fond du Lac invited physicians to tour community-based housing settings.
- Portage, Richland, La Crosse and Milwaukee have worked to educate and establish productive relationships with discharge planners at hospitals. In addition, Portage arranged to obtain discharge planning information from the local hospital via automated information systems.
- Milwaukee developed a Medicare and Medicaid consultant role to assist the teams in understanding the complexities of the two programs and coordinating with an in-home visiting physician program.

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.

## B. Consumer Direction/Advocacy

Consumers exert influence beyond care planning through varying degrees of directing their own care or through advocacy channels. Family Care promotes consumer direction through providing members the opportunity to select and manage services provided to them along a continuum of increasing control, from directing services to hiring and firing care workers. Opportunities for advocacy in Family Care exist to assure a fair and equitable system that honors consumer rights.

### *1. Self-directed Supports*

The DHFS contract requires CMOs to offer a self-directed support option after two years of operation. Portage, La Crosse, and Milwaukee have offered the option since the CMOs' beginning, Fond du Lac's began October 2001 and, with a state modification of their contract, Richland will offer the option in January 2004 rather than in 2003.

The CMOs expressed some concern about the implementation of the self-directed supports options. Fond du Lac noted having difficulty developing 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, rather than a maximum allowable amount as in the COP and waiver programs. As more members elect self-direction, La Crosse staff expressed concern over the potential amount of time interdisciplinary teams will need to spend training self-directing members. DHFS used its CMS Bridges to Work Grant to focus on the self-directed supports program in each CMO and develop "a personal futures planning" resource manual for use by each CMO.

*Exhibit VIII-6* indicates that approximately 20 percent of CMO members have exercised some self-direction, although the overall average belies differences among the CMOs. Fond du Lac, La Crosse, and Portage have similar models for the SDS option and participation ranges from 6 to 13 percent. 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.

**Exhibit VIII-6**
**CMO Members Self-Directing Care as of May 2002 and May 2003**

| CMO | Members Self Directing Care | | % of total CMO Enrollment | |
|---|---|---|---|---|
| | 2002 | 2003 | 2002 | 2003 |
| Fond du Lac | 59 | 52 | 6% | 6% |
| La Crosse | 75 | 117 | 7% | 9% |
| Milwaukee | 1,200, with independent providers[1] | 1,200 | 36% | 30% |
| Portage | 74 | 87 | 15% | 13% |
| Total | 1,408 | 1,456 | 23% | 20% |

**Source:** CMO reported information.

[1] Milwaukee employed 1,200 independent providers of members' choice, 10 of whom used a fiscal agent. This policy carried over from prior to the CMO's implementation when the county employed independent providers for 80% of all supportive home care.

**Note:** According to the CMO contract Richland does not have to offer the SDS option until January 2004. 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. Few Milwaukee CMO members use the fiscal agent option, however, pre-Family Care practices allowed 1,200 individuals to select their own provider, usually family members (but not spouses or parents).

### 2. Advocacy

Over the course of Family Care's evolution, there have been three formal advocacy positions – an independent advocate, which was a separate organization from the RC, CMO and the county; a member advocate, which serves as an internal advocate for CMO members; and disability benefit and elderly benefit specialists, which serve as advocates for individuals on eligibility and benefit issues.

From 2000 to October of 2001, when the Governor signed a biennial budget that eliminated funds for independent advocacy in Family Care, Wisconsin Coalition for Advocacy (WCA) provided independent advocacy in CMO counties. The role of the independent advocate included providing an impartial entity to assist consumers with grievances, appeals, and fair hearings related to entitlements and benefits broader than Family Care (e.g., social security, disability insurance, supplemental security income). It also included providing information and assistance, training, and technical support to individuals about how to obtain services and supports. 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. Since the independent advocate's elimination, some advocacy organizations still provide limited advocacy to CMO members. However, without state funding, these agencies do not have the resources to serve the entire CMO population.

The member advocate position is a CMO staff member outside the member's interdisciplinary team that reports to management at the CMO. He or she functions as a quality assurance mechanism to ensure care management teams honor consumer's preferences by: 1) following up with members at least two months after enrollment; 2) alerting members to advocacy options and answering questions; 3) assisting members with issues related to care management or service provision, including appeals and grievances; and 4) assisting with overall quality assurance at the CMO.

The Elderly Benefit Specialist (EBS), which existed prior to Family Care and is funded by Older Americans Act and state funds, and the Disability Benefit Specialist (DBS), created by the Family Care legislation, also serve as advocates for individuals primarily interacting with the RCs regarding eligibility for the CMO benefit. Their role includes providing advocacy for benefit programs on the following issues: eligibility, coverage/denials, terminations, overpayments, and explanation of notices. 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.

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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 (DHFS), Wisconsin Division of Supportive Living (DSL), and Wisconsin Bureau of Aging and Long-Term Care Resources (BALTCR).

## C. Quality Assurance and Improvement

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

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. DHFS 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 the ***Program Overview*** section) 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. In past reviews, 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.

### *1. 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. In 2001 and 2002, 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 great 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 state-wide 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.

In 2002, the other three CMOs had just begun to incorporate quality monitoring into their provider contract provisions.

In 2002, the small sample of providers we interviewed did not report any 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. MetaStar, DHFS' External Quality Review Organization (EQRO), will review these practices annually during upcoming quality site visits.

### 2. Member Outcomes

DHFS uses 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' perceptions 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 results of these interviews are highlighted in the ***Outcomes*** section. 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-centered quality efforts.

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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.

### 3. Grievances and Appeals

In response to stakeholder confusion regarding the complexity of the mechanisms for complaints, grievances and appeals, in the 2003 CMO contract the Department clarified members rights, including explicitly defining the requirements for filing grievances and the appeals process. The 2003 contracts dropped all references to complaints and defined grievances and appeals as shown in ***Exhibit VIII-7***. Appeals apply to a specific set of actions by CMOs related to provision of services and the acceptability of a member's Individual Service Plans. A grievance is a formal expression of dissatisfaction with matters other than those covered by the appeals process (e.g., quality of care or services provided, aspects of interpersonal relationships, or failure to respect enrollee's rights).

**Exhibit VIII-7**
**Definitions of Grievances and Appeals for Family Care CMOs**

| Appeal |
|---|
| Request for review of an action, where actions include:<br>1. Denial or limited authorization of a requested service, including type or level of service;<br>2. Reduction, suspension or termination of a previously authorized service;<br>3. Denial, in whole or in part, of payment for a service;<br>4. Failure to provide services and support items included in the member's Member Centered Plan (MCP) and Individual Service Plan (ISP) in a timely manner;<br>5. Failure of a CMO to act within specified timeframes; and<br>6. Unacceptability of the Individual Service Plan (ISP) to the member because of any of the following: a) contrary to member's wishes as to where to live; b) does not provide sufficient care. treatment or support items to meet the member's need and identified outcomes; and/or c) requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee. |
| **Grievance** |
| Means of expression of dissatisfaction about any matter other than an "action." |

**Source:** 2003 CMO contract.

CMOs must have a grievance process, an appeal process and a system in place for member to access the State's fair hearing system. The 2003 CMO contract spells out requirements for these processes and systems, in terms of filing, notifications, timing, assistance to members, documentation, continuation of benefits during the process, and resolution. Members can also appeal and/or grieve the same range of issues directly to the Department, either in conjunction with the CMO process or in lieu of it (although the CMOs have been instructed to encourage the internal process as the first step).

Finally, the State Fair Hearing process is limited to a subset of the actions under the appeals process (reduction of and timeliness of services, as well as unacceptability of the ISP) plus involuntary disenrollment. A fair hearing can be requested before, during or after using the CMO processes and is held by an Administrative Law Judge who works for the Wisconsin Division of Hearings and Appeals. This Division is independent of both the county that operates the CMO and the Department of Health and Family Services. The CMO must obey a hearing decision, unless it appeals the decision in the legal system.

The Resource Centers also must have a system for complaints and grievances and specified timelines. They also serve as one of the avenues for assistance to CMO members filing grievances or appeals. Individuals can also access the State Fair Hearing Process regarding the following Resource Center/Economic Support related issues:

- Determination of ineligibility for the Family Care CMO benefit;
- Determination of cost-sharing for the Family Care CMO benefit;
- Determination that the person is eligible for, but not entitled to the Family Care benefit (primarily would apply to those meeting the intermediate level of care);
- Determination in regard to divestment, treatment of trust amounts, and protection of income and resources of a couple for maintenance of the community spouse; and
- Failure of the Resource Center to provide timely services and support.

# PART THREE:
# PRELIMINARY OUTCOMES AND COST-EFFECTIVENESS

# IX. OVERVIEW OF OUTCOMES AND COST ANALYSES

As we noted in our 2002 Implementation Update, defining cost-effectiveness and measuring outcomes can be difficult. Issues related to "how to measure costs", "cost to whom?", "how to quantify outcomes or 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.[15] 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.

**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 to determine a monthly capitated amount that does not truly reflect price determined by the market. The capitated amounts and these analyses also do not include any member cost-share amounts (these generally represent less than one percent of total spending for Medicaid services), nor the start-up and other costs, such as DHFS staff time and training, 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 becomes a key factor. From the state's perspective, the state general revenue and county costs are of greater importance 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 percent 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, all of the costs would be taken into consideration.

Unless otherwise noted, costs examined in this report are total federal, state, and county spending captured through the administrative data systems for Medical Assistance, the Medicaid Management Information System (MMIS), and the long-term care portion of the Human Services Reporting System (HSRS). These systems do not capture all costs related to the CMO benefit and the comparison group spending. While the CMO capitated payment includes an allocation for CMO administrative expenses of 12 percent, the CMO long-term care benefit spending includes only the payments for services. Neither the capitated payment nor the CMO long-term care benefit spending include administrative costs associated with state oversight, or

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

in-kind support provided by the counties, such as discounted office space and payroll processing. The comparison group spending does not include county or state administrative spending, the routine seven percent added to COP and Medicaid HCBS waiver programs for administrative charges, nor any county spending for benefits that were not reported through the HSRS system.

**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. In addition, the functional screens used prior to the CMOs and up until recently in the remainder of the state were not the same as those used in conjunction with Family Care. 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 therefore, do not yet offer a measure of benefits gained. However, results from individuals on the other waivers offer a relative comparison.

**To what should costs and benefits be compared?** We have pursued a methodology that focuses on both 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. As outlined in the methodology section, for most of the cost measures, we choose to use an approach that accounts for changes over time unrelated to the Family Care program by adjusting for the change experienced by a similar group not subject to Family Care (comparison areas) called a difference-in-difference (DID) analysis. The underlying assumption is that the time trend in the control group is an adequate proxy for the time trend that would have occurred in the Family Care CMO counties in the absence of Family Care. The legislation authorizing Family Care also required a comparison to nursing home costs.

The outcome and cost-effectiveness analyses focused on the key components of the Family Care program: access to information and services; choice and self-determination; community integration; health and safety; and spending. ***Exhibit IX-1*** summarizes the key outcomes and cost analyses conducted. Details regarding each of the measures can be found in ***Appendix F***.

**Exhibit IX-1**
**Key Outcomes and Cost Analyses Conducted**

| Indicator | Analysis |
|---|---|
| **Access** | |
| *Information* | |
| RC Outreach Activities | Range of efforts by county over time |
| Resource Center Contacts | Relative to contract standard by county |
| *Benefits* | |
| Wait Lists | CMO counties trend relative to rest of state |
| CMO Enrollment | Trend by county and by target population |
| Choice of Providers | Number of contracted providers over time |
| Service Use by Type | Pre/post CMO counties relative to comparison |
| **Quality of Life/Care** | |
| *Choice and Self-Determination* | |
| Treated fairly | Member Outcome Tool for CMO & waiver |
| Privacy | Member Outcome Tool for CMO & waiver |
| Personal dignity & respect | Member Outcome Tool for CMO & waiver |
| Choose services | Member Outcome Tool for CMO & waiver |
| Choose daily routine | Member Outcome Tool for CMO & waiver |
| Achieve their employment objectives | Member Outcome Tool for CMO & waiver |
| Satisfied with services | Member Outcome Tool for CMO & waiver |
| *Community Integration* | |
| Choose where and with whom they live | Member Outcome Tool for CMO & waiver |
| Participate in the life of the community | Member Outcome Tool for CMO & waiver |
| Informal support networks connection | Member Outcome Tool for CMO & waiver |
| Residential care use | Post CMO counties relative to comparison |
| Nursing home use | Post CMO counties relative to comparison |
| *Health and Safety* | |
| Free from abuse and neglect | Member Outcome Tool for CMO & waiver |
| Best possible health | Member Outcome Tool for CMO & waiver |
| Safety | Member Outcome Tool for CMO & waiver |
| Continuity and security | Member Outcome Tool for CMO & waiver |
| Decubitis ulcer | Post CMO counties relative to comparison |
| Hospital use | Post CMO counties relative to comparison |
| Emergency room use | Post CMO counties relative to comparison |
| Death | Post CMO counties relative to comparison |
| **Spending** | |
| Total Medicaid & state benefit spending | Pre/post CMO counties relative to comparison |
| LTC Medicaid & state spending | Pre/post CMO counties relative to comparison |
| Spending on new enrollees | Post CMO relative to existing enrollees |
| Nursing Facility versus Community | CMO counties |



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# X. ACCESS

The evidence, much of it presented in the previous part of the report, suggests greater access to information in the nine Resource Center counties and to long-term care benefits in the five CMO counties.

## A. Access to Information

The measures used to assess the degree of access to information were: 1) the range of outreach activities the Resource Centers pursued; and 2) the number of contacts per capita for each of the target populations relative to DHFS established standards.

The Resource Centers appear to have increased the degree of access to information to the target populations. Prior to Family Care, most of the nine counties lacked a centralized source of information regarding long term care services available and options for meeting need. Today, the Resource Centers coordinate information for the three target groups (except in Milwaukee where the focus is only older adults) and actively conduct outreach through a variety of mechanisms (see ***Exhibit VII-3*** in the previous part of the report). The outreach activities have moved beyond the traditional approaches that generally created informational brochures and distributed them during community presentations and health fairs to encompass additional distribution avenues, such as websites and gatekeepers (e.g., groceries, pharmacies and paramedics), media, including radio and television, and targeted outreach to specific communities (e.g., Hmong, children entering the adult system, providers, and rural areas). In addition, all but two of the nine Resource Centers have met or exceeded a DHFS established standard of eight contacts per month per 1,000 for each of the target groups (see ***Exhibit VII-4*** in the previous part of the report). In the two counties that did not meet the standard, Marathon and Kenosha, this occurred only among the individuals with developmental disabilities; they met or exceeded the standard for the elderly and for individuals with physical disabilities.

## B. Access to Benefits

The measures used for access to benefits include: 1) wait lists in the CMO counties relative to the remainder of the state; 2) the trend in CMO enrollment; and 3) the mix of services received by CMO members relative to comparison areas. All three measures indicate increased access to benefits in the CMO counties.

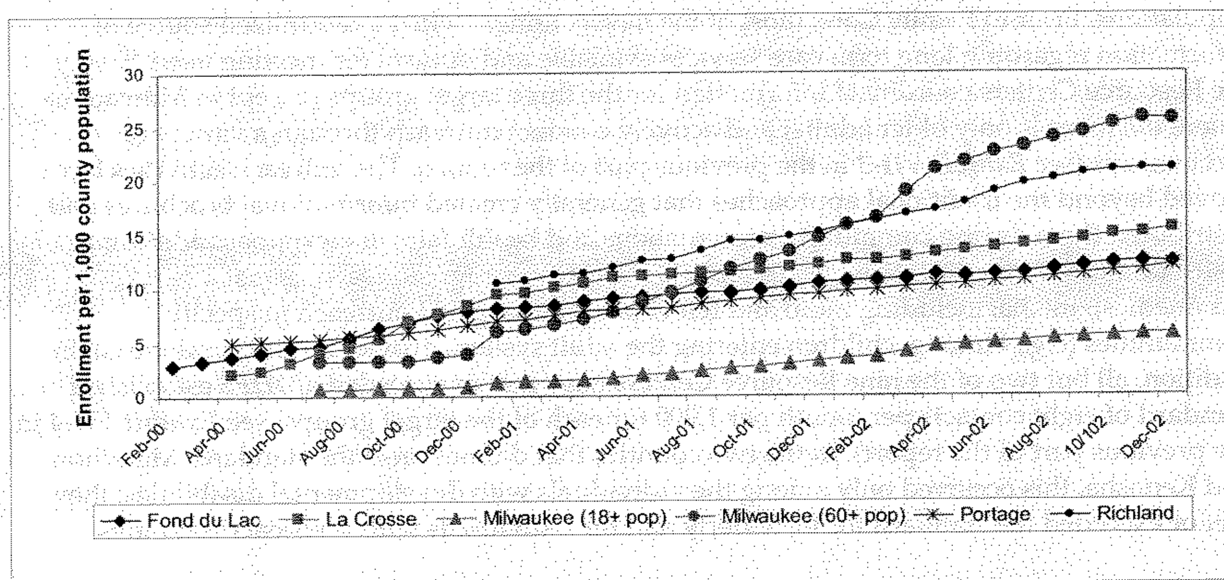
### *1. Wait Lists*

Previously, the number of people who could be served was limited by state and federal approval processes. Today, in the five CMO counties, individuals seeking long-term care services that qualify for Medical Assistance due to a lack of financial resources can enroll in a CMO and begin to receive services without having to wait for an opening in the program. Fond du Lac, La Crosse, and Portage moved all eligible individuals on their wait lists into services by the spring of 2001, while Milwaukee and Richland accomplished this by the end of summer 2002.

## 2. CMO Enrollment Trend

CMO enrollment grew steadily since the start of the program and only recently appears to be leveling off. ***Exhibit X-1*** shows CMO enrollment per 1,000 adult county population. This measure standardizes the level of enrollment across the counties and provides an indication of the relative access in each of the counties. However, the measure does not account for differences in the financial circumstances nor population in need of services, making it difficult to draw definitive conclusions based on the relative differences across the counties. ***Exhibit X-2*** provides disability rates and economic data for the CMO counties from the 2000 Decennial Census to inform the discussion below.

**Exhibit X-1**
**CMO Enrollment per 1,000 Adult 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 for December 2002 available March 2003, as well as 2000 Decennial Census population estimates.

**Note:** Enrollment data since January 2001 reflect totals presented in the most recent Family Care Activity Report. Revised data for 2000 were not available, possibly affecting the curve of data presented. The number of county residents remains the same for all of the calculations over the period.

Enrollment in Fond du Lac and Portage followed similar paths and, as of the end of 2002, approximately 1.2 percent of the counties' adult population were enrolled in the CMO. La Crosse had somewhat higher enrollment relative to population with approximately 1.5 percent enrolled in the CMO. These three counties have adult populations ranging in size from 51,000 in Portage to 73,000 in La Crosse. Based on 2000 Census data, they also had similar disability rates, however Fond du Lac had lower general poverty rates, but similar age 65+ poverty rates compared to the other two counties. Richland, the smallest and most rural county with approximately 18,000 residents, started with higher enrollment to population levels and continued to have higher levels through the end of 2002 with 2.1 percent of the adult population enrolled. In December 2002, Richland's enrollment rate among the adult population was