Family Care

Redesigning Wisconsin's Long Term Care System

Proposal
of the Department of
Health and Family Services
July 31, 1998

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This paper describes the proposal of the Department of Health and Family Services for redesign of the service system for elderly people and people with disabilities who need long term care and support. Session law included in 1998 Act 237 (the Annual Budget Review Bill) requires the Department to submit drafting instructions for legislation on this topic by July 31, 1998. We will request that legislation be drafted that would implement the system described in this document. At the same time, we recognize that the process of developing this legislation will continue over the coming months, through discussions with the federal government, stakeholder groups and legislative drafters. Ideas will be refined, and details will be added.

Comments and suggestions continue to be welcome. If you want to learn more about the development process or the content of this proposal, or to make suggestions or comments, please:

Visit our internet site at http://www.dhfs.state.wi.us/LTCare

or write: LTC Redesign Information
DHFS Office of Strategic Finance
1 W. Wilson Street - Rm. 618
Madison, WI 53707

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Executive Summary

In January 1998, Governor Tommy G. Thompson proposed to redesign Wisconsin's long term care system and to create a flexible, new "Family Care" benefit to cover long term care services. The new system will emphasize independence and quality of life while recognizing the need for interdependence and support. This paper outlines the Department of Health and Family Service's proposal to be considered by the Legislature in the winter and spring of 1999. Federal approval of changes that affect Medicaid also will be needed before the new system can be implemented.

The vision of the new long term care (LTC) system's structure and goals is contained in this revised proposal, which is the result of nearly three years of effort by many concerned citizens and policy experts. Hundreds of consumers and their family members have been involved in every phase of the proposal's development, through steering committees, work groups, focus groups, forums and other mechanisms. Many other stakeholders, including county and tribal representatives, service providers from various sectors of the LTC system, advocates and academics, have also provided their insight throughout the process.

The proposal covers elderly people and other adults with physical or developmental disabilities. Services for children with LTC needs, as well as the state's mental health and substance abuse systems, are being studied separately.

Aging and Disability Resource Centers

Located in each area of the state, Aging and Disability Resource Centers will provide one-stop shopping for information and assistance to help people connect with all kinds of services, benefits and community resources for elderly people, people with disabilities, and their families. Here, people can get accurate and timely advice about the options available to them and help in getting what they need. The Resource Centers will also provide prevention, early intervention and outreach services, to help people maintain their independence.

Resource Centers will be the access point for LTC services, screening for eligibility for the new Family Care benefit and for admission to residential LTC services, and determining client cost-sharing amounts. They will counsel clients about LTC options and, if they choose the new Family Care plan, enroll them for services in the care management organization (CMO) of the client's choice. As much as possible, Resource Centers also will provide access to other benefits that might be sought by elderly people and people with disabilities, including Medicaid and Food Stamps.

A Long Term Care Benefit with Options

In the current system, state and federal LTC funds flow through a confusing maze of many programs, each with its own eligibility criteria and service restrictions. In the new system, funds from all these programs will be used to fund one flexible new LTC benefit, individually

tailored around each person's needs, preferences, values and circumstances. Care Management Organizations (CMOs) will be established to help people arrange and manage their services.

The CMO will receive a fixed amount of funding each month for each person enrolled. This amount will be related to the projected need for LTC services based on the person's level of functional disability. Payment levels will reflect the different level of care requirements which different groups of people experience.

The monthly per person payment amount will be based on average actual costs for groups of people at various functional levels; **the actual cost for any given person will likely be higher or lower than the payment**. The monthly payment that a CMO receives related to a given individual will not limit the amount that may be spent on that person's care, nor does it "entitle" the person to services up to the level of the monthly payment amount. This averaging of costs and payments across caseloads is similar to that done now by counties under the Community Options Program and Home and Community Based Waivers and by nursing facilities under Medicaid. Whether a county or another organization manages funds, they will be responsible for meeting the needs of their clients within the funds that they receive.

The new benefit will offer services in three basic categories: Community Options (in-home services, supported apartment, and community day services), Nursing Home Options (intermediate and skilled nursing facilities, including ICF-MR), and Other Residential Options (residential care apartment complex, community based residential facility, adult family home).

Each CMO will be required to offer a state-established minimum array of service types. Since each consumer is different, the new benefit will also cover any other service that will meet consumers' LTC needs. A personalized assessment and service/care plan, developed for and with each consumer, will determine the preferred package of services and supports to meet his or her needs. Flexibility of funding is essential to achieving high quality outcomes for consumers and to promoting creative and cost-effective ways of meeting individuals' needs

Eligibility for the new benefit will be based on the degree to which a person's physical or cognitive condition limits his or her ability to manage independently the everyday activities of living such as moving around, eating, bathing and dressing. Two levels of eligibility will be established: comprehensive (equivalent to the level of care requirements for nursing home care or the Community Options Program), and intermediate (less severe disability than comprehensive level).

Everyone who meets the comprehensive level of functional eligibility will be assured of receiving services promptly. In addition, everyone who meets the intermediate (lower) level of functional eligibility and who is Medicaid-eligible and/or has a confirmed need for adult protective services will be assured prompt access to the Family Care services. Others at the intermediate level will be eligible for services, but may be placed on a waiting list if funding is not immediately available. If a waiting list is necessary, the Resource Center will develop an interim plan of care consisting of informal supports, local community resources and other services the person may be able to purchase. When funding for the Family Care benefit becomes available, people will be removed from the waiting list according to uniform criteria (i.e., functional capacity, risk factors and financial status) and referred to a CMO for services.

There will be no "cliff" of financial eligibility. All clients will be required to share in the cost of their services to the extent of their ability to pay, from nothing to 100%. Cost sharing will be determined on the combined factors of income and assets, offset by several types of deductions and exemptions. Current disincentives to employment will be substantially reduced. Private pay people will be welcome to purchase case management services from CMOs.

More Choices for More People

The current LTC system is biased toward institutional services, which are readily available and an entitlement under Medicaid. Community programs like the Community Options Program provide more choices for people, but have waiting lists. In the new system, the institutional bias will be eliminated; regardless of where they live and receive services, people who have high levels of need will not have to wait.

People will be free to choose whether or not to enroll in a Care Management Organization. Those who are Medicaid-eligible will have the option of obtaining services through the Medicaid fee-for-service system, which will continue to offer the current range of benefits. The new, flexible Family Care benefit will be available only through a CMO. Where a CMO is available, the Community Options Program and Home and Community Based Waivers will no longer be operated as separate programs.

An individual's service/care plan will be developed based on a comprehensive assessment, conducted with the person and others who know the person. The person's values and preferences must be solicited as part of the assessment and addressed in the service/care plan. The primary consideration about where a person lives will be his/her own preference. No one will be required to live in a nursing home as his or her long-term residence. No one currently living in a nursing home or other residential care facility will be required to move.

People will have the opportunity to live in housing that they have chosen unless there are essential health or long term support needs that cannot reasonably be met in such a setting or the preferred setting includes a package of services that exceeds the person's identified needs. Individual values and preferences, quality, cost, and the ability to meet the individual's needs will all be considerations in development of a service/care plan, including living arrangement. For people whose cost of care is very expensive, shared community living arrangements will be a likely alternative to nursing home care. Alternatives must be developed and offered to people who choose not to live in a nursing home, but those alternatives do not necessarily have to be more expensive than the cost of the nursing home.

People of working age will have more opportunities to work under the new system. Employment will be an important outcome for people of working age, and if employment is desired, it must be addressed in an individual's care/service plan. In return, the system will expect people of working age to contribute to their own support and the cost of their services.

Each CMO will be required to develop, in consultation with local consumers, a network of service providers that provides adequate consumer choice of readily accessible providers for all types of services. Consumers must be able to choose, without waiting, from among a broad array of providers with characteristics that consumers find convenient and desirable. Being

able to choose a specific provider is crucial when that provider is attending to intimate personal needs or comes frequently into the consumer's home. For these kinds of services, the CMO must purchase services, at a consumer's request, from any provider who meets the CMO's standard price and quality standards.

Family members may be paid for providing care in circumstances where it is appropriate, under criteria established by the state. In addition, each CMO must offer a self/family-directed care option for any consumer who is able and willing to choose and manage his or her own services and supports or who has support in decision-making from someone who is committed to the consumer and knows his or her preferences and needs.

Looking Out for Consumers

A variety of mechanisms will work together in the redesigned LTC system to protect consumers from failures in the system. A consumer bill of rights that universally protects consumers in all LTC settings will be a part of legislation to create the new LTC system. It will incorporate all existing rights to which consumers are entitled.

Formal and informal complaint and grievance mechanisms will be built into each part of the system, both internal to each Resource Center and Care Management Organization, and through independent, external organizations. Appeal processes will also be in place, including a direct appeal to a state administrative hearing. Advocacy will be multi-level, built into each organization, and also provided through one or more independent organizations. To help assure that the system maintains a consumer focus, consumers and their families will be a part of advisory and governing bodies at every level.

Quality assurance and improvement systems will focus more on consumer-defined and consumer-centered outcomes and, over time, less on regulating processes. The new system will focus on meeting (and exceeding) customer expectations more than on complying with rules about procedures. The values and preferences of people receiving care and their families will define the meaning of success. The state will establish performance standards, but allow flexibility in how contract organizations meet them. Each organization will be required to maintain a continuous quality improvement program to evaluate its own performance and that of its subcontractors. Some current regulatory activities will remain in place, such as licensing of some service providers.

Management of the New LTC System

Given their long experience in performing many of the roles envisioned for the new system, counties and tribes will be given preference to serve in key management roles, including first preference to be an Aging and Disability Center. If a county is unwilling to serve in this role, or cannot meet Resource Center performance standards, competition will be opened to private, not-for-profit organizations. Counties and tribes will also have right of first selection to serve as Care Management Organizations for one or more target groups. If a county chooses to operate a CMO and meets contract standards, it will have a two-year opportunity to establish operation without competition.

In cases where a county operates both, the Resource Center and CMO must have separate governing boards and separate managers, to assure that both roles receive the attention they need, and to provide insulation between their potentially conflicting roles. Existing boards and committees, such as the Aging Commission, can be reconfigured to meet this requirement.

A County LTC Council will be established in each county, or at local option, in a multi-county region. More than half of the Council's members must be elderly people, people with physical and developmental disabilities, and their family members, guardians and other advocates. At least two-thirds of these consumer representatives must be elderly people, people with physical disabilities, and people with developmental disabilities; not more than one-third may be family members, guardians and other advocates. When the Council is appointed, it may assume the duties of the currently required Long Term Support Planning Committee, which will no longer be required. The Council will develop an initial plan, within state guidelines, for the local structure of the LTC system, including the number and types of CMOs that should be available. Each county must consider this plan and consult with its County LTC Council when deciding whether to apply for certification to operate a Resource Center and/or Care Management Organization. After the start-up period, the County LTC Council will have ongoing responsibilities for guidance of the local LTC system.

A State LTC Council, also composed primarily of consumers and their families, will be created to provide guidance for the system at the statewide level. The State LTC Council will assist the Department to develop LTC policy issues, provide a forum for review and recommendations to the Department on its decisions regarding how many CMOs should operate in a particular local area and which organizations should receive CMO contracts from the Department, and assume other specific responsibilities.

Funding

Wisconsin's LTC system is currently one of the most expensive in the nation. On average, we spend about 50 percent more than the national average for each Medicaid-eligible older person. Only two states in the country spend a higher proportion of their Medicaid budgets on long term care. More people can be served within our current budget if we manage public LTC funds more efficiently and effectively. The LTC budget will have to increase in future years under any system, to account for higher numbers of elderly people and people with disabilities, and for inflation.

To obtain federal approval of this proposal, we must show that benefits in the new system would cost no more than LTC services would have cost under the current system. We will be able to assure more people of services and meet this federal requirement only if the new system achieves several key outcomes. First, we must reduce the cost per person served by providing services more cost effectively. Whenever feasible, services must be provided in less restrictive, less expensive settings and forms. The system must improve the capacity of people to do things for themselves, give value to the role of community and family, and respect the values and preferences of people. Second, we must reduce the need for services through strong prevention and early intervention programs. Third, we must reduce the need for public subsidy for services. The new system must provide good, timely information to people before and

when the need for long term care arises, to allow them to remain independent longer and conserve private resources by making informed choices about purchasing services.

Work is well underway to develop detailed cost and saving estimates for this proposal. Information gained from the already operating Resource Center pilots and from feedback sessions with major stakeholders will help to refine these estimates. In the event that cost/saving estimates indicate that this proposal would need to be modified to stay within budget, a public process will be used to assist in making needed changes.

Introduction

In January 1998, Governor Tommy G. Thompson proposed to redesign Wisconsin's long term care system to ensure that the system meets the needs of our citizens in the next century. The new system, including a new, flexible long term care benefit called "Family Care," will emphasize independence and quality of life while recognizing the need for interdependence, support and cost-effectiveness. This paper outlines the Department of Health and Family's proposal for legislation to be considered by the Legislature in the winter and spring of 1999.

The vision of the new long term care (LTC) system and its structure and goals are contained in this revised proposal. It is the result of nearly three years of effort by hundreds of concerned citizens and policy experts. This proposal replaces several earlier versions that were widely distributed for the purpose of securing extensive public input.

The process began in 1995 with focus groups composed of older citizens and persons with disabilities who are already receiving long-term care services, whether in their own homes, in nursing homes, or in residential facilities. They told us what was right about the current system, what was wrong, and how things should be changed.

Consumers and their families have been involved in every phase of the proposal's development, through steering committees, work groups, forums and other mechanisms. Other stakeholders, including county and tribal representatives, service providers from various sectors of the LTC system, advocates and academics, have also provided their insight throughout the process.

Many provider and consumer groups shared their own policy proposals, and the revised proposal has especially benefited from the efforts of a number of work groups that wrestled with difficult issues. The meeting schedule has sometimes been demanding, and Department staff offer their thanks to the many work group members who have contributed so generously of their time, expertise and varied perspectives and to those who continue to do so.

Background

Some 260,000 Wisconsin residents over age 15 have a permanent or long term disability (excluding serious and persistent mental illness) that is severe enough to interfere with their ability to live their daily lives with complete independence. Of these, about 38% are between the ages of 15-64 and about 62% are age 65 or older. There are an additional 10,000 children with serious disabilities. The number of people with long term care needs will continue to grow in coming years: many more people are living to very old ages, where the risk of disability is very high; and advances in medical technology are allowing younger people with chronic diseases or disabling injuries to live longer.

Many of these citizens are poor or near-poor. Among adults, about 23% have incomes below the poverty level and 49% have incomes between 100% and 300% of the poverty level. Only 23% have incomes above 300% of the poverty level.

About one-third of these citizens need help with three or more basic activities of daily living (bathing, dressing, moving around, toileting, eating, or transferring from bed to chair). Another one-third need help with one or two of these activities of daily living. The remaining third have impairments that make it necessary for them to have help with other activities such as managing medications, meal preparation, household chores and using the telephone.

Much of the help that people with disabling conditions receive is provided by families, friends and neighbors. The formal system of services and supports that supplements that care is composed of over 400 institutional facilities (nursing homes and intermediate care facilities for people with developmental disabilities), 1300 community based residential facilities, over 100 county agencies that manage and provide a variety of services, and thousands of agencies and individual providers of home health care, personal care, durable medical equipment, specialized transportation services, adult day services, work supports, and a myriad of other types of services. For the most part, people needing these services must either research for themselves what options are available to provide the supports they need, or are referred to a particular provider by a physician, hospital discharge planner, school counselor, or other professional.

Wisconsin's system of public funding for these long term support services is just as confusing. More than $2 billion in public funds now pay for these services through many different programs, each with its own set of eligibility requirements and specialized purposes.

A number of problems with the current long term care (LTC) system have provided the impetus for this effort to redesign the long term care system. These include:

- The "system" is confusing; it is less a system than a maze of various providers and programs.
- It is hard to get information about what options are available when support is needed. People often spend more than they need to for care, and need public subsidy sooner, because they don't know about less expensive alternatives.
- It is difficult to know how to plan for future LTC needs.
- For those new to the LTC system, it is difficult to arrange needed services and to assure that those services continue to meet support needs.
- Responsibility and authority for the evaluation, delivery and payment for publicly-funded LTC services is fragmented.
- Program rules and regulations often hamper creative and flexible use of funding to develop service packages tailored to an individual.
- Public funding for LTC is weighted heavily toward institutional and medical providers of care.
- There are long waiting lists for those limited programs that do provide flexible, personalized supports for people with LTC needs.

- As currently structured, the LTC system will not be able to handle the projected growth in the number of people needing LTC services.
- Medicaid, the major public payer for LTC, is structured so that there is a "cliff" of income and asset eligibility. People have to spend down to very minimal resource levels before any assistance is available.
- The current system is burdensome and expensive to administer.

Goals of Redesign

The primary goal of this effort to redesign the LTC system is to improve the quality of life of people who need supports. One important way to achieve that is by providing more choices for more people. Given the aging of our citizenry, and the growing number of people with disabilities, however, this will not be possible unless we are more cost-effective in the way we fund and manage long term care. Wisconsin spends about fifty percent more than the national average for each older person who receives Medicaid, at least in part because the proportion of older people in expensive settings like nursing homes is much higher in Wisconsin than in the nation as a whole.

The model

The model proposed here is based on several key components:

- Local Aging and Disability Resource Centers, where all citizens can easily get information and assistance on the full range of services, supports and community resources that are available to elderly people and people with disabilities, and where people who need long term care can access LTC benefits.
- Expanding consumer choices and respecting their preferences about where they live and how they receive needed services.
- A flexible, public LTC benefit, which funds services and supports designed around individual needs and preferences.
- A care management system that can help people find, organize and pay for the services and supports they need in a way that fits with their personal preferences and goals.
- Improved approaches to assuring and improving quality that rely more on measuring outcomes for people and less on enforcing compliance with procedures.
- Efficient management of services and systems by local organizations and the state.

The proposed model will require service providers, counties, consumers, the Department and other organizations to do business in an entirely new way. It is neither the current, fragmented system where some services are case managed for some people, nor a "traditional" managed care model. It goes beyond models used elsewhere in the country in several respects. Unlike systems used in other states (including Oregon), it will include people at all economic levels—not just those who are Medicaid eligible—and will be structured so that a wide range

of public funding sources will be not just coordinated, but pooled and managed for maximum flexibility.

Boundaries and limitations of this proposal

The proposal is currently designed to cover the frail elderly and other adults who have chronic conditions or disabilities that require some level of long term care or support. For these people, the proposed Family Care benefit will integrate the full array of long term care services. Aging and Disability Resource Centers will serve all elderly people and all people with physical or developmental disabilities, whether or not they are seeking long term care, as a source of information about and access to a wide variety of services and benefits.

Elderly and SSI-disabled Medicaid recipients who do not need long term care services will continue to be covered for the full array of Medicaid benefits, and will receive their health care services through delivery systems other than the LTC system. Medicaid-eligible people who need LTC will continue to be covered for all current Medicaid benefits, and may choose to access LTC services through Family Care.

The state's **mental health** system is being redesigned through a separate process. Mental Health and Substance Abuse pilot programs demonstrating new approaches to funding and management in this area are expected to begin in 1999. This document assumes that a person whose primary disabling condition is a serious and persistent mental illness or chronic substance abuse would be served through a parallel and linked system designed to meet their needs, which would be linked with the LTC system. Community mental health and substance abuse services will be a part of the new Family Care benefit for those elderly and disabled people who are covered by this new system.

A special committee, composed largely of parents of children with disabilities, is developing detailed recommendations for redesign of the system of supports and **services to children and families**. The committee expects that the model they develop will be different from the model developed for the adult LTC redesign. It will reflect the unique needs of children and families with appropriate linkages to the final adult redesign model.

Separate efforts are also underway to remove barriers to **employment** for working age adults with disabilities. Governor Thompson has proposed a new initiative called ***Pathways to Independence***. This joint effort by the Department of Health and Family Services and the Department of Workforce Development, Pathways to Independence is a research and demonstration project that will build on existing services and address the issues of health and long term care coverage and system complexity. During a five-year test period at multiple sites, the project would serve about 1,200 to 1,800 Wisconsin residents with physical disabilities, mental illness, HIV/AIDS and developmental disabilities. Proposed services include benefit counseling to help individuals navigate the current system, and intensive vocational services to help them set and meet their employment goals. Both Departments are negotiating with the federal government to obtain the necessary waivers to allow continued health and long term care coverage and cash benefits for project participants who are receiving these benefits when they become employed. Pathways to Independence would give individuals

with disabilities the freedom to seek and hold a job in a way that has not been available before, making them able to share in the emotional rewards and self-esteem of having a job.

Federal approval of changes in current requirements for Medicaid will be necessary before the proposed redesign of the LTC system can be fully implemented. Modifications may be necessary in order to gain that approval. Discussions with federal officials are underway to identify their concerns and more fully explain Wisconsin's goals and thinking behind this proposal.

The federal government has informed us that any changes must be budget neutral overall to Medicaid, in order to obtain a waiver that would allow continued federal participation in Medicaid funding. That is, the new system cannot cost Medicaid more than what would be expected without the redesign. Significant work has been done to estimate the costs and savings associated with the proposed system. Insights gained from feedback sessions with major stakeholders are helping us to develop informed assumptions about the fiscal implications of various components. If the completed cost model indicates that new costs will not allow us to stay budget neutral, the proposal will need to be modified. If that happens, a public process will be used to assist in making needed changes.

Finally, it should be noted that pilots are currently underway in eight counties and one tribe to develop and test various components of the Aging and Disability Resource Center concept. In addition, demonstration sites for pilot Care Management Organizations will be chosen later this year. These demonstrations will teach us more about the ideas contained in this proposal, and it is likely that some aspects of this proposal will change as more is learned.

Aging and Disability Resource Centers

Aging and Disability Resource Centers will be established in every part of Wisconsin; their strength is key to the success of Long Term Care Redesign. This part of the proposed system is designed to assure that everyone with a question or concern about long term care will know where to call, and will get good information, advice, and when appropriate, access to the new Family Care benefit. Resource Centers will provide convenient, one-stop shopping for information and access to a variety of services and programs related to age or disability.

Aging and Disability Resource Centers must be attractive and welcoming to all older people, all people with disabilities, and their families. Private pay individuals, low-income people, frail or seriously disabled people, individuals with less severe disabilities, and those in good health must all feel welcome in a system that they know belongs to them. The Centers must also be "user friendly" for all providers of aging and disability services, especially those who are helping people through transitions. The Resource Center is more than a place that people can visit. It is also an organization and a process. Although it must have accessible public locations, most contacts are likely to be by telephone and/or visits to consumers.

Resource Centers will play a key role in providing complete, accurate, timely and unbiased information and advice to people who are looking for information about a variety of aging and disability resources, including people who will purchase services privately. In the current system, people often purchase more than they really need because they do not have the information that would help them purchase more frugally. Providing planning services and timely advice about options will help people to remain as independent as possible, and to conserve their private resources, preventing or delaying the need to rely on government funds.

Resource Centers must have strong and effective prevention programs that will help to reduce the number of people who have disabling conditions. Outreach and early intervention programs must help people with mild disabilities to retain or improve functioning where possible, to delay or prevent the need to access comprehensive LTC services.

One-stop shopping

Aging and Disability Centers will have the same name throughout the state, and public education about them will be enhanced through statewide educational campaigns. They may be organized separately (an Aging Resource Center and a Disability Resource Center) or together (as one Aging and Disability Resource Center).

Resource Centers will serve as clearinghouses of information not just for elderly people and people with disabilities and their families, but also for the general public and for a variety of referral sources such as physicians, hospitals, managers of specialized housing and others. Centers will also, as much as possible, provide access to a variety of other benefits that may be sought by elderly people and people with disabilities, including Medicaid, Food Stamps and SSI-E.

Resource Centers will also determine functional eligibility and cost-sharing levels for clients seeking access to the Family Care benefit. Statewide, uniform tools and criteria will be used in making these determinations. A person who is found functionally eligible for LTC will receive thorough and unbiased information about the requirements for accessing services and about the choices available about whether to enroll in a **Care Management Organization (CMO)**, and the choices among CMOs that would be appropriate to meet the person's needs (see section on care management). A monthly payment level for the Family Care benefit will be assigned for the client based on the level of functional disability found through a **functional screen**.

Access to LTC services

Everyone who has a disability or condition requiring long term care that is expected to last at least 90 days is eligible to participate in the new long term care system, and will be offered a functional screen by the Resource Center. An individual must have a completed functional screen either to enroll in a CMO for Family Care, or to enter a nursing home or other LTC residential facility for a stay expected to last at least 90 days.

Wisconsin is currently among the few states that do not have pre-admission screening to assure that all new long term admissions to nursing homes and ICFs-MR meet a certain threshold of functional disability. In the redesigned system, the functional screen will serve as this pre-admission screening for LTC admission to all licensed and certified residential facilities, including: nursing homes, intermediate care facilities for the mentally retarded (ICFs-MR), adult family homes, residential care apartment complexes and community-based residential facilities, except CBRFs that exclusively serve people with alcohol or other drug abuse concerns, or corrections clients. Licensed or certified residential LTC facilities, as defined here, will be responsible for assuring that every long term admission, irrespective of the person's payment source (public or private), receives required pre-admission screening. Those residential care apartment complexes that are registered, but not certified, will be required to offer information about the services available at Resource Centers to people seeking admission.

Before discharge from a hospital, as well as during the admissions process associated with the licensed or certified residential facility, all individuals will be provided information about the services of the Resource Center and the new Family Care benefit. This information will explain how to access Resource Centers for further information and assistance, or to request an eligibility determination for Family Care. Individuals and their families, or other representatives (e.g., friend, guardian) will be able to request the functional screen, or general information and assistance, at any point in time and will be encouraged to do so. Resource Center staff will work with hospital discharge planners and residential facility staff to encourage early referrals whenever possible.

Anyone seeking admission to a licensed or certified residential facility from the community, with the exception of emergency or respite-related admissions, must be referred to the Resource Center. There, based on available information, the decision will be made whether a functional screen is required.

With regard to licensed nursing facility admissions from a hospital, the nursing facility will be required to provide information to the Resource Center, within a specified time period after admission (e.g., 14 days), sufficient to allow the Resource Center to determine whether a functional screen is necessary. A functional screen will be done if, based on the information available, it appears the person could reasonably be expected to stay in the nursing facility for 90 days or longer. The Resource Center determination of whether a functional screen is necessary must be timely, so as to allow a required functional screen to be completed within a specified time period (e.g., 7 days) following receipt of the information from the nursing facility.

Licensed or certified facilities will be held accountable for assuring that residents who are required to have the screen have been referred to the Resource Center within a specified time frame after admission.

Private pay clients accessing non-residential LTC services will not be required to have a functional screen. However, home health and personal care agencies will be required to inform these clients, as appropriate, of the availability of the screen and of information and counseling services at the Aging and Disability Resource Centers.

People who are seeking long term admission to a residential facility and who are financially eligible for the public subsidy for LTC, or who are likely to become eligible within 12 months, will be required to participate in a personal **assessment and service/care plan** provided by CMO staff. The assessment and service/care plan will be provided free of charge to such individuals. People who are unlikely to need public subsidy within a year will be offered the assessment and service/care plan; cost-sharing requirements may apply.

A person who is not currently eligible for any public subsidy of care costs cannot be obliged to follow the service/care plan developed by the care manager. For example, a person may choose to pay privately for services in a particular residential setting even though a service/care plan might indicate that in-home services or a less expensive residential facility would meet his or her needs. However, in the event that a person who is required to have an assessment and service/care plan refuses to participate or does not accept the offered service/care plan and later becomes eligible for public subsidy, a CMO will not necessarily be obligated to continue the person's original choices. For example, the CMO may not be obliged to provide more costly services than those in the original plan unless a change in the person's condition or support system warrants more costly care. Depending on the type of provider, the CMO also may not be obliged to fund care through a provider not in the CMO's network. (See sections on consumer choices among providers and care management.)

There will be no means test or fees for information and referral or for access services (such as the functional screen) through the Resource Centers. Other services that may be offered at the Resource Centers may be subject to cost sharing on a sliding fee basis.

Overview of Resource Center functions

Resource Centers will be responsible for the following functions, to provide convenient, one-stop shopping for customers:

- Provide information and referral/assistance services at hours that are convenient for the public.
- Provide outreach and public education.
- Provide 24-hour emergency screening and response.
- Provide prevention and early intervention services.
- Inform individuals seeking LTC services of their rights, including their right to designate someone to make decisions on their behalf (e.g., durable power of attorney, living will).
- Provide benefits counseling and financial planning services.
- Work with the families of young people who are approaching adulthood and with the children's service system to assure smooth transitions to the adult LTC system, including vocational services.
- Counsel clients on LTC services, personal goals and outcomes
- Determine functional eligibility for the Family Care benefit, using a uniform functional screening tool.
- Conduct Pre-admission Screening and Resident Review (PASARR) processes as required. *
- Assist LTC clients to determine whether to enroll in a CMO and if so, which available CMO would best fit their needs. *
- Assist people choosing this option to enroll in a CMO for the Family Care benefit. *
- Have a formal role in the mediation/arbitration of consumer disputes with CMOs that have not been resolved through the CMO's internal complaint resolution process. *
- Collect data from the LTC functional screen needed to assign an individual to a payment level for services.
- Determine maximum client cost-sharing amount.
- Collect client data and provide it to the state through an information system that meets state-specified standards.
- Manage any necessary waiting lists for Family Care for people who are eligible at the intermediate level and neither Medicaid-eligible nor confirmed as having a need for adult protective services.

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* **Note**: it is possible that federal Medicaid regulations will require starred functions to be done independently if the county is both the Resource Center and a CMO and/or operates a nursing home.

- Provide assessment of risk for each person who is on a waiting list for Family Care; develop, with the person, an interim plan of care and assist the person to arrange for services.
- Assure the provision of any needed emergency services until a client can receive them from a CMO.
- Assist in the identification of service gaps and in the development of local services and resources for the target group(s) served, including LTC services.
- If a public agency, provide adult protective services and elder abuse services, including abuse/neglect investigations, guardianship services, Watts reviews, and representative payee services. (If not a public agency, these services would remain the responsibility of the county, but could be co-located in the Resource Center.)
- Have a role in local quality assurance and improvement of LTC services, which is coordinated with the CMOs' quality assurance/improvement system and with the state's oversight and regulatory role.
- Certify eligibility for SSI-E, Medicaid and food stamps (if a public agency).

In addition, the centers will be encouraged to co-locate, when appropriate, the following functions that are already performed by counties and the aging network:

- Provide broadly used services (e.g., nutrition, recreation, volunteer programs).
- Administer housing assistance, energy assistance and/or other programs (if a public agency or under subcontract to a public agency for these functions).

It is recommended that Resource Centers enter into memoranda of agreement with AIDS Service Organizations (ASOs) to provide prevention, early intervention, outreach and similar services. Resource Centers should also consult with ASOs in completing functional screens for people with HIV/AIDS, to ensure that Resource Centers have the most up-to-date information about individuals who have already contacted the ASOs.

Requirements for Resource Centers

To secure a contract to operate an Aging/Disability Resource Center, an organization must demonstrate at least the following:

- Expertise in the needs of each target population the organization proposes to serve, and thorough knowledge of the providers that serve them.
- Strong linkages with service providers, volunteer agencies and community institutions.
- Expertise in information and referral activities.
- Thorough knowledge of local LTC resources, including those designed to provide services in the least restrictive setting possible.
- Financial solvency and stability.

- Ability to collect, monitor and analyze data in a timely and accurate manner, in systems that meet state standards.
- A governing board that meets established criteria (see Appendix 5).
- A commitment to adequate staffing by qualified personnel to effectively perform all functions.
- The ability to meet all performance standards established by the Department.
- Full accessibility of services for people with mobility or sensory limitations, under the requirements of the Americans with Disabilities Act, including the availability of sign language interpreters and written materials in alternative formats such as Braille and audiotapes.
- Accessibility to people of all racial, ethnic, and economic backgrounds and cultural competence, including the availability of bilingual staff and/or translators where needed.
- If operated by an organization that includes other functions, a separate telephone number that assures direct access to the Resource Center, and that is advertised separately.
- If not a county agency, links with eligibility determination staff, who must be public employees for some programs.
- If not a county agency, links with emergency response systems and court-related adult protective services and elder/vulnerable adult abuse and neglect investigations and reporting.
- Conformance with federal requirements that will enable the system to maximize federal funding.

Organizational requirements for Resource Centers

Counties and tribal governments are the first choice to serve in this capacity. They have long-standing experience in performing many of the functions envisioned for the Aging and Disability Resource Centers. In addition, if these Centers are public agencies, access to many more services and benefits can be integrated. County and tribal agencies, including county/tribal-sponsored quasi-public organizations, multi-county or county-tribal consortia, will have right of first selection to operate Resource Centers for their areas. Successful applicants must meet or exceed all contract standards. If a county or tribe chooses to operate both a Resource Center and a Care Management Organization, the requirements outlined under the section of this proposal titled "County and Tribal Roles" will apply. In areas where no county/tribal-based organization applies or none meets organizational and contract standards, competition will be opened to **private, not-for-profit** organizations.

There is considerable overlap between the functions currently performed by many Aging Units and those envisioned for the Resource Center. Where Aging Units are not the Aging

Resource Center, linkages and memoranda of agreement should be established to clarify roles and responsibilities of these two organizations.

Whether or not an Aging Unit operates the Resource Center, Older Americans Act and related programs for older people should continue to be governed in accordance with current relevant state and federal law. The Department's intent is to assure that older people will continue to govern the programs and services they use.

The Department will contract directly with Resource Centers, whether or not they are county agencies. To promote continuity for consumers and the public, and to reduce unnecessary expenditures for infrastructure costs, initial contracts will be for one year, with options for two annual renewals. Contractors that continue to meet or exceed standards will have rights of renewal. Contracts will spell out the conditions under which the state could terminate or refuse to renew contracts.

To assure that all areas of the state are covered, boundaries for Resource Center service areas will generally follow county lines, although exceptions may be made to accommodate tribal participation or municipalities that cross county lines. Multi-county areas may be developed in rural parts of the state.

Providing More Choices for More People

Guiding Principles

Choice has intrinsic value—something people esteem for its own sake. Being able to make choices about one's life is part of being human. Respect for consumer choice is one of the cornerstones underlying the success of Wisconsin's nationally acclaimed Community Options Program. One of the most significant concerns consumers have about the redesign of the long term care system is that they might have fewer available choices of where they live, the services they receive and who provides them. Recognizing these concerns, the Department has incorporated respect for consumer choices as one of the underlying guiding principles to which it will adhere in redesigning long term care. (See Appendix 1.)

Seventeen years' experience in the Community Options Program (COP) has taught us that consumers generally make very responsible choices. Individuals may at times make choices that are more costly or involve more risk, but when averaged across all consumers there is no direct correlation between an increase in consumer choice and increased costs or increased safety concerns. Consumers will have access to care managers for assistance in identifying options to reduce cost and risk.

More Choices for More People

In the redesigned system more people will know what options are open to them. Everyone who needs long term care will have access to the Resource Center, which will provide good information and advice in a timely manner about the alternatives available to them.

More people will be assured of receiving services. The institutional bias in the current system will be eliminated – people will not be forced to choose between a nursing home and a waiting list for community services. All people who meet the nursing home/COP level of care (i.e., the comprehensive support level) will be assured of services. Regardless of where they choose to live, they will not have to wait.

Many people who do not meet the nursing home/COP level of care, but who do have long term care needs, will also be assured of immediate access to Family Care. These are people at the intermediate support level who are Medicaid eligible, or who need adult protective services (APS). No one in this group will be placed on a waiting list.

Some people who have long term care needs, but who do not meet the nursing home/COP level of care, will be eligible for services, but not necessarily assured of receiving them immediately. These are less disabled people at the intermediate support level who are neither Medicaid eligible nor in need of adult protective services. If waiting lists are necessary, the Department will establish procedures to prioritize services to these individuals based on functional capacity, financial status and potential risk factors that may lead to further deterioration.

People who choose to enroll in Family Care will have more responsibility to collaborate in

designing a cost effective service package, but will also have more flexible benefits, options and choices available to tailor the service package to their individual needs and preferences. The intended result is that people will get exactly what they need, when they need it, and people will not have to settle for selecting services from a limited "menu." With larger and more diverse caseloads, CMOs will have both the need and the additional capacity to develop more varied types of services and providers.

Enabling People to Make Informed Choices

For people to make informed choices, they must have information about the available range of living arrangements, types of services, ways of delivering services, and the likely benefits, disadvantages and risks to each option. Prior to a decision about whether to enroll in Family Care, the Resource Center will provide consumers with general information about the range of available services and resources, and any limitations or restrictions, in both the CMO and the fee-for-service system and how each system works. They will also counsel consumers regarding the relative level of quality and consumer satisfaction with the fee-for-service system and any available CMOs as well as the major service providers in each. Consumers will also receive information about their rights and responsibilities, about the complaint, grievance and appeal system, and about independent advocacy assistance available.

Care Management Organizations will provide more specific information about service options pertinent to the individual consumer's particular situation, specific service providers available, and the consumer's rights related to assessment, care planning, care management and service delivery. The CMO will also provide information about the complaint, grievance and appeal system and independent advocacy services available to consumers.

Choice of Whether to Enroll in a Care Management Organization

People are free to choose whether or not to enroll in Family Care. People may enroll in any CMO available to them, and may switch CMOs with 90 days notice. Those who are Medicaid eligible will have the option of obtaining their services through the state-administered Medicaid fee-for-service program, which will continue to offer the current range of benefits, including nursing home, home health, personal care, and other card services. The new, flexible Family Care benefit, which will be available only through a CMO, will include some services not available under the Medicaid card, such as Community Options/Integration, assisted living, supported living and supported employment benefits. If the new system proves to be effective at meeting the needs and preferences of consumers, the Department will consider transition to a system in which all eligible people receive LTC services through Family Care. It is not yet clear under what conditions the federal government will allow this approach. Prior to any such decision, the Department will engage in a broad-based public participation process and seek endorsement from the Governor, the Legislature, and the federal government.

Making Care Plan Choices

When the consumer enrolls in Family Care, a multidisciplinary team at the CMO conducts a comprehensive assessment together with the consumer and people who know the consumer. The assessment must discover the consumer's values and preferences, and these must be addressed when developing the service/care plan. For people with cognitive disabilities, special attention will be given to assuring that family members, friends and others who know the individual and can help convey the person's preferences are included in the service planing process.

The consumer and the assessment team / care manager are partners working together to reach care planning decisions. Cost-effectiveness will be a consideration in developing service options, but care planning will not be entirely cost driven. Rather, care planning decisions will be based on the extent to which a service/care plan option will achieve the following desirable outcomes:

- Effectively meets an identified need.
- Is consistent with consumer values and preferences.
- Maintains the consumer's preferred lifestyle and living situation and promotes the consumer's life goals and choices consistent with the purpose of the long term care system.
- Fosters individuality, autonomy, self-determination, and personal economic independence.
- Maintains the health and safety of the consumer and others.
- Protects the rights of the consumer.
- Promotes community participation and social growth including support for family and social relationships and appropriate employment.
- Is cost-efficient with respect to the added long range benefit to the consumer of the other desirable accomplishments above.

Each CMO will have an ethics committee, which includes consumer representatives, to discuss and advise on issues related to the sometimes competing values of consumer safety, risk and independence.

Choice among Living Arrangements

The primary consideration about where a person lives will be his/her own preference. No one will be required to live in a nursing home as his or her long term residence. No one living in a nursing home or other residential care facility will be required to move.

The role of nursing homes has changed considerably over the past decade, and that trend is expected to accelerate under the redesigned system. Increasingly, nursing homes are not places for people to live over a long period of time; instead, they provide sub-acute care, convalescence and rehabilitation services, end-of-life, and other short-term or episodic care.

Everyone will have the opportunity to live in the setting that he or she chooses unless there are essential health or long term support needs that cannot reasonably be met in such a setting or the preferred setting includes a package of services that exceeds the person's identified needs. When some form of congregate housing must be used, the care manager will consider and support the person's choice and independence to the greatest extent possible, given the person's individual circumstances and preferences. Individual values and preferences, quality, cost, and the ability to meet the individual's needs will all be considerations in development of a service/care plan, including living arrangement. For people whose cost of care is very expensive, shared community living arrangements will be a likely alternative to nursing home care. Alternatives must be developed and offered to people who choose not to live in a nursing home, but those alternatives do not necessarily have to be more expensive than the cost of the nursing home. Care plans must document the efforts that were undertaken to find or develop cost-effective alternatives that responded to consumers' preferences.

When a person is admitted to a nursing home or other residential care facility for intensive rehabilitation, respite or emergency care, the care manager must document a plan to return the person to her/his home within 90 days. If at the end of 90 days the person continues to need rehabilitative care in a nursing home or other residential care facility or his/her care giver continues to require respite, the care manager must either determine that the person meets the criteria for long term residence, and document it accordingly, or create a new plan for return to a private home in the next 90 days.

Choice to Be Employed

Wisconsin has a strong work ethic and believes that, to the extent possible, all citizens of working age should be contributing to the wealth and well-being of its citizenship. In support of that belief, employment and/or artistic endeavors which produce income will be important outcomes for every working-age person within the LTC system. Regardless of severity of disability, people of working-age can work. People may need assistance with developing skills on the job, adaptive equipment to modify the environment, flexible work schedules, therapies, and other supports to meet their needs. Work, if desired, must be an area addressed in an individual's care/service plan. In return, the system will expect people of working age to generate earnings and to contribute from their earnings towards their own support and the cost of their services.

In addition to inclusion of work-related services in the Family Care benefit, this proposal includes significant changes to financial eligibility and cost-sharing requirements that would create incentives for individuals of working age to be employed. (For details, see Appendix 3.) The Department is also collaborating with the Department of Workforce Development to develop and obtain federal waivers for a new initiative called Pathways to Independence that would provide intensive services to individuals with disabilities and allow them to retain health and LTC coverage and cash benefits when they earn income. (See page 4 for additional information.)

Choice of Provider

One of the principal concerns consumers have expressed about a care managed system is the fear that they will lose the ability to choose among providers. They want the redesigned long term care system to allow as much choice of providers as possible. Consumers have also told us that being able to choose a provider is especially important when the service is more personal (e.g., when a provider is attending to intimate personal needs, or comes frequently into the consumer's home).

The redesigned long term care system will include a multi-faceted approach of consumer rights and CMO standards and requirements to ensure consumer choice of providers.

General requirements

The CMO will develop a network of service providers under contract with (or employed by) the CMO. For all types of services (see benefits), the CMO must have a sufficient number of accessible in-network providers to ensure that consumers can choose, without waiting, from among a broad array of providers with characteristics that consumers as a group find convenient and desirable. CMOs may have preferred providers to whom they will routinely refer consumers who express no provider preference. Each CMO must develop, in consultation with the local LTC Council, a provider network that provides adequate choice of providers to its members. A CMO applicant must demonstrate to the satisfaction of the Department that it meets the following certification requirements in regard to provider networks. Standards for meeting these requirements will be defined by the state.

- The adequate availability of providers with the expertise and ability to provide services that are responsive to the disabilities or conditions of all the CMO's members. (For example, an organization serving the elderly target group would need providers with expertise to manage care and services for elders who have suffered strokes, Parkinson's, dementia, or chronic obstructive pulmonary disease. An organization serving people with developmental disabilities would need providers with expertise in a range of disabilities including autism, brain injury, and mental retardation. An organization serving people who use ventilators would need providers proficient in extended care nursing and respiratory therapy. An organization whose membership includes people with sensory impairments would need providers with specialized skills and the ability to communicate information in alternate formats such as Braille or American Sign Language.)
- Providers with programmatic philosophies that fit the variety of preferences and needs of their members, e.g., medical/social orientation, emphasis on rehabilitation, independence, assistance or support, degree of consumer control and individualization/congregate services and individualized services/support to participate in mainstream community activities.
- Providers with cultural orientations that reflect those of their members, e.g., targeted to Native Americans, deaf people, Spanish-speaking people or other non-English-speaking people.

- Providers who can meet the preferences and needs of their members for services at various times, including evenings and weekends and, when applicable, on a 24-hour basis.
- Providers who are able and willing to perform all the tasks identified in consumers' service/care plans that are within their scope of expertise.
- Residential and day services that are geographically accessible to consumers' homes, family and friends.
- Supported living arrangements of the types and sizes that meet their members' preferences and needs.

The CMO must develop its plan for how its provider network will meet the needs of its members and provide adequate choices to them, in consultation with the local LTC Council, whose membership is at least 51 percent consumers. In addition, the state will evaluate the adequacy of the CMO provider network as part of its approval of the CMO's certification application and through ongoing contract monitoring. Standards will be evaluated in the context of the size of the CMO's service area, the size of its target population, the availability of provider resources, the feasibility of developing new providers, and input from consumers. Performance indicators related to network adequacy will be used by the state to require focused quality assurance and improvement efforts within the CMO, and will be used by Resource Centers in providing enrollment advice to consumers.

Choice of critical personal service providers and care manager

Being able to choose the specific provider is crucial when that provider is attending to intimate personal needs or comes frequently into the consumer's home. Examples include personal care worker, attendant, home health aide, and private duty nurse. For these kinds of services, at the request of a consumer, a CMO must purchase services from any qualified provider who will accept the unit cost and other provisions of the CMO's standard contract. This includes a consumer option to select an individual, consumer-directed attendant, rather than an agency-provided service. All consumers must be informed of this option. The CMO's rates for consumer-directed attendants must be sufficient to allow quality services.

A CMO must assign an alternate ongoing care manager at the consumer's request (limited to two changes in a year).

Choice of providers of other services

For all other types of services, the CMO is required to bring additional providers into its network in a timely manner when necessary to meet individual needs that cannot be met by a provider already in the network. If the CMO's members or the local LTC Council request that a provider be added to the preferred network, the CMO will be required to make reasonable efforts to include the provider in its network. A consumer who is unable to secure an appropriate provider within a time frame that meets the consumer's needs will have the right

to use all grievance and appeal mechanisms, including a direct appeal to the state administrative hearing process.

Family members as paid providers

A family member may be paid for providing care if all of the following apply:

- The CMO assessment team/care manager/consumer determine that the consumer requires paid personal care.
- The consumer prefers that a family member provide the care.
- The family member meets hiring requirements including assessment for Basic or Advanced Competency Personal Care Worker/Daily Living Assistant Standards and training and monitoring requirements.
- The family member will either:
    - Provide an amount of personal care that exceeds normal family care giving responsibilities for a person in a similar family relationship who is not chronically ill or disabled, or
    - Find it necessary to forego paid employment in order to provide the requisite care, and is not receiving a pension (including Social Security retirement benefits).

The CMO is responsible to ensure that a family caregiver is trained and meets competency standards. The CMO assessment team / care manager specifies in the consumer's service/care plan the tasks the family caregiver will perform, the number of hours initially authorized and the process by which changes may be made to those hours, based on the consumer's need. The CMO will use onsite observation and consumer feedback to determine whether the family member should continue to be paid for providing personal care.

Consumer-directed support option

A self-directed care option must be made available by each CMO to any consumer who is:

- Able and willing to choose and manage his or her own services and supports, or
- Has support in decision-making from at least one family member or other unpaid person who is committed to the consumer and knowledgeable about the consumer's needs and preferences.

In a consumer-directed support model, the consumer, with the help of another individual if necessary, develops and implements a person-centered plan. The individual is provided with a set budget, from which needed paid supports can be purchased. The person is not limited to those providers in a CMO's network, but may purchase through the CMO to take advantage of volume purchasing discounts. The Department will establish a work group to assist in the further development of self-directed support models. (See Appendix 4 "Draft Elements of Consumer-Directed Support" for more detail about current development of this model.)

The Department will establish standards for how CMOs structure self-directed care options, how the self-directed care budget is set, the support services CMOs must make available to people who select this option, and for monitoring the situation of people who select this option.

Choice for People with Cognitive Impairments

CMOs will offer people with cognitive impairments the same range of choices and options as other consumers. When an individual's decision-making capacity is impaired, the care manager will actively seek out information from the consumer, family, friends and current support providers, the person's life history, and the person's responses to different places, opportunities and experiences. For people whose life experience and/or familiarity with support options are limited, the system and case manager will make a conscious effort to help the person learn about a full range of choices, including opportunities to see and experience options where necessary to gain a fuller understanding.

Individual planning will address the need for support in decision-making with goals of maximizing personal autonomy and control over choices, with support as needed, and providing substitute decision-making where necessary to prevent abuse, neglect or exploitation arising from the person's cognitive impairments. Guardianship and other protective services will be tailored to complement the individual's needs and abilities, as are other forms of support. The system will seek transfer only of those decision-making powers which the person cannot be supported to exercise safely, and the system will seek adjustment of guardianships as the person's needs and abilities change. The person's expressed preferences will always be sought and considered with respect, even in areas where a substitute decision-maker has been appointed.

The redesigned long-term care system will provide for agencies independent of the resource center and CMO that will recruit people with the interest and ability to act as guardians, match guardians to people needing decision-making support, and provide training and ongoing support to people who act as guardians.

Looking Out for Consumers

In a system that serves vulnerable citizens, some of whom may be somewhat isolated or limited in their means of communications, a variety of approaches to looking out for their interests is necessary. Several different kinds of mechanisms are necessary to react to and protect consumers from failures in the system. Approaches to empowering consumers and promoting their interests are needed to resolve individual problems with the long term care system, to improve the effectiveness of long-term care, and to encourage consumer self-determination. All of the following mechanisms must work together and will be supported in the redesigned long-term care system:

- **Quality Improvement:** Continuous planning, evaluation, correction or innovation by the organizations responsible for management and delivery of services to meet (and exceed) the expectations of customers.
- **Quality Assurance:** Systems of inspection, monitoring and measuring performance conducted by an external (regulatory) agency to promote healthy and safe environments, good practices in the delivery of services, and to enforce minimum performance standards.
- **Consumer Protection:** Shield consumers from practices, personnel, environments or policies which damage or threaten their well-being, by responding to complaints and grievances, conducting studies to discover problems, and taking direct action to remedy the problems. Provided through complaint and grievance mechanisms within each agency, state or local law enforcement or regulatory agencies, ombudsman, legal advocate or consumer peer support group.
- **Advocacy:** Represent consumers in adversarial or mediation proceedings to contest decisions within the system regarding such issues as eligibility, choice of providers, allocation of resources, and violation of rights. Represent and/or assist consumers in working for improvements in service systems or public policy.
- **Consumer participation in decision-making:** Inclusion of consumers in every aspect of policy and program development and implementation, including advisory and governing boards, committees for special purposes, and other development and governance processes at every level of the system.

A work group is currently meeting to assist the Department in designing a coordinated system of informed choice, consumer rights, fair and user-friendly due process protections, and access to consumer advocacy that is linked to quality assurance and improvement. The work group's membership includes consumers, advocates, county representatives and other providers.

Protection of rights

Requirements for informing clients about their rights and ensuring that those rights are protected will be built into the contracts with each Resource Center and Care Management Organization. All information about rights and responsibilities will be presented in a manner that is both accessible and culturally sensitive .

Current state and federal rights related to specific funding sources (e.g., Medicaid) and settings (e.g., statutes governing the rights of residents of certain facilities) will remain in place. In addition, a new statutory provision specific to the rights of clients in the new LTC system will be included in the Department's proposed LTC redesign legislation, that:

- Is based on the values expressed in the LTC Redesign guiding principles (see Appendix 1).
- Incorporates all existing rights to which consumers are currently entitled by statute or rule.

- Universally protects all long term care consumers and potential consumers in all settings.
- Is a simple, user-friendly, living document that can be used by consumers and potential consumers throughout their experience with the long term care system.
- Includes a statement that apprises consumers and potential consumers of their responsibilities in negotiating the long term care system.

Client responsibilities

Clients will have responsibilities as well as rights in the new system. Examples of such responsibilities include:

- To provide all information needed to develop a full assessment and individualized service/care plan;
- To provide accurate and complete information needed to determine eligibility and cost-sharing and to report any relevant changes in finances or household circumstances;
- To treat care givers with respect;
- To take advantage of opportunities to improve self sufficiency (e.g., through education and/or the use of assistive devices);
- To cooperate with services agreed to in the service/care plan;
- To pay any required cost share.

Complaint, grievance and appeal mechanisms

Complaint, grievance and appeal processes will be available for clients wishing to dispute such issues as eligibility and cost share determinations or certain care/service plan decisions. These processes will be multi-level, with specified issues being appealable to the state level. Requirements for timeliness will be specified. The process for resolving disputes with the Resource Center, CMO and contracted providers will include:

- An internal component that reaches top level management (consumers will be encouraged to resolve complaints at this level if possible).
- Other external mechanisms (e.g., through the Resource Center for CMO-related issues, or through the local LTC Council).
- A state administrative hearing review (consumers may access this process at any time).

Resource Centers and CMOs must have processes for informal and formal complaints, as well as formal grievances and appeals and their disposition. The state will establish standards to assure timely and equitable resolution of all complaints, grievances and appeals.

Advocacy mechanisms

Advocacy services will be available on several levels, and will all work together to: (1) represent consumers in adversarial or mediation proceedings contesting decisions within the system regarding such issues as eligibility, choice of providers, allocation of resources, violations of rights; and (2) represent or assist consumers to petition for improvements in service systems or public policy.

- First level advocacy is part of the job of employees of Resource Centers, CMOs and contracted providers.
- As part of its QA/QI system, each CMO will have a mechanism by which complaints, grievances, appeals and consumer advocacy concerns reach top level management.
- One or more independent entities with no conflict of interest will be designated and funded by the Department to provide advocacy services to consumers throughout the long term care system. The independent entity/entities will have the capacity to pursue all appropriate remedies. The Department will begin the process of developing the advocacy component of the new system with discussions with existing advocacy organizations, including Area Agencies on Aging, Independent Living Centers, Wisconsin Coalition for Advocacy, Board on Aging and Long Term Care, Coalition of Wisconsin Aging Groups, ARC-Wisconsin, and the Wisconsin Council on Developmental Disabilities. Piloting of independent advocacy will occur with the care management pilots, which will begin soon.

Quality assurance and improvement mechanisms

Consumer choice will be a prime focus of ***quality assurance and improvement efforts*** (see "An Improved Approach to Achieving High Quality"), including evaluation of:

- Effective informing of consumers of the options and choices available to them.
- The extent to which consumers are informed of their rights and responsibilities, including grievance and appeal rights.
- Effective support of consumer's advance directives, and to support substitute decision making at a level appropriate with each individual consumer's abilities.
- Effective support of individuals in the living arrangement of their choice.
- The adequacy of providers available within a CMO network.
- The extent to which a CMO purchases services from out of network providers selected by consumers, especially providers of critical personal services.
- The extent to which CMOs reimburse family members for providing services beyond what would "normally" be provided by a family.
- The extent to which CMOs offer consumers the option of self directed care and provide support (at a level the consumer chooses) for those who select this option.

- Respect for consumer values and preferences in making service/care plan decisions, as documented in service/care plans.

Participation in system planning

A fundamental principle of a successful service delivery system is "customer-mindedness." This principle calls for continuous commitment to understanding and eliciting the needs and expectations of people who can benefit from the services of an organization or system. The new LTC system will be designed to assure that consumers of LTC services have a strong role in the planning and management of the system at every level, including membership on policy councils and governing boards, in service planning and evaluation, and in quality assurance and improvement efforts. (See sections on Resource Centers, Care Management, Quality, County and Tribal Roles, and Appendix 5).

At the local level, elderly people, people with physical disabilities, and people with developmental disabilities or their family members or guardians will be a majority of the members of a LTC Council in each county—or at local option, in a multi-county region. The local LTC Council will be responsible for developing a plan for the structure of the local LTC system which must be considered by the County Board (and County Executive/Administrator, if applicable) in deciding whether and how to apply to become a Resource Center and/or CMO. The Council's recommendations will also be attached to applications for state certification of any CMO or Resource Center in the area. The Council will also have significant ongoing responsibilities for guidance of the system (see section on County and Tribal roles and Appendix 5). In addition, each Resource Center and each CMO must include in the membership of its governing board a minimum of 25 percent consumer representatives.

At the state level, a state LTC Council, also with a majority of consumer representatives, will be established to advise the Department on broad policy issues and provide a forum for review, at the request of counties, tribes, local LTC Councils, or applicant organizations, of Department decisions regarding how many CMOs should operate in a given geographic area and which organizations should receive CMO contracts from the Department.

At all levels, consumer representatives must be trained and supported to enable them to participate effectively in the deliberations of the Council or board, and reimbursed for reasonable expenses associated with participating. **(For more detail on the composition and roles of various councils and boards, see section on County and Tribal Roles, and Appendix 5.)**

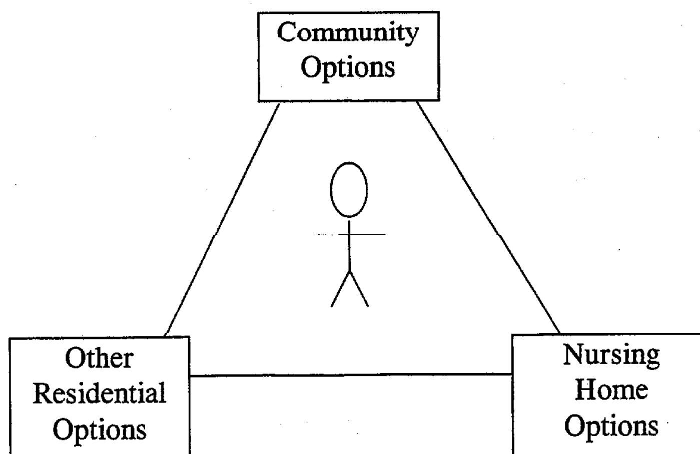
A LTC benefit with options

Wisconsin proposes to go beyond other states that coordinate various LTC services and funding streams under one umbrella agency. This is the model that is used in Oregon, for example, and that will be used in the beginning stages of the CMO demonstrations in Wisconsin. In the fully redesigned system, funds will be consolidated to create one flexible benefit, with one set of eligibility criteria, to provide individualized services not tied to current program restrictions.

Flexibility of LTC services

The service/care plan, which is developed in conjunction with the consumer, will fall into three basic categories of options for consumers to choose:

- **Community Options / Integration** Person lives at home (including a supported apartment) and the CMO provides in-home services (e.g., supportive home care) and community day services (e.g., adult day care or supported employment) from a wide array of community-based providers. Includes flexible services covered under current Community Options Program and Community Integration Programs, as well as home and community services now covered under Medicaid fee-for-service system.
- **Other Residential Options** Person lives in a residential care apartment complex, Community Based Residential Facility (CBRF), or Adult Family Home. The CMO purchases most core services from the residential facility, and some from other community-based providers, resulting in fewer choices for consumers among providers of some types. For example, the CBRF may specify the provider of nursing services that are included in its rates.
- **Nursing Home Options** Person lives in intermediate or skilled nursing facility, including ICF-MR, for the duration of need for specialized services. In this option, most or all services are included in the package of services offered by the facility and purchased by the CMO, resulting in more closely coordinated service to the resident but restricting access to outside providers of some services. Long term institutional services will be available only to those who have high levels of functional disability.



The service/care plan will also specify the services or supports appropriate to the living arrangement that are necessary to meet the needs identified in the comprehensive assessment. As in the Community Options Program, the focus will be on the least restrictive living environment for consumers, individual preferences and values, and natural supports being used before paid formal supports are added to the service/care plan.

The new Family Care benefit will not be limited to a specified list of services. Flexibility of the benefit is essential to achieving high quality outcomes for consumers and to promoting creative and cost-effective ways of meeting individuals' needs. For those who enroll, services will be accessed through an individualized service/care plan, and will not be subject to current state prior authorization or other utilization controls.

The following list of required services is intended to ensure uniformity in the minimum level and types of services available statewide. It does not limit what additional types of services may be offered to meet individual needs. **In addition to any other cost-effective services that will meet its members' needs**, each CMO must make available the following array of services:

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Select Alcohol and Other Drug Abuse Services (non-physician outpatient, clinic and office services)
- Assessment and Case Planning
- Case Management
- Communication Aids and Interpreter Services
- Community Support
- Counseling/Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Disposable Medical Supplies (in all settings except hospital inpatient)
- Durable Medical Equipment (in all settings except hospital inpatient)
- Employment Services (including prevocational services, supported employment, and other services that enable work)
- Home Health
- Home Modifications
- Hospice
- Select Mental Health Services (non-physician outpatient, clinic and office services)

- Nursing Facility Services
- Nursing Services
- Nutrition Services (including home delivered and congregate meals)
- Personal Care
- Personal Emergency Response System Services
- Private Duty Nursing
- Residential Services: Residential Care Apartment Complex (RCAC, also known as assisted living), Community Based Residential Facility (CBRF), Intermediate Care Facility for People with Mental Retardation (ICF-MR), and Adult Family Home
- Respite Care (for care givers and members in non-institutional and institutional settings)
- Services to Support/Maintain Community Connections
- Specialized Medical Supplies
- Support for Self-Directed Care
- Supported Apartment Services
- Supportive Home Care (including chore services)
- Therapy Services (including Outpatient Hospital Therapy Services): Enteral Therapy, Infusion Therapy Services, Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory Therapy
- Transportation: All non-Medicaid-covered, and Select Medicaid-covered (all Medicaid-covered Transportation Services except for Air and Ground Ambulance Services)

If a CMO wishes to offer the following services in its benefit package, it must develop its plan for how this will be accomplished in consultation with the local, consumer-dominated LTC Council, and obtain the approval of the state. The CMO's plan for inclusion of these services must address whether these services will be optional for its members (i.e., whether consumers can enroll for only the required services listed above). If the CMO does not offer these services, they will continue to be accessed by Medicaid-eligible consumers on a fee-for-service basis:

- Select Alcohol and Other Drug Abuse Services: Physician Services and Inpatient Services
- Audiology
- Chiropractic
- Dentistry
- Emergency Care (including air and ground ambulance)

- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospital: Inpatient and Outpatient (except for Outpatient Therapy)
- Lab & x-ray
- Optometry
- Pharmaceuticals (including over the counter drugs)
- Physician and Clinic Services
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- Select Mental Health Services: Physician Services and Inpatient Services

Consolidating funding streams

To pay for the new Family Care benefit for those who choose it, current public funding streams for institutional and home and community-based long term care services will be pooled[1]. Separate categories will be created in the state budget for funds supporting the new LTC system, including the new Family Care benefit and Resource Center functions. Funds proposed to be included in allocations to Resource Centers and in the monthly per member payment to CMOs include:

- Medicaid fee-for-service funds for long term care services.
- Medicaid home and community-based waiver programs (CIP-I, CIP-II, and COP-Waiver, CSLA and Brain Injury Waiver).
- Community Options Program funds.
- Portions of state and federal funding for the basic county allocation under Community Aids.
- Alzheimer's Family and Caregiver Support Program (categorical portion of Community Aids).

Some of these funding programs provide a mix of LTC and other kinds of services. Where this is the case, only that portion now funding LTC services for LTC consumers will be used

1 Federal regulations may require that some funds be accounted for separately. The Department intends that as much as possible this will be done at the state level in a manner that will maintain a seamless system for local agencies and consumers. It should also be noted that since the current fee-for-service system will remain as an option for consumers, Medicaid funds will be transferred to the new LTC benefit only as needed to support voluntary enrollees.

for the new benefit. Similarly, some of these programs currently serve more than one population group. Where that is the case, only that portion now funding populations covered by the proposed new system will be consolidated. A work group is currently working out the details of the appropriate amount of Community Aids to be included in the new LTC system, and will recommend equitable methods for reducing current allocations. The group includes representatives of each of the affected target groups and several county staff.

Some funding sources will not be integrated because of federal restrictions, but they will be closely coordinated with the Family Care benefit. These include Title-III Older Americans Act funding, Senior Companion and Community Services Programs and the Benefit Specialist Program funds. Other funding sources will not be integrated with Family Care, including AIDS service funds and Chronic Disease Aids funds, which are targeted to specific individuals who may not all meet the LTC eligibility criteria, and Independent Living Center funding, which is regional and used for a variety of functions.

The LTC system will be designed to assure the appropriate use of all other funding sources. This includes structuring the system so that Family Care is the payer of last resort, following Medicare, private insurance, and each person's cost-sharing when available.

The Department will pursue the feasibility of continuing the Intergovernmental Transfer Program (IGT) and the nursing facility bed tax as additional revenue sources for Family Care. It is still unclear whether the IGT and bed tax programs will be applicable in the new design, how facility deficits will be determined, and how federal funds will be distributed.

Counties currently are required to match Community Aids allocations and many counties provide significant overmatch. No local match will be required for the Family Care benefit under the new system. However, a county match will be required for funding for certain adult protective services functions (see section on county and tribal roles) and possibly for certain Resource Center functions. The percentage match requirement will be designed to capture a dollar amount equal to currently required match on Community Aids used for LTC and APS functions and services.

Benefit levels and functional eligibility

Eligibility for the Family Care benefit will be limited to those who meet functional eligibility criteria established by the Department. Two functional eligibility levels, comprehensive and intermediate, will be established. Each of the two functional eligibility levels has an associated benefit level. A client's functional capacity will determine which Family Care benefit level is available to him or her.

Public subsidy for long term *institutional* services is available *only* for people who meet eligibility criteria at the comprehensive level (i.e., only for people with high levels of disability). Institutional services include skilled nursing facilities and intermediate care facilities (including the State Centers for the Developmentally Disabled and other ICFs-MR). A flexible range of all other LTC services is available to people who meet *either* benefit level. The table below briefly describes the two benefit levels; *see Appendix 2 for detailed information about functional eligibility criteria.*

	Comprehensive level	Intermediate level
Functional eligibility	**People with long term irreversible conditions requiring ongoing assistance from another person to meet their needs; health and safety is in serious jeopardy if they do not receive services; may need a wide range of services. This category of functional eligibility is intended to be generally equivalent to current eligibility under Medicaid for nursing home or other institutional care or for the Medicaid waivers or the Community Options Program.**	People with long term or potentially long term conditions who are at risk of losing independence or are at risk of serious decline in functional capacity; need periodic assistance from another person to meet their needs; are likely to need only a small number/amount of services and may or may not need ongoing case management.
Services available	Flexible LTC benefit, including full range of institutional, residential, in-home and community-based LTC services.	Flexible LTC benefit, including full range of in-home and community-based residential and day services. Long term institutional care is not available for people at this level of functional ability.

Assuring services to those most in need

If there are sufficient resources, the new system will provide public subsidy for needed services to all Wisconsin citizens who have any level of need for LTC and who meet financial criteria for public subsidy. Until additional data are gathered and analyzed, it is not possible to determine whether this will be feasible. If it is not feasible to guarantee publicly-subsidized services to every one functionally and financially eligible, the following groups will be assured of flexible, Family Care services:

(1) Everyone functionally eligible for the new Family Care benefit at the *comprehensive* level (i.e., those with the most severe needs);

(2) Everyone who is functionally eligible for the Family Care benefit at the (less disabled) *intermediate* level and financially eligible for Medicaid; and

(3) Everyone who is functionally eligible for the *intermediate* support benefit and is confirmed to have an adult protective service (APS) need, including confirmed victims of elder abuse.

Of those who are eligible for the Family Care benefit, but not assured of public subsidy (i.e., people at the intermediate level of need who are not Medicaid-eligible and who have no confirmed APS need), as many people as possible will be served. The functional screen

provided at the Resource Center will determine whether people have comprehensive or intermediate long term care needs. People who have comprehensive needs, and people who have intermediate needs and are Medicaid-eligible and/or have a confirmed need for adult protective services, are assured prompt access to the new benefit. The Resource Center will provide information on the available care management organizations and the fee-for-service option. The consumer will choose whether to enroll in a CMO. If a Medicaid-eligible person chooses the fee-for-service option, he or she will be referred to appropriate service providers. If the consumer chooses the Family Care benefit, the relative merits of available CMOs will be discussed and a referral made to the CMO the consumer selects.

People at the intermediate level who are not Medicaid-eligible and do not need adult protective services are eligible for services, but may be placed on a waiting list if funding is not immediately available. (These are people who would not qualify for nursing home admission, the Community Options Program or the Community Integration Program in the current system.) Information about the number of people on waiting lists and the level of their needs must be reported periodically to the local and state LTC Councils.

Resource Centers will provide people in this group with an assessment of risk that goes beyond that provided through the functional screen. Further, the Resource Center will develop an interim plan of care consisting of informal supports, local community resources and other services the person may be able to purchase. Each Resource Center will receive non-Medicaid funds to assist with the development and support of informal and voluntary services for eligible people waiting for access to Family Care. When Family Care funding becomes available, such people will be removed from the waiting list according to uniform criteria (i.e., functional capacity, risk factors and financial status) and referred to a CMO for services. Criteria are currently being developed by a workgroup that includes county staff.

If multiple individuals have similar functional status, risk factors and financial status, the initial date of application for the Family Care benefit will be used to determine who should receive access to publicly subsidized services.

Once enrolled in a CMO for services, no one will be involuntarily disenrolled unless they no longer met eligibility criteria, or under very limited circumstances to be defined by the state and conditioned on prior state approval. People who lose financial eligibility for the public subsidy would remain enrolled if they choose, but their cost share would increase to 100 percent.

Medicaid-eligible people are entitled to all Wisconsin Medicaid benefits; those with LTC needs will be assured of the Family Care benefit regardless of which level of support (intermediate or comprehensive) they need. All Medicaid services continue to be an entitlement for all Medicaid recipients, regardless of whether they have any level of functional disability. However, the determinant of need for long term institutional care will be that the person meets functional eligibility criteria at the comprehensive support level.

Level of functional capacity	Medicaid eligible	Not Medicaid eligible
Meet functional eligibility criteria at the **comprehensive level**	Everyone meeting functional eligibility criteria at this level is assured of services included in this benefit level as determined necessary by an individualized assessment and service/care plan.	
Meet functional eligibility criteria at the **intermediate level** (but not at comprehensive)	Medicaid-eligible individuals meeting functional eligibility criteria for this level are assured of those services included in this benefit level (i.e., all except institutional LTC) as determined necessary by an individualized assessment and service/care plan.	Non-Medicaid-eligible individuals who meet functional eligibility criteria for this level and who have confirmed adult protective services needs are assured of the services included in this benefit level (i.e., all except institutional LTC) as determined necessary by an individualized assessment and service/care plan. Other non-Medicaid-eligible individuals meeting this functional eligibility threshold will receive services in this benefit package within the level of funding available, according to a priority system based on urgency of need for services. Within this range of functional ability levels, a ranking system will be established based on functional disability, level of risk and financial status. Available funding will determine how many levels can be funded for new clients.
Do not meet functional eligibility test at either level	Not eligible for Family Care. Medicaid-eligible individuals continue to be entitled to all Wisconsin Medicaid benefits under the state plan except long term institutional LTC services.	

Note: Being "assured of services" does not necessarily imply being assured of public subsidy. Individuals will be required to contribute to the cost of their services to the extent of their ability to pay. See below for discussion of financial eligibility and cost-sharing requirements.

Financial eligibility and cost-sharing

The new LTC system will be designed so that there will be no "cliff" of in/out financial eligibility for public subsidy. There will be no specific, separate income or asset thresholds. Instead, cost sharing will be determined based on the combined factors of income and assets. This approach, similar to the one now used in the Community Options Program, provides the most complete and realistic assessment of a person's financial resources and ability to contribute to LTC costs.

Any individual who meets the functional eligibility test for needing LTC is "eligible" for Family Care. However, all clients will be required to share in the cost of their services to the extent of their ability to pay. Cost share requirements will range from none (for those least able to contribute) to the full cost of the service/care plan for those with more personal resources. No client cost share will be required for people whose resource levels would entitle them to SSI cash payments. People eligible for SSI cash payments will not have to undergo a separate financial test for LTC public subsidy. Cost sharing requirements will be designed to substantially reduce the disincentives to work that exist in some current programs. Spousal impoverishment protections will be maintained in Family Care. Divestment and estate recovery provisions will apply.

In calculating client cost sharing, the following exemptions and deductions will be applied.

Asset exemptions and deductions:

The client's home, household goods and personal possessions, a car, income-producing business property in current use, spousal impoverishment protections and, for clients currently employed, a savings or checking account composed of work earnings. A general asset exemption will replace current categorical exemptions for life insurance, prepaid burial expenses and/or burial trust fund; this general asset exemption could be used for any purpose at death and will not be subject to estate recovery.

Income exemptions and deductions:

A living allowance for the client and any dependents, most earnings from current employment, out-of-pocket medical and remedial expenses, court-ordered payments and cost-share or benefit reduction requirements for other programs.

After all exemptions and deductions, all remaining financial resources will be required to be used as the client's cost-share, up to the cost of the individual's service/care plan for LTC services. Specific dollar amounts used in calculating cost sharing will be indexed for inflation.

For further detail about financial eligibility and cost sharing, please see Appendix 3.

Care management

The Family Care benefit will be accessed through and managed by a **care management organization** (CMO). The CMO will, in partnership with the consumer, design and manage services and supports tailored to the individual needs and preferences of its consumers in the most cost-effective manner.

After a person has been found functionally eligible by the Resource Center, staff there will help each person make an informed choice about future care, provide counseling about available choices among CMOs with the appropriate expertise to meet the person's needs and help the person to enroll in the CMO of his or her choice.

Participating CMOs must accept **all** appropriate referrals from the Resource Centers and may not disenroll members except under very narrowly defined and unusual circumstances. Any CMO's request to refuse to accept or to disenroll a person will be subject to state review and approval.

Qualified case managers at the CMO and other professionals as needed, who must have appropriate expertise to assess the individual's needs, will conduct a **full assessment** with the person and/or family or guardian, which must include a face-to-face interview. To assure that all required areas of inquiry are included in the assessment, it will be conducted using a statewide, uniform tool. The assessment will contain all of the following elements:

- Physical health (including medical, restorative or (re)habilitative care).
- Nutritional status and requirements.
- Physical activities of daily living.
- Instrumental activities of daily living (e.g., laundry, cooking, cleaning).
- Communication.
- Emotional functioning.
- Mental health/cognitive functioning.
- Substance abuse risk.
- Social participation and functioning, including consideration of age and culturally appropriate behaviors.
- Educational/vocational activities.
- Informal support systems.
- Physical environment.
- Economic resources/benefits counseling needs.
- Capacity for self-care, including the use of adaptive equipment or training.
- Personal history, values and preferences (using, for example, such tools as "Personal Futures Planning" for people with developmental or physical disabilities, "Life Reviews" for elderly and terminally ill individuals).

- The extent to which potential community resources would facilitate the following:
    - Personal safety.
    - Optimization and maintenance of health.
    - Individuality, autonomy and self-determination.
    - Protection of rights.
    - Personal continuity, continuous growth and learning.
    - Maximum desired community participation and social growth, including work.
    - Viability of least restrictive setting.

The case manager and the consumer with his/her family, or other supports as appropriate, will jointly develop a personalized, written **service/care plan**. The service/care plan will be developed in a manner that provides individuals with impaired mental, physical or sensory functioning an equal opportunity to participate in and benefit from the development of the service/care plan. Communication aids such as taped or Bräille material, or interpreters for people with hearing impairments shall be provided at no cost.

In developing the service/care plan, a priority will be placed on services in settings where physical and mental competence can be best used to encourage self-care and self-sufficiency, and where family and voluntary care can be maximized. The costs of paid services in the plan will be calculated and reviewed with the consumer. The required elements in a service/care plan will be:

- Prognosis, rehabilitation potential, and measurable time-specific goals and expected outcomes.
- A description of family and informal supports provided to applicant (including case management assistance required to preserve informal support involvement).
- A comprehensive description which covers all supports (formal and informal) and services which are necessary to maintain an applicant in the least restrictive setting possible.
- The identity of providers for each service, location, cost, payer source, and amount of each service on a monthly basis (including availability of community resources).
- A description of the type of service and service providers preferred by the applicant, including any medical long term care service (e.g., routine insulin shots, IV medications, hot pack treatments etc.).
- The beginning and ending dates of service delivery for each contracted provider.
- The designation of case manager and extent of involvement in service/care plan including estimated frequency of contact.
- A description of the type of monitoring of services, including how agencies and case manager will direct and supervise direct care workers.
- A description of the process whereby a person can change his or her service/care plan.

- A description of the linkages required between care management agency and other supporting agencies (e.g., DVR and other employment-focused organizations, Social Security Administration etc.).
- A description of the type of physician coordination and consultation required for medical care, including medications, linkage with the primary care system.
- Written information for the person about whom to contact including after hours and weekends and what to do in the case of an emergency.
- Notation of any services identified as needed that will not be provided, and why, including refusal by applicant to accept the service.
- Documentation of any significant risks in the individual's service/care plan that the agency is aware have been discussed between the individual and the case manager.
- Evidence that the person and guardian (where appropriate) have participated in the care plan development and reviewed and accept the service/care plan.
- If a person's stated preferences were not met in the service/care plan, documentation of the reasons why they could not be met.

Unless the person chooses and meets state-established standards for a self/family-directed care option (see Appendix 4), the CMO will be responsible for arranging and monitoring all services identified in the service/care plan. The CMO will be responsible for the cost of all paid services in the service/care plan, less any required consumer cost-share or third-party payment.

The CMO will receive a fixed amount of funding each month for each person enrolled. This amount will be related to the projected need for LTC services based on the person's level of functional disability. Payment levels will reflect the different level of care requirements which different groups of people experience, based on information about actual costs in the current system.

The monthly per person payment amount will assume an **average cost** per person at a certain functional level; **the actual cost for any given person will likely be higher or lower than the payment.** The monthly payment that a CMO receives related to a given individual will not limit the amount that may be spent on that person's care, nor does it "entitle" the person to services up to the level of the monthly payment amount. This averaging of costs and payments across caseloads is similar to that done now by counties under the Community Options Program and Home and Community Based Waivers.

Under this new funding mechanism, local CMOs will have more responsibility to manage directly the funding and services for people who are enrolled. The state will transfer more management authority to CMOs. For people enrolled in a CMO, there will be no further need for such state-level management tools as state prior authorization of services, caps on Medicaid services, maximums on the percentage of people served in specific settings, or "significant proportions" requirements by target group.

For most people, a functional screen will be sufficient to determine the level of functional disability and assign a corresponding monthly payment level for LTC services. For some,

however, further evaluation will be needed to accomplish this accurately. For those individuals whose conditions are unstable (for example, they are just leaving the hospital after an acute episode), the Resource Center will recheck within a specified time period to assure that the original determination of their LTC needs was correct. If, after a thorough assessment, the CMO feels that the original determination assigned an inappropriately low level of care and monthly payment amount, it could request a re-determination from the Resource Center.

All publicly subsidized LTC consumers will be required to receive an assessment and service/care plan from a CMO. Some consumers or their families may be interested in arranging their own services, however, and the Department is committed to developing a **consumer-directed support** option in the new system (see Appendix 4). A work group is currently developing the details of this consumer option.

The CMO must demonstrate strong linkages with any providers of health services that are not part of the CMO's direct financial responsibility. The Department will establish requirements for these other service systems to cooperate and coordinate with the CMO.

Each CMO must serve people who need LTC but are not financially eligible for public subsidy. These private-pay individuals will be able to purchase care management services from the CMO.

Functions of the Care Management Organization

A care management organization will perform the following functions as specified in contract:

- Provide educational and informational services for consumers, including referrals to other service providers and community resources.
- Conduct comprehensive assessment and reassessment.
- Develop, with the consumer, a comprehensive service/care plan for LTC services.
- Assure that services are provided as required in its contract with the state.
- Contract for and/or provide a broad range of services sufficient to insure that all members of the CMO have timely access to a variety of high quality, effective and consumer-responsive services which are well coordinated.
- Coordinate, monitor, and adjust as needed, the consumer's overall service/care plan and specific service arrangements.
- Maintain communications among consumers, their informal support networks, and paid care providers to maximize consumers' exercise of choice and the efficiency of service delivery.
- Provide training and support for consumers and/or family members wishing to manage their own LTC services directly.
- In conjunction with consumers, coordinate with services provided outside the CMO's direct responsibility; for CMOs serving younger adults, this must include working with

the children's system, even before a young person attains adulthood, to assure smooth transitions from the children's system to the adult system.

- Manage the agency's budget for services and maintain appropriate financial, service and quality assurance records.
- Plan and develop service resources in the area it serves.
- Provide training for caregivers, both paid direct service workers and informal supports.
- Maintain an internal quality assurance/improvement system covering both care management processes and sub-contracted or directly provided services.
- Maintain internal complaint, grievance and dispute resolution processes for its members.
- Be responsible for the adherence of service providers in its network to all state and federal requirements for licensure, certification, the quality assurance plan of the CMO and other conditions of program participation.
- Monitor and be responsible for maintaining high quality and the appropriate extent of services provided by subcontractors.
- Maintain cooperative arrangements with Resource Center(s) from whom the CMO receives referrals, state and local agencies performing consumer advocacy and/or quality assurance functions, and other components of the overall system as needed.
- Assure financial solvency and stability.
- Meet all other contract requirements.

Requirements for Care Management Organizations

A CMO may specialize in one target group or serve several groups, but must demonstrate specific expertise in the needs of each group it proposes to serve and connections to that group's typical service providers. If the CMO specializes, it must assure that it can meet the special needs of members whose needs cross target group definitions. The number of CMOs serving a given target group in a geographic area may be limited, and the Department will certify an organization as qualified to operate a CMO in an area only if doing so would meet the criteria outlined in the section of this proposal on county and tribal roles.

All CMOs, whether public or private, must meet the same standards to be certified, and the same performance standards to continue operation. In order to be certified by the state as qualified to operate a CMO, an organization must demonstrate at least the following:

- Expertise in determining and meeting the needs of any target population(s) the organization proposes to serve and connections to their service providers.
- Strong linkages with service providers, volunteer agencies and community institutions.

- Thorough knowledge of local LTC and other community resources, including LTC resources designed to serve consumers in the least restrictive environment possible.
- The ability to manage and deliver, either directly or through subcontracts or partnerships with other organizations, the full range of benefits to be included in the monthly payment amount.
- Thorough knowledge of methods for maximizing informal caregivers and community resources and integrating them into an overall service/care plan.
- A clear long term care focus and a public name that will encourage participation by all members of the community, including those who pay privately for services.
- An existing relationship with a network of competent and accessible direct LTC service providers that is adequate to ensure that consumers can choose, without waiting, from among a broad array of providers with characteristics that consumers as a group find convenient and desirable, or the ability to create such a network. The organization's plan for its provider network must be developed in consultation with the consumer-dominated local LTC Council.
- The ability to develop strong linkages with systems and services that are not in its direct responsibility but that are important to the target group(s) it proposes to serve, including acute and primary health care providers.
- Linkages with local safety net organizations and emergency response systems.
- If not a county, linkages with the county aging unit, social service department, and/or human service department.
- A commitment to adequate and competent staffing by qualified personnel to effectively provide all functions it will undertake, including the ability to provide 24-hour emergency responses to problems and the ability to provide care management services in consumers' homes or other places of residence.
- The ability to adjust staff levels quickly as needed to adapt to changing caseloads and consumer needs.
- The ability to meet all performance standards established by the Department, including case management standards.
- The ability to conform to all quality assurance, monitoring and improvement requirements.
- The ability to respond in a timely and effective way to all complaints, grievances and appeals.
- The ability to adhere to all contract provisions and requirements as defined by DHFS and any applicable regulatory requirements of the Office of the Commissioner of Insurance.
- The ability to provide fully accessible services, including such issues as physical accessibility of office facilities, TTY telephone capability, and the availability of

interpreter services when needed for hearing impaired people and Braille or taped information for visually impaired people.

- Cultural competence, including the availability of bilingual staff and/or translators where needed.
- Financial solvency, stability, and the ability to assume the level of financial risk required.
- The ability to collect, monitor and analyze data for purposes of financial management and quality assurance/ improvement, in systems that meet state-established standards; and the ability to provide required data to the state.
- A governing board that meets established criteria (see Appendix 5).
- Conformance with federal requirements that will enable the system to secure appropriate federal funding.

Counties and tribes will have right of first selection to operate a CMO for all of the covered target groups or for selected group(s). Where a county elects to serve in this capacity, and meets performance standards, it will have a two-year opportunity to establish operation without competition from other organizations (except for existing PACE and Partnership programs). After this start-up period, the state will accept applications from private organizations to operate CMO(s) in areas where population bases would support more than one. The goal is to offer choices among CMOs to consumers wherever feasible.

Plans for how many CMOs should operate in a given area and which organizations should serve in the CMO role will be developed by local LTC Councils and recommendations from local LTC Councils must be attached to all applications to the state for certification as a CMO. (See section on County and Tribal Roles for more detail on this process.)

AIDS Service Organizations will be allowed to implement a statewide or regional CMO, exclusively for people with HIV/AIDS, to the extent the ASOs meet relevant requirements. Statewide or regional CMOs may also be desirable for other small, specialized populations, such as people with brain injury or people who are ventilator-dependent. The existence of any regional or statewide CMO for a specialized population will not limit an individual consumer's choice to enroll in a locally-based CMO instead. Any organization wishing to operate a statewide CMO must consult with the State LTC Council in developing its application for certification, and must attach a copy of the Council's recommendations to its application.

In general, the minimum service area for a CMO will be a full county to assure coverage of rural parts of the state. Multi-county service areas must cover contiguous counties. These requirements may be waived by the Department if necessary to accommodate tribal participation, coverage of municipalities that cross county lines, partial county coverage in Milwaukee and Dane counties, reasonable phase-in plans across an area, or for other reasons if the Department finds it in the public interest after consulting with local LTC Councils.

Improved Approaches to Achieving High Quality

For a consumer-centered LTC system to be successful, approaches to defining, assuring and improving quality must also be consumer-centered. That means delegating more responsibility and choice from the state or county government to the consumers, their families or guardians and their case managers. The users of services best define quality in LTC. They must be participants in assuring basic quality and improving it toward excellence. As a payer for long-term care and support, the state also has a clear role in holding the system accountable for quality. Resource Centers, as the access point for the LTC system and the primary locus for prevention and information for the community, will have responsibilities to make sure that the system is responsive to the needs of the people who will use it and the community as a whole. Care management organizations, as the purchasers of services, have the central responsibility to continuously improve quality and responsiveness of direct services and vendors.

Over time, the Department proposes to move away from a quality assurance system that primarily measures *process* issues and toward a system that is concerned with achieving consumer-defined *outcomes*. The new system should focus on meeting customer expectations more than on complying with rules about which procedures should be used. Service providers and suppliers will be expected to cultivate a culture of quality within their workforce and organization, working in partnership with care management organizations to achieve desirable outcomes. In the long run, building quality into the system through self-correcting mechanisms such as data collection and analysis and continuous customer feedback will be more effective than total reliance on external inspections.

External advocacy mechanisms, including consumer protection and advocacy by ombudsmen, consumer peer organizations, and legal and lay advocates will be supported in the LTC system to solve problems when quality systems fail individuals. External protection and advocacy will also be supported to encourage continuous improvement and the repair, when needed, of statewide or local LTC systems. Consumer involvement and representation in advising and governing are addressed elsewhere in this proposal.

Quality Assurance and Improvement in the LTC System

The voice of the consumer will be amplified in the LTC system through roles in governance, in care management, in expressing and exercising choices, in critiquing the services rendered, and in advising on quality improvement. To the extent possible, the consumer's own views about the quality of their services will be explored by a variety of tested methods. Views of families and guardians will also be solicited and reviewed.

Consumer-centered quality approaches, and financing associated with individual needs, can enable more people to be served more flexibly, and assure that consumers' goals (rather than regulators' or providers') are given priority in the allocation of limited resources. Quality and cost-effectiveness are not seen as competing goals but complementary. Financing and payment

structures will be aligned with the LTC Guiding Principles and will encourage high quality services.

Outcome-based approaches and quality improvement efforts are expected to gradually replace some process-driven regulatory strategies. Traditional regulatory approaches must remain in place to assure basic health and safety of consumers while new approaches are tested and phased in. The Department has undertaken a Regulation and Licensing Re-engineering Project to improve regulatory processes related to LTC and health providers. Some current approaches that will continue are listed at the end of this section.

Quality Assurance and Improvement in Resource Centers

Quality assurance and quality improvement in the Resource Centers will be addressed in the same way as outlined below for CMOs. Details are currently being developed by consensus in a workgroup of major stakeholders. Lessons from the current nine Resource Center Pilots will be incorporated in this process as well.

Quality Assurance and Improvement in CMOs

Quality assurance and improvement within CMOs will be ensured through a combination of mechanisms. Requirements for external quality review will remain, including those required by the federal government. The two major innovations proposed here are:

- Achievement of *consumer outcomes.*
- Continuous incorporation of *the voice of the consumer* at all levels.

Consumer Outcomes

The primary focus for quality assurance and improvement will be the achievement of desired consumer outcomes. A consumer outcome oriented approach focuses on *changes that occur in consumers' lives as a result of services* provided through the service networks of the CMO. The first step is to identify the outcomes, then focus on interventions (i.e., structures and processes) to determine what works and what doesn't work, and to continually improve services to achieve the desired outcomes. In this way, quality control is exercised through focusing on interventions that work rather than on compliance to rules and policies.

This approach will track each CMO's success at achieving consumer outcomes for the entire consumer population, for specific target groups, or for individuals for whom the outcome is especially critical. The performance within one care management organization will be compared with results of other CMOs and statewide results in order to analyze performance. Performance over time will be tracked for each organization to monitor trends and rates of improvement.

To achieve these outcomes will require prudent purchasing of care, giving value and primacy to the role of community and family, improving the capacity of people to do things for themselves, and accepting the values and preferences of people in defining the meaning of

success in their lives. The following are the consumer outcomes that have been developed to date by the Designing Quality workgroup (a diverse 35-member group of stakeholders).

Outcomes for People

- People are treated fairly.
- People have privacy.
- People feel they are treated with respect and dignity.
- People choose their services.
- People choose their daily routine.
- People achieve their employment objectives.
- People choose where and with whom they live.
- People participate in the life of the community.
- People remain connected to informal support networks.
- People are free from abuse and neglect.
- People have the best possible health.
- People are safe.
- People are confident that the system is reliable and predictable.
- People are satisfied with services.

These outcomes are "universal," which means that they apply in general to all people—regardless of age, disability, lack of disability, or health status. However, the details and importance of each outcome varies significantly among individuals.

The monitoring of outcomes in the long-term care system will provide objective information (data) on quality of life issues, and the quality of services or care. The data will help consumers, the CMO and the state to evaluate the performance of CMOs and their service networks. For example, if a CMO overuses particular settings for greater cost efficiency without regard to consumers' preferences, this will be evident in evaluating the outcome, "People choose where and with whom they live."

The measurement of outcomes will be built on the preferences of individual consumers. In each instance, the universal expectation is modified by the personal. For example, consider the outcome, "People participate in the life of the community." This outcome is achieved for an individual if he or she indicates, "I participate in my community *as much as I want to*."

Methods for obtaining and measuring data will be developed by drawing upon state-of-the-art approaches from around the country, including interviewing, surveys, peer reviews, etc. The aggregate data (e.g., overall numbers or percentages of consumers achieving each outcome) can be analyzed for internal quality improvement in a CMO. For example, a CMO could document that over a four-year period, it increased the percentage of its members with developmental disabilities who chose where they live from 60 percent to 80 percent. The

aggregate data can also be used in "report card" comparisons of CMOs, and for overall analysis of the system by DHFS.

Performance Standards

In addition to consumer outcomes, the approach to quality will focus on performance standards. Performance standards are consistent and reliable organizational structures and processes that help to bring about the desired consumer outcomes. The standards will inform organizations of what systems are needed in order to qualify for the contract, and will help the Department assess whether or not an organization is qualified to serve consumers. When the performance standards are finalized for each outcome, the Department will establish an approach for applying the standards, and will develop methods for using them to determine contract eligibility. The following are examples of performance standards that relate to several consumer outcomes:

- The LTC Guiding Principles govern all levels of the CMO's practice.
- The CMO identifies a person's preferences in all areas.
- The CMO fully informs people of their options in all areas.
- The CMO develops or seeks out options to meet the person's preferences.
- The consumer (or family/advocate) is the central member in the team that develops his or her care/service plan. The care/service plan is dynamic, and changes to meet the person's needs.
- The CMO solicits and uses consumer input for systems development and change.
- The CMO contracts with a wide array of providers that accept and advance a consumer centered approach.

Notice that performance standards are not precise prescriptions. The Department will develop guidelines for how performance standards can be implemented, but these guidelines will allow flexibility in how each CMO meets them. This approach fosters creativity and innovation, which leads to improvement over time, and shifts the emphasis from reporting compliance to attaining desired outcomes.

More specific performance standards are being developed. Examples concerning health care are provided in the section below on "Linkages with Acute and Primary Health Care."

Performance Measures

Performance measures are minimum performance levels each contracting organization will be expected to achieve and will assist in determining which CMOs are achieving desired outcomes. The measures developed will be designed to count events related to outcomes, use them as yardsticks to measure progress, and show the CMO and the Department where changes may be necessary.

Consider, for example, the outcome, "People are treated fairly." Meeting this outcome requires, among other things, that people know what their rights are, and can exercise their rights free from coercion or retribution. The following are examples of performance standards and performance measures that relate to this outcome:

Performance Standards:

- People receive clear explanations of their rights that they can understand.
- Written policies and procedures address the care and treatment of consumers who are unable to give informed consent.
- A system exists for adequately addressing and documenting consumer formal and informal complaints.

Performance Measures:

(Note: Minimum requirements will be established. Each CMO will seek to continuously exceed those minimums.)

- Percent of people who feel they can exercise their rights without fear of retribution.
- Percent of CMO and contracted staff at all levels, caregivers, and consumers who pass a randomly administered consumer rights "quiz."

Linkages with acute and primary care

Detailed performance standards are being developed to ensure that CMOs have effective linkages with acute and primary health care providers. A few examples include the following:

- The CMO implements processes to help members access health care services as needed.
- Mechanisms exist for communication of health-related concerns both within the CMO and outside of it. *(For example, direct caregivers are given basic information on what to report and whom to call with questions or concerns.)*
- The CMO implements a process for obtaining informed consent from members or representatives to share confidential medical and treatment planning information across providers.
- The CMO implements processes for sharing clinical information, including management of medications.

Performance measures will be developed to promote access to appropriate health care and to prevent health crises. Financial incentives for health promotion, and disincentives for causing episodes of illness or deterioration of health status, will be developed over time.

Structural consumer protections

Complaint, grievance and appeal processes beginning with informal and formal mechanisms at the service level, through levels of grievance and appeal will be built into the system. These will be similar to processes currently in place, but will be rendered more effective through the use of advocacy, and through some specific performance standards. External consumer protection and advocacy services, including ombudsman, legal and lay advocacy, and peer support organizations will be supported as well.

Empowering consumers through education, information and access

Well-informed consumers and families will be able to make sound choices about their own care and to assist the system in improving quality. At all levels of the system, agencies have the responsibility of informing and empowering consumers and their families to make cost-effective decisions which will support their quality of life. Resource Centers have a major role in outreach and consumer education, to encourage prevention, personal planning for long-term care (and substitute decision-making), and enabling consumers to understand and access the array of opportunities in long term care. Resource Centers will eventually be able to make people aware of the quality reviews of care management organizations, and to advise them of their rights when making referrals to CMOs.

Within the service system, consumers will be engaged in a process of discovery of their abilities, needs and options, the costs of care and support, and the most current data or information regarding their conditions and treatment. Consumers will be encouraged to be active participants in maintaining and improving their abilities and health status.

Education of family caregivers, support for their role, and response to their needs for information, respite and advice will be provided by either the Resource Center or the CMO, whichever is serving the consumer.

Preserving current quality assurance

Although it is a goal to reduce the need for certain regulatory activities over time, some quality assurance functions are best performed at the state level for the benefit of providers, CMOs and consumers. These functions include:

- Licensing and certification of providers
- Monitoring for compliance with a variety of environmental safety and other regulations, involving DHFS and several other state agencies.
- Enforcement of contract requirements, including performance standards related to outcomes, standards of health care, service and safety related provisions, and civil rights enforcement.

- Complaint, grievance and appeal processes that involve the Resource Centers, the CMOs and the state.
- Enforcement of requirements which protect workers in the LTC system.
- Training and development activities by the Department and state educational systems to promote a competent and up-to-date service provider system.

Information about the results of some of these processes (e.g., licensing and contract review), will feed into the quality improvement process and may be included in published "report cards" about CMOs and providers.

Quality improvement and quality management

Each CMO will be required to maintain a continuous quality improvement program that will serve to monitor and evaluate its own performance and that of its providers. Most of the CMO's internal quality improvement will be documented by increases in the number of people attaining consumer outcomes. In order to achieve the goal of providing excellent care that continues to improve over time, a CMO must be able to collect and report data on desired outcome indicators and identify people who do not achieve desired outcomes. Through ongoing data gathering and analysis, consumer feedback mechanisms and self-assessment and self-correcting mechanisms, the CMO will demonstrate that it is able to continuously improve its management and delivery of services.

All facets of quality assurance/improvement will be integrated so that approaches support and reinforce each other. At the local level, each Resource Center and each CMO will be required to support a QA/QI team to coordinate internal self-correcting activities. Within DHFS, a QA/QI management team will be established to assure the integrity of the quality system related to the LTC Guiding Principles. A Leadership Committee on Quality will be formed involving consumers, providers, academicians, managers and regulators to continuously review and recommend approaches to measuring and improving quality.

Efficient management of the new LTC system

County and tribal roles and responsibilities

Counties and tribes play critical roles in the current LTC system. They administer a variety of home and community-based programs for people who need LTC, including the Community Options Program and Medicaid home and community-based waiver programs, which are the major case-managed LTC programs currently in existence. They have established networks of home and community care providers, that could be the basis of an expanded network for the broader Family Care benefit. Most counties are also direct service providers, operating nursing homes, home health and personal care agencies, public health, and other services. County governments also have statutory responsibilities (e.g., under Chapters 51 and 55) for providing services to people with developmental disabilities or mental illness and other vulnerable adults.

County government serves as the safety net for the protection of elders and other vulnerable adults against abuse and neglect. It also provides access to many public benefits (including eligibility determination), and is often a primary source of information to citizens about available services.

Given their long experience in performing many of the functions envisioned for the new LTC system, counties and tribes are encouraged to be active participants and will be given preference to serve in key roles. However, participation will differ from the current system, where counties are mandated to perform various functions and the state is obligated to fund and contract with county/tribal agencies for these purposes, even if they do not meet performance expectations. Instead, each county and tribe will have the opportunity to choose which roles it can and wants to play, and will need to meet standards in order to get and retain a state contract.

Phasing in the new system

The new system will be phased in across the state over a five-year period, during which counties and tribes will have the opportunity to apply for certification as a Resource Center and/or a CMO. (See section on Transitions.) In consultation with local, consumer-dominated LTC Councils[2] (see below), counties and tribes will have the **right of first selection** to serve as Aging and Disability Resource Centers. County/tribal operation of the Resource Centers will facilitate integration of many related public functions such as adult protective services, and eligibility determination and application for a variety of public benefits. Only if a county is unwilling to serve in this role, or is unable to meet contract performance standards, will the state open competition to private not-for-profit organizations. Tribal organizations will be

2 For more detail about the structure, composition and roles of state and local councils and governing boards, see Appendix 4.

given similar first preference, either to operate a distinct tribal Resource Center or to be a part of a county/tribal network.

Counties and tribes will also have right of first selection, in consultation with local LTC Councils, to operate Care Management Organizations for one or more target populations, which must include private pay individuals, if they meet certification criteria. Counties choosing to operate CMOs will have reasonable opportunity (two years) to establish operation without competition from other organizations, except for existing PACE and Partnership programs and possible statewide CMOs for small sub-populations. During and after this two-year start-up period, the state will retain the right and responsibility to contract with another party if a county or tribal CMO does not meet performance standards and has had reasonable notice and opportunity to improve. In order to maintain direct accountability and avoid unnecessary administrative overhead costs, the state will contract directly with all CMOs.

Competition will be opened to other organizations prior to the end of the two-year period if a county does not exercise its option to operate CMO(s) for all eligible individuals, cannot meet certification standards, or the County LTC Council recommends additional CMOs and the County Board/County Executive agree. During this start-up period, applications from non-county/tribal organizations to serve as a CMO in a single county or multi-county region will be accepted only with the approval of affected counties and local LTC Councils. Applications from organizations to serve as a statewide, specialized CMO for a small sub-population (such as people with HIV/AIDS) will be accepted prior to the end of the two-year start-up period. Such organizations must attach to their application the recommendations of the State LTC Council (see State Roles section).

In determining the optimum number of CMOs permitted in an area, the following criteria will be considered by the state, each local LTC Council, and the State LTC Council (see below):

- Population/client base needed to make each CMO financially viable
- Financial stability and solvency of existing and potential CMOs
- Information about client needs and service costs
- Ability of the system to serve the particular needs of specific target groups
- Ability of the system to serve the needs of people who span target group definitions
- Administrative efficiency and overhead costs
- Quality and consumer satisfaction with any existing CMOs and applicant organizations
- Federal regulations

County LTC Council: start up roles

A County[3] LTC Council will be established in each county, or at local option, in a multi-county region. At least 51 percent of the Council's members must be elderly people, people with physical disabilities, and people with developmental disabilities or their family members, guardians or other advocates, proportional among the three target groups. Of these consumer representative, at least two-thirds must be elderly people, people with physical disabilities and people with developmental disabilities; not more than one-third may be family members, guardians or other advocates. Consumer members will be appointed by the County Board(s) (or County Executive if applicable)[4] from a pool of people nominated by consumers, family members, guardians, and local organizations representing older people and/or people with disabilities. Consumer representatives must be trained and supported to enable them to participate effectively in the deliberations of the Council, and reimbursed for reasonable expenses associated with participating.

The balance of the County LTC Council members will include County Board Supervisors, service providers, and other county residents who have recognized ability and demonstrated interest in the needs of people with developmental disabilities, people with physical disabilities, and elderly people, and services that address those needs.

The County LTC Council will develop an **initial plan**, within state guidelines, for the local structure of the LTC system. This initial plan will include recommendations on:

1. Whether the county should exercise its right of first selection to operate the Aging and Disability Resource Center(s).
   - If the Council recommends that the county assume this role, it will specify where these functions should be housed. Options would include existing county agency(ies), a newly created county or quasi-governmental agency, or participation in a multi-county organization or county/tribal organization.
   - If the Council recommends that the county not apply for this function, it may make recommendations regarding local private, not-for-profit organizations that would be appropriate alternatives.
2. Whether the county should exercise its right of first selection to operate a CMO for one or more target groups, and whether the county should exercise its option to be the only CMO for one or more target groups during the first two years of operation.
   - If the Council recommends that the county assume all or part of the CMO role, it will specify for each target group where these functions should be housed. Options

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[3] Requirements for tribes cannot be exactly the same as those for counties; for example, the state cannot dictate that tribes establish tribal LTC Councils. However, if a tribal organization wishes to apply to be certified as a Resource Center or CMO, it must demonstrate that a similar process for involving consumers and other tribal members was used in making this decision and developing the application. Tribal LTC Councils must include representatives of affected counties.

[4] If tribal lands are located in the county, at least one member of the Council must be appointed by the elected governing body of the affected tribe.

would include existing county agency(ies), a newly created organization such as a quasi-governmental authority, participation in a multi-county organization or county/tribal organization, or participation in a partnership with a private organization.

- If the Council recommends that the county not apply to serve as the CMO for one or more target groups, or that additional CMOs should be available in addition to county-operated CMO(s), it may make recommendations regarding local private organizations that would be appropriate in this role.

3. If the tribal reservation lands are located in the county, the plan shall include recommendations on how county-operated functions would interact with any planned tribal Resource Centers and/or CMOs.

The County Board(s) and, if applicable, County Executive(s) of affected counties shall consider the plan and consult with the County LTC Council in making their decisions about whether to authorize one or more county (or multi-county) agencies to apply for certification as a Resource Center and/or CMO. During this start-up period, all applications to the Department for certification as a Resource Center or CMO must include a copy of the initial plan of the County LTC Council and any subsequent amendments to it.

The Department will consider the recommendations of the County LTC Council, will consult with the Council during the approval process for certification, and will notify the Council and the county of its preliminary decision prior to signing a contract or denying certification. If either the county or the local Council disagrees with the decision of the Department to certify or not certify an organization, it may request a review by the State LTC Council (see section on State Roles).

After the start-up period

In order to offer more choices to consumers where affected population bases would make multiple CMOs feasible, opportunities will be offered to non-county/tribal organizations two years after the first contract for service in a county, or sooner if approved by affected counties and County LTC Councils. Each application must include the recommendations of any affected local LTC Council(s).

Depending on initial decisions about the structure of the local LTC system, local LTC Councils may need to be reconfigured at this time. For example, if individual counties have formed LTC Councils to develop initial plans, but Resource Centers and/or CMOs will be multi-county, a new multi-county Council may be more appropriate. If non-county/tribal organizations have been chosen to serve as a Resource Center or CMO, their representatives should be included in the Council's membership.

Local LTC Councils will have the following ongoing responsibilities for guidance of the local system:

- Make recommendations to the Department on any additional CMOs needed in the area to provide additional choices for consumers, within the criteria outlined above for the optimum number of CMOs permitted in an area.
- Provide recommendations on each application for initial or renewal certification of Resource Centers and CMOs in the area, which the organization will attach to its application; assist the Department in its review and evaluation of all applications to operate a Resource Center or CMO in the Council's geographic area.
- Receive and monitor concerns from CMO consumers about the adequacy of the CMO's network. Review initial plans and existing provider networks of local CMOs , to assist CMOs in developing a sufficient number of accessible in-network providers to ensure that its members can choose, without waiting, from among a broad array of providers with characteristics that their members, as a group, find convenient and desirable. Any application for initial or renewal certification as a CMO must include attached recommendations from local LTC Council(s) in the CMO's service area regarding its proposed or existing provider network.
- Make recommendations to local CMOs regarding whether the CMO should offer optional acute and primary health care services and if so, how these benefits would be offered to members. Each application for initial or renewal certification that proposes to include these services must include attached relevant recommendations from local LTC Council(s) in the CMO's service area.
- Review the utilization of various types of services by CMOs.
- Monitor the pattern of enrollments and disenrollments in local CMOs.
- Identify gaps in services, living arrangements and community resources and develop strategies to build local capacity to serve elderly and disabled people, including those with long term care needs.
- Perform long range planning for elderly and disabled citizens locally.
- Review and make recommendations as appropriate on the interaction among Resource Centers and CMOs in an area, to assure a coordinated overall LTC system for consumers, including annual review of required interagency agreements.
- Review the number and types of complaints and grievances from customers of Resource Centers and CMOs to determine whether patterns of complaints and grievances indicate the need for system changes; recommend system or other changes when appropriate.
- At local option, may be part of local grievance process (i.e., review and act on grievances from individual consumers).
- Identify potential new sources of funding for Resource Center(s) and CMO(s)
- Participate in monitoring and evaluations of Resource Center(s) and CMO(s)
- Advocate for local system improvements that will improve overall service to elderly people and people with disabilities and their families.

- Report annually to the Department and to the State LTC Council on significant achievements and problems in the local LTC system.

Relationship between Resource Center and CMO(s) when county/tribe operates both

To assure that key roles of the Aging and Disability Resource Centers are kept strong, some level of independence from care management roles must be preserved. LTC Redesign will not succeed in its goals if Resource Centers do not have strong information and assistance, prevention, and early intervention components. The roles envisioned for the Resource Center are very different from those of the CMO. Each is critical and neither must be overshadowed by the other. Given that the CMO's need to manage considerable service funding and broad provider networks, it would be easy for the Resource Center's roles to be subordinated without some level of separation and mechanisms to assure that adequate support is given to them.

In addition, there are inherent conflicts of interest between certain functions of the Resource Center and those of the CMO. This is not to say that there cannot be coordination between the two parts of the system, or that the two cannot work together when appropriate. The person who completes the functional screen, for example, could follow the person to a CMO to assist the person in accessing services there, including participating in the full assessment and development of a service/care plan.

The state will contract separately for Aging/Disability Resource Center and CMO functions. If a county or tribe chooses to operate both a Resource Center and a CMO, it must meet all certification standards for both roles. In addition, it must assure that the two roles will be distinct in certain respects.

Each Resource Center and each CMO must have a governing board that meets the structural requirements outlined in Appendix 5, with not more than 25 percent overlap between their memberships. Depending on local governing structures, board members will be appointed by the County Board, County Executive(s), subject to County Board confirmation, or elected tribal governing body. So long as appointment and membership requirements are met, these new boards could be reconstituted from currently required committees and boards that will no longer be needed. For example, each county now is required to have a Long Term Support Planning Committee; when the new LTC Council is appointed and functioning, this requirement will be waived and the Council will take over the responsibilities of the LTS Planning Committee If the County/Tribal Aging Unit operates the Resource Center, or is integrated into the Resource Center, the County Aging Commission could become that agency's governing board or a subcommittee of it.

The CMO and the Resource Center must have different managers, who are of equal standing and who report through distinct chains of command. Separate agencies are preferred to house the two sets of functions, with the two directors reporting, through their respective governing boards, to the County Board, to the County Executive/Administrator (in counties that have an Executive/Administrator), or to the elected tribal governing body.

Another option, less preferable from the standpoint of maintaining independence of Resource Centers, is that both functions would be housed in one agency, with the two managers both reporting to the agency's director. In this case, the governing boards of the Resource Center and the CMO could be committees of the overall governing board of the agency, subject to the requirements for membership, including appointment authority, outlined in Appendix 5.

As part of its application for certification, the county or tribe will need to assure the following:

- The Aging and Disability Resource Center and the Care Management Organization will each be highly visible, with distinct identities.
- The proposed arrangement will meet all federal and state requirements for separation of the following functions[5] from the receipt of funding for the provision of services.
  - Translation of functional eligibility screening information into monthly payment levels.
  - Counseling of citizens about services available to them, including the choice of whether to enroll in a CMO, and if so, choosing among available CMOs.
- Clients of both the Resource Center and the CMO will be assured access to independent advocacy services to assist them in obtaining their rights and in negotiating the system.
- The Resource Center will maintain a strong consumer focus.
- The Resource Center will maintain strong and effective prevention, early intervention and public education programs that will:
  - Reduce the incidence of disabling conditions among the county's citizens.
  - Prevent unnecessary loss of functioning for elderly people and people with some level of disability who are not members of a CMO.
  - Prevent private pay individuals from spending more than is necessary for services they may need.

The state will provide training in the use of uniform eligibility determination tools. Benchmarks will be established for expected distribution of clients among rate bands (i.e., level of disability found through the functional screen). Regular state audits of all eligibility determinations will be conducted on a statistically valid sampling basis. If an organization's determinations fall significantly outside of expected benchmarks, more intensive auditing would be undertaken, at the organization's expense, and corrective action taken if irregularities are found, including automatic state override of assigned payment rates and/or penalties where warranted.

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5 It is possible that the federal government will require that these functions be performed by an external organization with no interest in the results of these activities.

If the county or tribe subcontracts for overall CMO functions (i.e., subcapitates for the full range of case-managed LTC services), each subcontracted organization must meet all certification standards. In addition, there will be requirements for the proportion of overall funding that must be passed on to subcontracted CMOs for direct services.

Adult protective services

The provision of adult protective services (APS) is currently a function of county government and will remain so in the redesigned system. Further, APS will continue to be subject to separate standards and requirements, beyond those governing long term care-related functions of the Resource Center.

While there is some overlap between APS and long term care, APS is viewed as a distinct function requiring special skills and expertise. It encompasses such "core" services as investigations of alleged abuse, neglect or exploitation; short-term protective interventions, including petitioning for guardianship and protective placement when necessary; court-required reviews, including an annual review of court-ordered placements (i.e., Watts Reviews); advocacy; and brief services. Core APS services may also include long term care management, to the extent a person with APS needs refused care management offered by a long term care management organization (CMO) in the redesigned system.

Where the county operates the Resource Center, adult protective services would become a component of the Resource Center, but would be funded separately from other Resource Center functions. Where the county does not operate the Resource Center, the county would retain its APS-related responsibilities. Under such circumstances, close coordination with the Resource Center will be necessary to effectively serve people with both APS and long term care needs.

Some people determined to be eligible for Family Care may need adult protective services, including elder abuse services. People needing either comprehensive- or intermediate-level long term support, who also have APS needs, will be referred to a care management organization (CMO) for a comprehensive assessment and service/care plan. Court-ordered assessments of such people, as well as assessments requested by the county APS unit, will also be completed by the CMO. APS core services, such as those described above, will continue to be provided by county specialists. Again, close coordination between these two entities (i.e., the county APS unit and the long term care management organization) is essential.

Some people with both long term care and APS needs may refuse to cooperate with the CMO (e.g., refuse the assessment, ignore the service/care plan, fail to pay their cost-share). Under such circumstances, the APS unit will encourage the person to accept needed services and meet related financial obligations. In addition, the APS unit will attempt to provide care management services until such time as the person agrees to cooperate with the CMO.

People eligible for Family Care who are declared to be incompetent will, with the cooperation and assistance of their guardians, be referred to the CMO for services. For Medicaid-eligible people enrolled in a CMO, court-ordered services will be the responsibility

of the CMO. The court will make arrangements for any necessary payments from an individual's funds for cost sharing.

Many people who need protection do not also need long term care. Such people will not be eligible for Family Care and will not be referred to the CMO. It will remain the responsibility of the APS unit to assure that such people receive the services they do need. Those services will be funded through a mechanism which is separate from long term care funding.

Changes in other current county responsibilities

Current statutes need to be changed to allow for the possibility that entities other than the county could be providing LTC services as a CMO. A technical work group, which will include county and consumer representatives, will work through the specifics of those statutory changes. In making these changes, care must be given not to abridge current rights (e.g., under Chapter 51) or to limit the range of services available to clients.

Funding changes

When the new LTC system is fully implemented, state and federal service funding that now goes to counties through Medicaid, the Community Options Program, and Community Aids will instead be pooled with other resources at the state level and used to fund Family Care. If a county is a CMO, it will receive a per person monthly payment amount for services to its members.

Community Aids funds currently used for LTC services and functions will be transferred to the new LTC appropriations. A work group has been formed to work out the details of the appropriate amount of Community Aids to be included in the new LTC system, and to recommend equitable methods for reducing current allocations. The group includes representatives of each of the affected target groups and several county staff.

In order to capture the full amount of available state/federal Community Aids allocations, counties are currently required to provide a match. In the new system, county match will be required on state funding for Adult Protective Services, as defined above, (and possibly on some other Resource Center functions) at a percentage designed to capture the dollar amount of the currently required county match on the portion of Community Aids funds now used for long term care and APS services and functions. No county match will be required on service funding provided to CMOs, regardless of whether the county operates the CMO.

In addition to the county match required, many counties provide additional county funds for a variety of human services, including LTC-related services. The technical work group on Community Aids noted above will develop information on the amount and use of current county overmatch and develop options and recommendations on whether, and if so, how, this funding should be included in the new LTC system.

Additional tools for counties and tribes

In order to provide additional tools that may be useful to some counties and tribes in undertaking the functions of the new LTC system, the following will be pursued as part of the LTC Redesign effort:

- As an option for counties, LTC legislation will authorize the creation of quasi-public corporations to operate CMOs, similar in structure to housing authorities. Statutory provisions will be included to preserve the benefits and rights (e.g., participation in the public employee pension plan) of current county employees who would be transferred to the auspices of the corporation. The sponsorship of the corporation could be single-county or multi-county in nature (similar to multi-county 51 Boards).
- As another option, the creation of private, not-for-profit organizations, similar in structure to current Aging Commissions in some counties, will be authorized in statute.
- The state will develop uniform information technology standards for CMO and Resource Center functions and assist in the development of local information systems. Further work is needed to determine the degree to which local information systems need to be uniform across the state, and for which functions.
- As much as possible within federal restrictions, statutory allowable cost policies that could constrict counties' ability to be prudent purchasers of quality services will be modified or eliminated for CMOs.
- The state will provide technical assistance to help county and tribal agencies build the capacity to serve in the various roles of the new LTC system.

Special tribal considerations

- The new LTC system will comply with federal regulations under Medicare and Medicaid which provide unique rights to members of Indian tribes.
- Barriers that could impede the ability of tribes and tribal organizations from serving in various roles in the new LTC system, including those of Resource Center, CMO and service provider, will be identified and removed.
- Cultural competency issues related to Native Americans will be separately and specifically addressed throughout the new system.
- To the extent possible while maintaining quality standards, state certification and subcontracting requirements will be simplified in order to maximize flexibility and minimize administrative costs for small provider agencies, such as those operated by some tribes.
- In the case where a tribe and a county both operate a Resource Center, tribal members who live on the tribe's reservation lands may be required by the tribe to go through the tribal Resource Center for access to LTC services.

State roles and responsibilities

State LTC Council

A 25 member State LTC Council will be established, at least 51 percent of whose members will be elderly people, people with physical disabilities, people with developmental disabilities, and their family members, guardians and other advocates. Of these consumer representatives, at least two-thirds must be elderly people, people with physical disabilities and people with developmental disabilities; not more than one-third may be family members, guardians or other advocates. The balance of the Council's members will be county and tribal representatives, service providers, advocates, state officials and other community leaders. The Governor will appoint the Chair of the Council. Nominations for other members of the Council will be solicited by the Secretary of the Department and the Governor will appoint the balance of members from pools of names submitted by respective stakeholders.

Based on its own expertise and the information it receives from local LTC Councils and other sources, the State LTC Council will assist the Department in developing broad policy issues related to LTC. It will help the Department to develop, implement, coordinate and guide the state's LTC system, including reviewing and making recommendations on standard contract provisions for Resource Centers and CMOs, the new Family Care benefit (including per person rate structure), and, for as long as they are a part of the system, the Community Options Program, the Community Integration Program and other Medicaid Home and Community-Based Waiver Programs, and the Medicaid fee-for-service system.

It will also provide a forum for review, at the request of counties, tribes, local LTC Councils, or applicant organizations, of Department decisions regarding how many CMOs should operate in a given geographic area, which organizations should receive CMO contracts from the Department, and whether specific contracts should be terminated. The State LTC Council will review disputed decisions in light of materials presented by the applicant organization, any affected CMO already operating in the same geographic area, any affected local LTC Council and the Department. The State LTC Council will review these cases within established guidelines and make recommendations to the Department. The final Department decision on the matter must include consideration of the Council's recommendations; if the Department's final decision does not agree with the Council's recommendations, it must explain in writing its reasons for not doing so.

The Council will also: monitor patterns of complaints, grievances and appeals across the state; monitor information about waiting lists; review service utilization patterns by CMOs; monitor the statewide pattern of enrollments and disenrollments in CMOs; review annual reports from local LTC Councils and the results of quality reviews; and report annually to the Governor and the Legislature on the status, significant achievements and problems in the statewide LTC system, making recommendations, if it wishes, on changes that may be needed.

Within three months of enactment of enabling legislation, the Secretary of DHFS will solicit nominations from various stakeholders, including consumers and their families, for membership in the State LTC Council. These nominations will be submitted to the Governor,

and appointments will be made from these lists. The Department will provide training and support to consumer representatives on the Council to enable them to participate effectively in the deliberations of the Council and will reimburse them for reasonable expenses associated with participating.

For more detail about the composition and roles of this Council, please see Appendix 5.

Department roles

As the new LTC system evolves, many current roles of the Department of Health and Family Services will change. Authority and responsibility will be shared to a greater degree with consumers and other local citizens, and with local organizations who will have more flexibility to manage services and funding in ways that make sense to the people who need them.

One major change will be DHFS's movement toward being an informed purchaser of outcome-based services. Currently, the roles of the Department are more aptly described as (1) a payer of specific service providers, for funds such as Medicaid, and (2) an enforcer of county mandates, for funds such as Community Aids and Community Options. Another example is the change proposed in the way the Department will approach issues of quality assurance and quality improvement in the new system.

The Department will also face adjustments in its role as a direct service provider through the State Centers for the Developmentally Disabled. Like all other LTC clients, Center residents can choose to enroll in a CMO to access Family Care. The Centers will need the flexibility to compete cost-effectively while maintaining the special expertise and services that have made them a valuable resource in the current system. Many options will need to be considered as the role of the Centers evolves in the new system.

The Department will also need to develop standards for management information systems for the new LTC system. Information systems will need to serve the purposes of the state (e.g., monitoring key consumer outcomes), the CMOs (e.g., service management) and the Resource Centers (e.g., eligibility determination).

Other current state roles will remain in the new LTC system; however, the associated focus and methods may need to change to fit with the new system. Among these are:

- Developing and maintaining public LTC policy and budgets, including addressing related matters with the federal government as appropriate.
- Providing stewardship of resources.
- Protecting vulnerable populations.
- Assuring a consumer focus in the system.
- Building system capacity.
- Developing and assuring compliance with performance standards and other contract requirements.

- Developing and maintaining uniform standards for needed information systems.
- Providing training and technical assistance.
- Rendering decisions regarding formal complaints, grievances and appeals lodged by consumers.
- Evaluating the effectiveness of new policies and procedures.
- Licensing, regulating and certifying service providers.
- Operating the Medicaid fee-for-service system.
- Making residency determinations and administering interstate compacts.

The legislation enabling redesign of the LTC system will require that the Department, within six months of enactment, submit a proposal for how it will reorganize itself to effectively implement and manage the new system.

Budgeting for the new system

Wisconsin's population is aging. Growth is most rapid among the oldest age groups, where the risk of needing long term care is highest. With improvements in medical technology, younger people with disabilities are living longer, and with more severe disabilities. The number of people needing long term care services is growing and will continue to increase. The public budget for long term care will grow in the future beyond inflationary increases, simply to cover the increased number of people who will need care.

This proposal would increase access to the kinds of LTC services that people have told us they prefer, making it likely that more people will want to enter the public system. It would make more people eligible for public subsidy, many of whom would not qualify for Medicaid, but would qualify to receive partial funding for their services in the new system. It would assure more people with high-level need for services that they would receive those services without spending long periods on a waiting list. It will include strong new information and assistance, prevention and early intervention components. Overall, this proposal includes a number of changes that will result in increased costs to the system.

The federal government has informed us that any changes must be budget neutral overall to Medicaid, in order to retain federal participation in Medicaid funding. That is, the new system cannot cost Medicaid more than what would be expected without the redesign. Attaining this goal is possible if we design a new system that manages public LTC funds more efficiently and effectively. On average, Wisconsin currently spends about 50 percent more than the national average for each older person who receives Medicaid, at least in part because the proportion of older people in expensive settings like nursing homes is much higher in Wisconsin than in the nation as a whole. Over half our Medicaid budget is used for long term care; only two states in the country use a higher proportion for this purpose.

To achieve the cost efficiencies needed to support more people and remain budget neutral, it will be critical that the new system achieve the following outcomes:

- **Reduce current costs per person served by providing services more cost effectively.** Whenever feasible, services must be provided in less restrictive, less expensive settings and forms. Nursing home lengths of stay must be reduced, by helping people find alternatives to long stays. Similarly, some cost-effective in-home services can delay entry into more expensive alternative community living settings, preserving natural support systems. In the current LTC system, complete packages of services are often purchased, both publicly and privately, when only selected services are needed to allow a person to remain independent.
- **Reduce the need for services.** A strong prevention and early intervention system must be developed in the new system, to help people avoid disabling conditions and to prevent unnecessary loss of functioning in people with mild disabilities or chronic illnesses.
- **Reduce the need for public subsidy for services.** The new system must provide good, timely information to people before and when the need for long term care arises, to allow them to make informed choices about purchasing services. This will allow them not only to remain independent longer, but also to conserve private resources, delaying or preventing the need for public subsidy.

Significant work has been done to estimate the costs and savings associated with redesigning the LTC system. Information gained through the Resource Center pilots, discussions with informed stakeholders and other sources are helping to refine the assumptions used in this cost model. If it is determined that new costs will not allow us to stay budget neutral, the proposal will need to be modified. If that happens, a public process will be used to assist in making needed changes.

Managing financial risk

In the redesigned system, both authority and responsibility will move closer to the individuals being served. The intent of such movement is to improve responsiveness to consumers, provide a better quality of life, and increase cost-effectiveness.

Moving responsibility and authority toward consumers means that consumers and organizations dedicated to managing their services have more discretion to make important decisions. They have more flexibility to use funding where it makes the most sense for the consumer.

With increased authority comes increased responsibility to manage spending within acceptable limits, to be cost-conscious, and to get the maximum value for each dollar spent. Accepting increased responsibility for spending involves certain risks. One risk is that service expenses will exceed the revenues from the average monthly payment per person.

Counties and other organizations manage considerable financial risk now. They have developed many techniques to protect themselves against unexpected expenses and to manage situations where expenses are high in one year but much less in other years. The redesigned system will make additional tools available that do not require reliance on the property tax.

The state will assure that all CMOs have the tools necessary to manage the risk inherent in increased responsibility. The state will also continue to share risk with CMOs. Risk and responsibility will be phased-in over time (3 years) until the appropriate balance between state and CMO responsibility is reached. The rate at which this happens will depend on the extent to which needed tools are available, the desire of the CMO for more responsibility and the capability of that CMO to manage more authority and more responsibility. Risk management experts from the state, counties and the private sector are currently working to flesh out the details of risk-sharing arrangements.

Assuring adequate funding for direct services

The Department will establish requirements to assure that a high percentage of the per-person monthly payments will be used for direct, current-year benefits to consumers. Administrative overhead costs must be managed in the new system so that funding for services will provide the level of service that people need. Limits on non-service costs will vary by the size of the organization (number of members). Higher allowances for administrative costs are likely during a start-up period, when the organization has few members.

The requirement that a high percentage of payments be used for direct benefits will apply to the overall system. If a county or other organization serving as a CMO wishes to sub-contract the entire CMO function (i.e., transfer care management and service provision to another organization) for a group of people, the requirement will apply to the original service payment amount, not to each organization separately. In addition, all sub-contracted organizations of this type must meet the same certification standards as the primary CMO, and be approved by the Department.

Preventing cost shifting between systems

Potential cost shifting from the local system to the state. Enrollment in a CMO for the new Family Care benefit will be voluntary, with Medicaid-eligible consumers having the option to obtain LTC services through their Medicaid cards. Some have argued that enrollment should be required to access all LTC services. They recognize that with a voluntary system, there is an incentive to cost-shift away from the CMO toward the state by encouraging consumers needing expensive services not to enroll in a CMO or, once enrolled, to voluntarily disenroll. Others, especially some consumers, feel strongly that they want to keep the option

to rely on the Medicaid card for their LTC services, at least until the new system has proven itself. It is not yet clear under what conditions the federal government will allow mandatory enrollment. For as long as enrollment in a CMO is voluntary and LTC services remain available through the Medicaid card, the following procedures will be in place to encourage enrollment in a CMO and discourage potential cost-shifting:

- Resource Centers will provide pre-admission screening for all new long term nursing home admissions and inform them of all the services available at the Resource Center and of the Family Care benefit.
- Care Management Organizations will provide full assessments and service/care plans to all new nursing home admissions who are eligible for public subsidy or are likely to become so within one year.
- Resource Centers will inform all current residents of nursing homes about Resource Center services and about Family Care within a specified time frame. Residents will have the option to receive an assessment and service/care plan and to enroll in Family Care if they choose.
- The Department and State and local LTC Councils will all monitor the pattern of CMO enrollments and disenrollments.
- There will be strict limits on the ability of CMOs to involuntarily disenroll members. All such requests will be reviewed and approved by the Department.
- If a person disenrolls from a CMO to receive fee-for-service Medicaid services, the CMO will remain responsible, for one year after the disenrollment, for all Medicaid costs for those services included in the CMO's monthly per person payment that exceed the person's monthly payment level at the time of disenrollment.
- There will be performance expectations that use of Medicaid fee-for-service by people whose costs are high will decline.

Potential shifting of costs from other system to the LTC system. The LTC system will be designed to make efficient and appropriate use of other funding sources. This includes structuring the system so that Family Care is the payer of last resort, following Medicare and private insurance, when available. Services will be structured to utilize Medicare payment when Medicare-funded services are appropriate under the person's service/care plan. CMO members must retain free access to Medicare and private benefits, and CMOs and other providers will be expected to assist people in accessing those benefits when this is appropriate.

The new system will assure that Medicare beneficiaries can take advantage of Medicare benefits, such as short-term nursing home stays or post-hospital home health services for recuperative or rehabilitative care. To address this concern, the Department proposes that nursing homes continue to bill Medicare directly for services that are Medicare-covered. Other Medicare providers will also continue to bill Medicare directly for Medicare-covered services. Rates for per person payments to CMOs will reflect past state experience of Medicare and private pay payments. (See Appendix 6 for more detail.)

Provider rates

For its first two years of operation, the Department will require a CMO to pay no more than state-established Medicaid rates except under an approved variance. This will allow time for CMOs to develop their networks without the added burden of negotiating rates with providers, and provide consistency for provider organizations that may contract with several CMOs.

In the longer term, the expectation will be that CMOs develop more creative mechanisms for purchasing services, and will move toward contracting for outcomes rather than for units of service. Regional purchasing consortia will be encouraged, to create opportunities for volume purchasing of some services in rural areas and to increase the level of consistency in rates and billing processes for providers.

For additional detail about fiscal management mechanisms, see Appendix 6.

Transition to the new system

Changes of the magnitude proposed here cannot be accomplished overnight. A thoughtful transition plan must be developed and adapted as the system evolves.

Aging and Disability Resource Center pilots are currently underway in eight counties and one tribe to develop and test the functional screen and to develop effective information and assistance processes. Application materials have gone out to counties and tribes for piloting care management components of LTC redesign. Until legislation is passed, these pilots will be limited to management strategies and funding mechanisms available under current state and federal law. They will provide valuable information about clients, service utilization, and costs across settings and funding sources. In addition, they will demonstrate the capacity of counties and tribes to manage services more broadly.

After passage of enabling legislation and securing of any needed federal waivers, the new system will be phased in over a five-year period. As soon as enabling legislation is enacted, counties and tribes will be encouraged to establish a LTC Council to begin the planning process for the local system. In each of the five years following enactment, counties will have an opportunity to volunteer to operate a Resource Center and/or a CMO. To assure an orderly transition, the Department will accept up to a specified number of new counties in each year. The Department will propose to the federal government that counties and tribes have the opportunity to be the sole CMO for the first two years of operation within a given county/tribe, after which the county/tribe would have to compete with other organizations to retain its contract. (A similar arrangement was approved in Michigan's federal waiver.)

As with the current care management demonstrations, each county would begin the process of implementation of a CMO with a year of planning and infrastructure development. In each county, per person monthly payment rates will be adjusted over the initial years of CMO implementation as experience is gained, and risk will gradually be transferred to CMOs over several years. Once a CMO is in place to provide the flexible Family Care benefit for all covered target groups, a county will no longer be required to operate the Community Options or Medicaid Waiver programs. Existing clients will be offered the opportunity to enroll in Family Care or, if Medicaid-eligible, to receive Medicaid card services through the fee-for-service system.

The following table illustrates, in general, how the Department proposes to phase in the new system. Details of how many counties/tribes would be accepted could change, and the actual start date will depend on passage of state legislation and approval of needed federal waivers.

Calendar Year	Resource Centers	CMOs: Planning and Development Phase	Fully Implemented CMOs
1999	8 pilot counties	Group 1: 3-6 pilot counties	
2000	Expand pilots to full Resource Centers; Add 10-20 counties (including all CMO pilot counties).	Group 2: 8-10 additional counties	Group 1
2001	Expand to additional 30-35 counties (including all counties with CMOs in Groups 1-3 below)	Group 3: 15-20 new counties	Group 2
2002	Expand to all remaining (9-24) counties	Group 4: 25-30 new counties	Group 3
2003		Group 5: All remaining (15-31) counties	Group 4
2004			Group 5

If a county has informed the Department that it does not intend to apply to operate a Resource Center, or has not applied by 2002, the Department will seek other applicants. If a county has informed the Department that it does not intend to apply to operate a CMO, or has

not volunteered to begin the planning and development phase of CMO implementation by 2003, the Department will seek other applicants. Tribes may voluntarily apply to operate a Resource Center and/or CMO at any time. The goal is to have Resource Centers available to all Wisconsin citizens by 2002, and CMOs available to enable people who are eligible to access the Family Care benefit by 2004.Long term care funds will be "pooled" (as described earlier in this paper) into a single LTC funding stream at the beginning of the program. Initially, a portion of the LTC "pool" of funds will be used to fund LTC services that are paid on a fee-for-service basis or allocated to counties, and a portion will be used for monthly per member payments to CMOs to provide Family Care. The proportion of the LTC pool used to fund Family Care will change over time to reflect the extent to which people enroll in CMOs for Family Care.

Evaluation

During the transition, ongoing evaluation will be performed to determine whether the new system is achieving its goals and what effects the system changes are having on consumers. Problem areas discovered by the evaluation or other processes will be addressed as the system is fine-tuned during implementation.

Transitions for consumers

The new system cannot be expected to accommodate all current and potential new clients at once. In general, the following will be the phase-in plan. As soon as the Resource Centers are in place in an area, everyone who is newly seeking admission to licensed or certified residential LTC services will be required to access those services through a Resource Center. As soon as a CMO appropriate to a client's needs is available in an area, any new or current LTC client meeting functional eligibility may enroll in a CMO to access Family Care.

Current nursing home residents will not be required to have a functional screen, but Resource Centers will be required to offer them information about the services of the Resource Center and the new Family Care benefit within a specified time frame. Residents will have the opportunity to receive an assessment and service/care plan and to enroll in Family Care if they choose. No nursing home resident will be required to move to a different setting, but all will be free to choose that option if a requested service/care plan indicates that it is feasible.

For the foreseeable future, we envision a voluntary system where individuals are able to choose services through Family Care or through the current fee-for-service system. If the new system proves to be effective at meeting the needs and preferences of consumers, the Department will consider transition to a system in which all eligible people receive LTC services through Family Care. Prior to any such decision, the Department will engage in a broad-based public participation process and seek endorsement from the Governor, the Legislature, and the federal government.

To the extent people currently served in nursing homes, the Community Options Program, and Medicaid Home and Community Based Waiver Programs have a "long-term, irreversible condition," they should also meet criteria established for the new comprehensive level of

support. It is the Department's intent to continue eligibility to people served by these programs, or at this level of care, if for some reason they do not meet the "comprehensive support" criteria for Family Care. While they would retain their eligibility, the actual services they receive under Family Care may vary, based on their comprehensive assessment and service/care plan.

Transitions for counties

Counties currently operate a number of community care programs from which consumers will be free to transfer to Family Care. To assist in the transition from the old system to the new, enabling legislation for redesign will include provisions designed to give counties more flexibility and allow them to prepare for the new system. These will include provisions to:

- Allow the Department to waive any statutory provision or regulation governing the Community Options Program, Home and Community-Based Waiver Programs, or Medicaid fee-for-service for up to five years, provided that (a) such waivers are in compliance with federal law and are consistent the program's intent; and (b) the waivers are deemed necessary for the effective implementation of Family Care.
- Remove the limitation that COP funds carried over by a county must be spent within the following year, and authorize carried-over funds to be used either for client services or for investment in a risk reserve for Family Care.
- Remove the $500,000 limit on the statewide COP high cost fund and expand allowed uses of the fund to include planning and implementation of the new system.
- Authorize counties to create risk reserves for Family Care.
- Authorize counties to contract with providers using prepaid or postpaid contracts that provide a fixed payment for each person served by the provider in return for a defined set of expected outcomes determined by the county.
- Amend current statutes related to allowable costs as possible under federal regulations.
- Authorize counties to enter into a joint venture with a private or public organization, provided that certain protections are in place.

The Department will work continue to work closely with counties and tribes to assure that their concerns are adequately addressed.

Transitions for service providers

Major redesign of funding mechanisms for LTC will also have serious implications for service providers. Many current providers will need to change current arrangements and business practices to be effective in the new system. New providers may also emerge to fill current gaps in the system. The Department will provide training and technical assistance to providers to assist in this transition. Providers will be asked to help design this training.

Some service providers have expressed concern about the possibility that they will need to interact with many different rate schedules and processes to access public funding for the services they provide. A great deal of inconsistency from one CMO to another could increase overhead costs for billing processes. For the foreseeable future, the Department will therefore establish standards for a minimum level of consistency in rates for common services and require CMOs to pay no more than state-established Medicaid rates except under an approved variance. After more experience is gained, the Department will evaluate the results and finalize a set of standards that achieves reasonable balance between the need for consistency and the need of organizations to negotiate the most appropriate rates. The Department will also explore the possibility of establishing uniform standards for billing and service authorization forms.

Nursing home operators have expressed concern (a) that the proposed pre-admission screening process could delay new admissions, if not done well; (b) that transition to the new system could temporarily affect stability of the resident census; and (c) that Medicare funds for short term stays would be lost. This proposal addresses these concerns in several ways, including timeliness requirements for Resource Centers, mechanisms allowing nursing homes to continue to bill Medicare directly, and allowance for a reasonable time frame for completion of the functional screen for post-hospital and emergency admissions. To further develop the details of an effective transition plan, the Department will establish a work group, that will include representatives of the nursing home industry. The plan will address such issues as timeliness and coordination of functional screen and related processes, consumer protections against CMO-proposed changes in consumer residence, and the time table for implementation of the new system.

Appendix 1:
LTC definition; goal and guiding principles of redesign

Long term care is any service or support that a person needs because a disability or chronic illness limits his or her ability to do the everyday things in life, such as bathing, eating, dressing, using the toilet, or moving around one's living environment. Long term care can be provided in many settings, including: a person's own home; a nursing home; a residential facility such as a group home, community based residential facility, assisted living facility, or adult family home; or a community setting such as adult day care or the workplace.

For purposes of this proposal, "long term care" is defined as follows:

Long term care and support encompasses the organization, delivery, financing, administration and coordination of an array of services designed to assist people who are limited in their ability to function independently over a relatively long period of time. The intensity of the need may vary over time. The long term care system coordinates social, supportive, rehabilitative and health services across all settings.

Long term care and support services are designed to help individuals and families:

- Perform basic life functions.
- Improve skills and capabilities to maximize independence and function.
- Maintain optimal health status.
- Establish and maintain social and personal relationships in the individual's own neighborhood and community.
- Care for family members with functional limitations.
- Provide comfort, supervision and support to people with an irreversible illness or condition when needed.

These services include (but are not limited to) assessment, care management and coordination of services and supports, assistance in eating, bathing, dressing, getting in and out of bed, moving about living area, doing housework, getting and/or keeping own home, vocational services, managing illness symptoms including taking medications, rehabilitative services, adaptive aids, transportation, nursing homes, and other residential services. It also includes medical treatment and skilled and therapeutic care for the management of chronic and long term conditions.

The **goal** of the redesign is to foster the development of a statewide and comprehensive long term care system that maximizes independence, recovery and quality of life, while at the same time recognizing the need for interdependence and support. The redesigned system would provide individuals and their families with meaningful choices of LTC supports, services, providers, and residential settings, as long as such care or support is necessary, meets an adequate level of quality, is cost-effective, is consistent with the individual's values and preferences, and is within available resources. The system would also assure that primary

and acute health care services are coordinated with LTC services for all people who have LTC needs.

Among the key **guiding principles** for the redesign effort were the following:

- The system should be understandable, efficient, responsive, reliable and easy to access.
- The system should maximize flexibility, effectiveness, innovation, practicality and creativity in funding sources, services and resources.
- The system should be consumer centered and family focused.
- The system should maximize support to and from friends, family, neighbors and the community, recognizing the importance of informal supports.
- Resources and funding should follow the person.
- The system should ensure access to a range of flexible LTC services and supports, with supports based on an individualized assessment and service/care plan.
- Providers should have shared responsibility with consumers for positive outcomes.
- The system should provide opportunities and support for people to sustain or create important relationships and social roles, to be included in the life of the community, to contribute to society, and to achieve the greatest fulfillment possible.
- The system should provide supports that facilitate, promote and reward personal responsibility.
- The system should seek to provide maximum value and quality for dollars spent.
- The system should encourage collaboration among federal, state, county, tribal and private agencies and consumers in the design and provision of LTC.
- The system should assure that services are provided according to quality standards and outcomes desired by the consumer.

Appendix 2: Functional eligibility requirements

Although there are other ways to measure a person's need for LTC services, the most commonly used are screens that measure a person's limitations in activities of daily living. These limitations have been found to predict nursing home admission, use of paid home care and other alternate care arrangements. Wisconsin's experience, as well as that of other states, has shown that determining an individual's care level based on individual functional need is an accurate and appropriate indicator of eligibility for LTC services. A number of screening and assessment tools currently in use around the country are based, at least in part, on these measurements and could serve as models for such instruments to determine eligibility for Family Care.

Eligibility for the new benefit at either the comprehensive support or the intermediate support level will be based on the findings of a functional screen performed by staff of the Resource Center. Information found by the functional screen will follow a person found functionally eligible to the CMO, where the information will feed into a full assessment of needs, strengths and preferences.

Definitions and background

- **Activities of Daily Living (ADLs)**: The functions or activities normally performed in the course of a normal day in an individual's life, including bathing, dressing, eating, transferring, toileting, and mobility.

  1. **Bathing**: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn on and off faucets, regulate appropriate water temperature, wash and dry fully.
  2. **Dressing**: The ability to dress and undress as necessary and choose the appropriate clothing for weather and street attire. This also includes the ability to put on prostheses or assistive devices and fine motor coordination for buttons and zippers.
  3. **Toileting**: The ability to use the toilet room, commode, bedpan, or urinal. This includes transferring on/off the toileting utensil, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting of clothing.
  4. **Transferring**: The ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to reach assistive devices necessary for ambulating.
  5. **Mobility**: The ability to move between locations in the individual's living environment.
  6. **Eating**: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to chew, swallow and cut food.

- **Instrumental Activities of Daily Living (IADLs):**

These include a range of self maintaining activities more complex than those needed for personal care and include being able to cook, shop, telephone, do housekeeping tasks, manage medications and treatments, arrange transportation and manage finances.

Generally, people may show limitations on instrumental activities of daily living and still be able to take care of all activities of daily living independently. However, people with deficiencies in one or more instrumental activities of daily living have been shown to be more likely than those who are totally independent to be hospitalized, to enter a nursing home, to require other alternate care arrangements or to die within the year.

The following six **identified IADLs** are essential to an individual's maintenance of health, safety and quality of life:

1. **Meal preparation/nutrition**: The ability to obtain, plan or prepare routine hot and/or cold, nutritionally balanced meals. This includes the ability to independently open containers and use kitchen appliances.
2. **Management of medications and/or treatments**: The ability to self-administer medications and perform treatments as ordered by a physician.
3. **Use of telephone**: The ability to use a telephone to communicate essential needs. This includes the ability to answer, dial, articulate and comprehend.
4. **Money management**: The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle paper work and coins. This includes the ability to read, write and count sufficiently.
5. **Transportation**: The ability to use public or private common carrier transportation without accompaniment during the ride.
6. **Employment**: The ability to function at a job site without assistance, to perform on-going job duties. This does not include the need for assistance with ADLs and other IADLs.

- **Functional limitation**: The individual's overall age-appropriate functional capacity is diminished because the person's condition, illness, injury or disability interferes with the individual's ability to function within a reasonable range of independence. The individual's functional abilities are limited in the areas of activities of daily living or instrumental activities of daily living. In addition, as a consequence of the individual's functional limitation, the person requires periodic assistance from another person to meet his/her needs. The person is at risk of losing independence.
- **Physical assistance**: The physical presence of another individual for hands on care, cueing or supervision. The need for physical assistance means that the individual cannot perform the activity safely or appropriately without the help of another person.
- **Need for cueing**: The individual is unable to remember or understand specific activities and/or is unable to make the decision to initiate an activity. Activities would not be completed without the presence of another person.

- **Need for supervision**: The individual requires the physical presence of another person to assure activities are completed adequately and safely. Supervision includes oversight, encouragement or cueing.
- **Developmental Disability** (state definition):A disability attributable to brain injury (without regard to age of onset), cerebral palsy, epilepsy, autism, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. Developmental disability does not include senility which is primarily caused by the process of aging or the infirmities of aging.

Functional eligibility criteria for comprehensive support

People who meet the criteria for this benefit category have long term, irreversible conditions that impair either their cognitive or physical functioning, requiring that they receive ongoing assistance from another person to meet their needs. These are individuals whose health and safety is in serious jeopardy if they do not receive service. A full range of case-managed LTC services must be available to address LTC needs. People eligible for this level of support are assured prompt access to services.

The following list of programs and levels of care are included here for comparative purposes. To the extent people served in these programs, or at these levels of care, have a "long-term, irreversible condition," they should also meet criteria established for the new comprehensive level of support. It is the Department's intent to continue eligibility to people served by these programs, if for some reason they do not meet the new comprehensive support criteria. While they would retain their eligibility, the actual services they receive under the new benefit may vary, based on their comprehensive assessment and service/care plan.

- Intensive Skilled Nursing Level
- Skilled Nursing Level Facility
- Intermediate Care Facility Levels I and II
- Intermediate Care Facility for the Mentally Retarded (ICF-MR)
- Alzheimer's Family Caregiver Support Program
- Community Integration Program 1A
- Community Integration Program 1B
- Community Integration Program II
- Brain Injury Waiver
- Community Options Waiver
- Community Options Program

Functional Eligibility Criteria for Comprehensive Support Level

Long Term, Irreversible Condition. Must have an irreversible or long term condition expected to last at least 90 days or to result in death within 1 year from date of eligibility.

AND

Functional Limitation. The person needs ongoing assistance (hands on care, cueing, or supervision) from another person in safely, or appropriately performing:

- 3 or more of the critical 6 ADLs (bathing, dressing, using the toilet, eating, mobility, transferring) or,
- 2 or more of the 6 ADLs and one or more of the identified IADLs (meal preparation/ nutrition, management of medications and/or treatments, use of telephone, money management, transportation, or employment) or,
- Five of the above 6 IADLs.

OR

A. Complicating Condition. The person has a complicating condition which limits the person's ability to independently meet his/her needs as evidenced by meeting at least one criterion from each of the following groups:

- Complicating condition criteria (must meet one)

1. Requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or
2. Requires frequent changes in service due to intermittent or unpredictable changes in his/her condition which are either medical or cognitive in nature, or
3. Requires a range of interventions (medical or social) due to a multiplicity of conditions, which are either medical or cognitive in nature.

AND

B. Objective criteria (must meet one)

1. Meets definition of a developmental disability and requires specialized services.
2. Has impaired cognition which is exhibited by the following:
   - Short term memory loss
   - Disorientation to person, place, time and location
3. Impaired decision making ability which is exhibited by two of the following:
   - Wandering
   - Physical abuse of others
   - Resistive to care.
4. Has condition requiring special care/complex intervention:
   - Intravenous intervention
   - Oxygen therapy
   - Stage 3 or 4 pressure ulcer
   - Tracheotomy care
   - Ventilator or respirator use
   - AIDS

Functional eligibility criteria for intermediate support

People who meet the criteria for this benefit category have long term or potentially long term conditions that put them at risk of losing independence or at risk of serious decline in age-appropriate functional capacity. Because of physical or cognitive impairments, they need periodic assistance from another person to meet their needs. A wide array of community based services must be available to address their needs. People eligible for this level of support are assured access to non-institutional long-term care (i.e., they are assured of non-institutional services under the new benefit), if they are Medicaid-eligible or have confirmed adult protective service (APS) needs. People eligible for this level of support who are not Medicaid-eligible, or who do not have confirmed APS needs, will be served to the extent possible, but are not assured of the new benefit.

People currently receiving services under the following programs/funding sources, may meet the intermediate support level criteria: certain Community Aids funded services, such as snow shoveling and chore services, or home-delivered meals, under the Older Americans Act. Some people currently receiving adult protective services may also be found eligible at this level. The Intermediate Support level criteria are as follows:

Long Term or Potentially Long Term Condition. Condition, illness, injury or disability with potential to last at least 90 days from date of service eligibility.

AND

Functional Limitation Criteria. The person needs at least periodic assistance (hands on care, cueing or supervision) from another person in safely or appropriately performing:

- 1 of 6 identified ADLs **or**
- 1 of these critical IADLs: meal preparation/nutrition or management of medications and/or treatments.

Appendix 3: Client financial eligibility and cost sharing

The new LTC system will be designed so that there is no "cliff" of in/out financial eligibility. There will be no specific income or asset threshold. Instead, cost sharing will be designed on a "sliding scale" based on the combined factors of income and assets. This approach, similar to the one now used in the Community Options program, provides the most complete and realistic assessment of a person's financial resources and ability to contribute to LTC costs.

All clients will be required to share in the cost of their services to the extent of their ability to pay. Cost share requirements will range from none (for those with few financial resources) to the full cost of the service/care plan for those with more personal resources. Persons eligible for SSI cash payments will not have to undergo a separate financial test for public subsidy of LTC and will have no cost share. Cost sharing requirements will be designed to substantially reduce the disincentives to work that exist in some current programs. Spousal impoverishment protections will be maintained in Family Care. Divestment and estate recovery provisions will apply to Family Care. All set amounts used in the calculations for cost sharing will be indexed for inflation.

Assets

The following assets will be exempt (i.e., not counted as available for client cost-share:

(a) the client's home while the client, spouse, child under 21, disabled child, and/or other dependent is residing in it. For a client in an out-of-home placement (i.e., nursing home, CBRF, adult family home, or assisted living), the client's residence is exempt for up to 1 year after the client leaves his/her residence, unless one of the above persons resides therein or special circumstances warrant an extension.

(b) household goods and personal possessions,

(c) a car used for essential purposes,

(d) income-producing business property that is in current use, as defined in SSI and Medicaid rules,

(e) spousal impoverishment protections, (Under the spousal impoverishment program, a portion of the couple's assets is exempt from the client's cost-sharing requirement on the grounds that these resources enable the client's spouse to live in the couple's residence and remain as self-sufficient as possible.)

(f) a savings or checking account composed of work earnings,

(g) a lump-sum asset deduction of $12,000 for individuals living in their own residences and $9,000 for individuals in out-of-home placements. These assets could be used for any purpose (insurance, burial trust, legacy, home repairs, etc.). The amount of this exemption will be indexed for inflation in future years. The higher amount of exempt assets for homeowners (or renters who are responsible for repairs) is intended to reflect the need for capital repairs (e.g., roof or furnace replacement).

Notes about proposed asset exemptions

Exemptions (a), (b), and (c): All of these assets are currently exempt for financial eligibility determination for MA and SSI. (The housing asset exemption period currently in MA and SSI for clients in out-of-home placements differs somewhat from the exemption period recommended above.) Because they are instrumental in enhancing an individual's independence and ability to remain in a community-based setting, these asset exemptions will be maintained for the new Family Care benefit.

Exemption (d): Income-Producing Business Property: Income-producing business property will be exempt provided that it is in current use and generates positive net income over a reasonable time period, consistent with current SSI and MA rules. The income from the property would not be exempt, but would be subject to the cost-sharing rules described below. The rationale for providing an exemption for income-producing business property is that it creates an income flow that can be applied by the client to his/her cost-sharing obligation. The requirement that the property be in current use to be exempt is a current requirement in SSI. A farm qualifies as business property.

Exemption (e): Spousal Impoverishment Protections: Under the spousal impoverishment program, a portion of a couple's assets is exempt from the client's cost-sharing requirement on the grounds that these resources enable the client's spouse to live in the couple's residence and remain as self-sufficient as possible.

Exemption (f): Savings and Checking Accounts composed of Work Earnings: The purpose of this exclusion is to provide an incentive for long-term care clients to work by providing them the opportunity to accumulate work earnings over time. A segregated account of similar nature is currently used in the SSI program as part of a PASS (plan for achieving self-support) plan under which an individual may set aside income and/or assets for a vocational goal. These resources are not counted against the SSI limits for up to 4 years. For the Family Care benefit, there will be no time limits and no restrictions on the use of funds from these accounts, such as requiring that the earnings be used for work-related expenses (e.g., a computer), purchasing or remodeling a home, or a car. Monitoring the expenditures from such accounts to ensure that the expenditures meet specified criteria would create a new administrative burden and could contradict the purpose of the exemption, which is to encourage work by clients who are able to work and wish to do so.

Exemption (g): Lump-sum asset exemption: A single asset exemption amount would replace the current separate asset exemptions for liquid assets, life insurance, prepaid burial items, and a burial trust. Currently, an individual has the following separate asset exemptions in MA and SSI:

- $2000 Maximum Value of Liquid Assets
- 1500 Maximum Value of Life Insurance
- 2000 Maximum Value of Burial Trust
- Any Value of Pre-paid Funeral Expenses. (The average amount of prepaid expenses for MA and SSI recipients is $1800.)
- In the Community Options Program, a LTC client living in his or her own residence is allowed to retain an additional $3,000 of assets. The rationale is that these additional assets can be used to address unexpected expenses, such as home repairs, that arise for individuals living in their own residences. The exemption will be available to a person who owns the home they live in or to a renter who is responsible for repairs and maintenance.

If a person is admitted to a residential LTC facility and a determination is made that he or she will not return to his/her residence, the client's asset exemption would be reduced by $3,000 since he/she will no longer have need of an "emergency fund."

The $12,000 initial level for the lump sum asset exemption is proposed because it covers the value of the current separate exemptions, provides some adjustment for inflation for the liquid asset exemption, and provides an amount for emergency expenditures for individuals living in their own residences.

Exempted employment income

The following income will be exempt in calculating cost sharing for the Family Care benefit:

- a portion of earnings from current employment; specifically, $200 plus 2/3 of the remaining monthly earnings up to a maximum exemption of $1250/month (after taxes).

As part of the current SSI and SSI-related MA financial eligibility, an individual is allowed to exempt from client cost-share consideration $65 plus half of his/her remaining after-tax earnings from current employment. This exemption will be changed in the redesign legislation to $200 plus 2/3 of the remaining monthly after-tax earnings up to a maximum exemption of $1250/month. Both the $200 initial exemption and the cap would be indexed to inflation.

This formula (without the cap) was proposed by the federal SSI Modernization Project in 1992. Adopting the Modernization Commission's earned income deduction is consistent with the objective of setting a stronger work incentive than current policy. This exemption will apply only to earnings from current employment, not to other types of income such as pension payments, rental income, capital gains, or interest or dividend earnings from investments. Other deductions noted below (e.g., for basic living expenses, dependent care allowance, etc.) would apply to the "countable" (non-exempt) portion of the client's earnings from current employment. The purpose of setting a maximum or cap on this exemption is to ensure that individuals with moderate or high levels of work earnings are contributing to their cost of care.

Deductions from combined, non-exempt assets and income

In calculating a client's monthly cost share amount, the following will be deducted:

(a) allowance for dependent(s), such as a spouse or dependent children, set at $452/dependent for 1998 and adjusted annually for inflation;

(b) out of pocket medically and remedial-related expenses,

(c) court-ordered payments and cost-share requirements for other programs paid by the client;

(d) basic living expenses, set at a floor of the SSI-E level (currently $674) and a ceiling of $1000 for clients in their own residences, and at $65 for clients in out-of-home placements, with the ceiling adjusted annually for inflation;

(e) other exemptions that can be authorized by DHFS.

Notes about deductions

Exemption (a): Allowance for Dependent(s): Currently, the Community Options Program (COP) provides an allowance of $418 per dependent. This amount changes annually and is based on the federal family poverty levels. The same dependent allowance would be maintained for the new Family Care benefit.

Exemption (b): Out-of-Pocket Medically and Remedial Related Expenses: The current major long-term care programs (MA and COP) allow deductions of health insurance premiums and other out-of-pocket medically or remedial-related expenditures in determining client cost-sharing and/or financial eligibility. This is required by federal law. The current COP policy regarding these types of deductions would be maintained for the new Family Care benefit. The COP program has developed a list of examples of allowable medical and remedial expenses for deduction purposes. Since the client will need to make these payments for medically and remedial related expenses, this income should not be "counted" as available for LTC cost-sharing.

Exemption (c): Court-Ordered Payments and Cost-Share Requirements for Other Programs Paid by the Client: Since the client is required to make these payments, this income should not be "counted" as available for LTC cost-sharing.

Exemption (d): Basic Living Expenses: For LTC clients living in settings other than nursing homes, ICFs-MR, CBRFs and adult family homes, the deduction for monthly housing and living expenses will be set so there is a "floor" equal to the SSI-E payment (currently $674) and a "ceiling" of $1,000. If a client's actual basic living expenses are lower than the

minimum or "floor" amount, the client receives the "floor" level deduction of $674. If actual housing and living expenses for the client fall between the floor and ceiling, the individual would deduct the amount of actual expenses. If actual housing and living expenses for the client exceed the $1,000 ceiling, the client would be allowed to deduct only the ceiling amount. The minimum or floor level was chosen to ensure that SSI and non-SSI clients are treated in a consistent, equitable manner. The ceiling is based on the Medicaid Waiver personal allowance upper limit, and will be adjusted annually for inflation. It should be noted that LTC clients often need special housing to accommodate their needs, such as an extra bedroom for a live-in attendant.

The care management organization (CMO) would pay the room and board costs of nursing homes, ICFs-MR, CBRFs, and adult family homes. For clients in these settings, the basic living expense allowance would be $65 per month. This level is similar to the personal needs allowance currently in Medicaid. The remainder of the client's income is subject to the cost-sharing rules.

Exemption (e): Other Exemptions that Can be Authorized by DHFS: The Workgroup recommends that the cost-share formula include a provision that allows DHFS to authorize other exemptions or deductions from income or assets on a case-by-base basis. This provision will allow DHFS to respond to unusual or unforeseeable circumstances in particular cases. It is expected that this provision would be utilized infrequently.

SSI recipients

Because SSI eligibility levels are set below the poverty threshold and the above exemptions and deductions are slightly higher than SSI levels, SSI recipients will not be subject to a cost-sharing requirement for services under the LTC system. (That is, persons who are eligible for SSI cash payments will have income and assets below the "floor" where client cost-sharing begins for the LTC system.) SSI recipients may be required, however, to contribute to the room and board costs associated with residential services, as is now the case. To retain SSI income assistance benefits, SSI recipients who are LTC clients will need to adhere to the stricter SSI financial eligibility criteria regarding income and assets, rather than the higher income and asset rules under the LTC Redesign System. SSI recipients will not be subject to another financial assessment for the LTC System. On the attached form this is reflected in the first line, where SSI recipients are instructed to go directly to the last line of the form and enter "0" for client cost-sharing requirement.

Treatment of remaining resources

All client financial resources remaining after exemptions and deductions will be required to be used as the client's LTC cost-sharing contribution, up to the cost of the client's service/care plan for LTC services. The LTC maximum for cost sharing will be based on the cost estimates for paid services that are developed as part of the care planning process. It will not be based on actual expenditures, which may vary slightly from original cost estimates from month to

month. This is the approach currently used in the Community Options Program and in Medicaid coverage for nursing home care. The following examples illustrate the proposed approach.

Client A: After asset and income deductions and exemptions noted above, client has monthly financial resources of $1000. Client's LTC care/service plan costs total $1500/month. Client would be required to contribute full $1000 of remaining monthly resources to LTC program.

Client B: After asset and income deductions and exemptions noted above, client has monthly financial resources of $1000. Client's LTC service/care plan costs total $700/month. Client would be required to contribute $700/month to LTC program and would retain $300/month for him/herself.

The last page of this appendix describes the relationship among the client's capitation rate, service/care plan cost, cost-sharing requirement, and estate recovery assessment.

Implementation issues

Review Procedures: A client's cost-sharing requirement will be redetermined at least once every six months to ensure that the cost-sharing requirement accurately reflects the client's financial and service/care plan status. If the client's income, assets, or care/service plan costs change by a significant amount, the client cost-share requirement should be redetermined immediately. The client will be responsible for reporting any change in income or assets.

WI LONG TERM CARE FUNCTIONAL and FINANCIAL ELIGIBILITY SCREEN [6]

Module VII: Financial Information -- Client Cost Share

Participant's Name:

PRE-SCREEN INCOME ESTIMATION

SINGLE:		COUPLE OR FAMILY:	
☐	Under $8,000	☐	Under $11,000
☐	$8,000--$14,999	☐	$11,000--$14,999
☐	$15,000--$24,999	☐	$15,000--$24,999
☐	$25,000--$39,999	☐	$24,000--$39,999
☐	$40,000 or higher	☐	$40,000 or higher

PART 1.

A. SSI / MEDICAID STATUS	
1a **CHECK** if person is receiving SSI cash benefit. If so, enter zero on line 29 (client's cost sharing).	☐ 1A. Yes
1b **CHECK** if person is receiving Medicaid but not SSI. If so, enter zero on line 9, and continue.	☐ 1 B. Yes
If neither Medicaid nor SSI is checked, continue with next section to determine eligibility.	

B. Eligibility Based on Twelve-month Resource Estimate Assets of Participant without Spouse:	
2 ENTER the estimated total of cash on hand plus amounts in checking and savings accounts plus value of stocks and securities plus the estimated cash value of life insurance.	2

[6] This worksheet is currently being tested in Aging and Disability Resource Center Pilots.

3 ENTER estimated value of countable property. (See Instructions)	3
4 ADD the amounts in 2-3.	4
5 SPOUSAL ALLOWANCE: If applicant has spouse living in own residence, enter allowance according to the following schedule.	
If couple's total countable assets are: a. $161,520 or more; b. Less than $161,520, but greater than $100,000; c. $100,000 or less — **THEN allowance is:** a. $80,760; b. One-half of couple's total countable assets; c. $50,000	5
6 Subtract line 5 from line 4.	6
7 SUBTRACT a $9,000 allowance from line 6 if participant will be living in an out-of-home placement.	7
8 SUBTRACT a $12,000 allowance from line 6 if participant will be living in his or her own residence. If the result is zero, enter zero.	8
9 MULTIPLY line 7 or 8 by 0.0833 to determine portion of assets to be added to income each month for 12 months.	9

C. Income of Person(s) Applying for LTC Service Funding

10. ENTER participant's after-tax monthly income from current employment.	10
11. ENTER $200 of earnings plus 2/3 of remaining after tax earnings, or $1250, whichever is less.	11
12. SUBTRACT line 11 from line 10 to find countable income from current employment.	12
13. ENTER all other monthly income (Soc. sec., net rent, pensions, interest, etc.).	13
14. ADD lines 12 and 13 to find **TOTAL COUNTABLE MONTHLY INCOME.**	14

PART 2. PARTICIPANT SHARE

15. COPY the asset amount from line 9 in PART 1.	15

16.	COPY income from line 14.	16
17.	Enter all UNEARNED monthly income of dependent children (dependent as defined in tax code) except means-tested or social security payments. Leave out EARNED income of these children.	17
18.	ADD lines 15 through 17 to determine monthly resources.	18
19.	Spousal Income Allowance (See instructions)	19
20.	Allowance for children & other dependents living in the home. The number of dependents is _______ times $452 = For each child who lives outside participant's home, multiply $452 by the proportion of time child is in participant's home.	20
21.	Enter average out-of-pocket medically and remedial related expenses anticipated when LTC case plan is in effect. (See instructions for definition of medically and remedial related)	21
22.	Enter court-ordered payments paid by participant.	22
23.	Enter other Cost share amount(s) to public or private programs paid by participant (See instructions).	23
24.	Enter allowance for housing maintenance when in out-of-home placement. (See instructions.)	24
25.	A. If living in own residence, ENTER $674 as a personal maintenance allowance OR enter actual monthly personal maintenance costs, if between $674 and $1000. (See instructions.) Do not enter more than $1000. B. If living in an out-of-home placement, enter $65.	25
26.	Total of lines 19 through 25.	26
27.	SUBTRACT line 26 from line 18 to find monthly resources available for cost sharing allowed by the State.	27
28.	Enter any special allowance(s) authorized by DHFS for the individual.	28
29.	SUBTRACT line 28 from line 27. Use this amount as the Maximum Monthly Participant Contribution.	29

Relationship among client's capitation rate, care/service plan cost, cost sharing requirement and estate recovery requirement

Note: Client cost share and estate recovery assessment for the new benefit are based on the client's service/care plan cost. It will not be based on the capitation rate, nor on actual expenditures. Unless there is a major change in a client's income or assets, or a new service/care plan is developed due to a change in the client's condition or natural support network, the cost sharing amount will be stable over a long period of time.

Example 1:	Client A	Client B
Capitation Rate	$2,000	$2,000
Care/service plan Cost	$1,500	$2,500
Client Cost Share	$1,000	$2,000
Estate Recovery Assessment	$500	$500

(Client Care/service plan Cost minus Client Cost Share)

Net Effect on State		
Client Share Payments	$1000	$2000
Estate Recovery	$500	$500
Cap. Payment to MCO	-$2000	-$2000
Total	-$500	$500

Example 2:	Client A	Client B
Capitation Rate	$2,000	$2,000
Care/service plan Cost	$1,700	$2,300
Client Cost Share	$700	$2,200
Estate Recovery Assessment	$1000	$100

(Client Care/service plan Cost minus Client Cost Share)

Net Effect on State		
Client Share Payments	$700	$2200
Estate Recovery	$1000	$100
Cap. Payment to MCO	-$2000	-$2000
Total	-$300	$300

Appendix 4: Elements of Consumer-Directed Support

Guiding principles of Long Term Care Redesign provide that decisions will be made by the person who is closest to and most knowledgeable about the consumer's needs and preferences, that the system will maximize flexibility and creativity, and that the system will maximize support from family, friends, neighbors and the community. This appendix provides an outline of the elements of a consumer-directed support option as a strategy to implement these principles. It draws from the planning and experience coming out of the Robert Wood Johnson Self-Determination Learning Projects being carried out by several county developmental disabilities service systems. The model will be further refined by a work group currently underway that includes consumers from all target groups included in this proposal. Elements of consumer-directed support include:

Consumer control over an individual budget. An annual budget is set for the individual based on factors that take into account the person's past support costs and current circumstances and support needs. The individual and his/her support circle, working with a support coordinator, is then responsible for living within the budget, but has broad discretion over what to buy and when to buy it. A person's budget for future years is not reduced because he or she comes in under budget. Reserve funds, within established limits, are available to allow for changing or emergency needs. An appeal mechanism is available for consumers who believe that their budgets are inadequate to meet their support needs.

Availability of a support "coordinator" or "broker." The support coordinator is responsible for assisting with development and implementation of a person-centered plan. The support coordinator is different from a traditional case manager in: (1) being chosen by the consumer and support circle; (2) having a primary mission of implementing the consumer's goals, rather than goals set by the system; (3) having the skills to identify informal and generic sources of support, as well as traditional human services, and in assisting consumers and support circles to choose supports and fit them into a budget; and (4) assisting the consumer and support circle in negotiating rates and contracting for services with chosen providers. The option should be available for the consumer or circle to choose to do the tasks of a support broker, except for a minimal level of review to ensure that public funds are used for allowable purposes and to ensure health and safety.

Flexibility in nature of services and provider. Consumer-directed support is distinguished not by the nature of the service or the service provider, but by the fact that the purpose, type and means of support are chosen by the consumer and/or those closest to the consumer through a system that supports and facilitates self-determination. A central goal of consumer-directed services is to promote the use of informal supports, generic services, and innovative ways of meeting client needs. Use of existing community resources avoids "professionalizing" the person's human needs, builds community connections at the same time as support needs

are met, and in many cases is more efficient than human service solutions. For these reasons, services available as consumer-directed supports are not limited to a list of traditional human services, and providers are not limited to preset qualifications. Rather, the consumer's individual plan must show how a particular use of resources will address plan goals, and set individual criteria for support or provider characteristics needed to ensure effectiveness and consumer health and safety. This does not preclude the individual from choosing more traditional human services from contract providers where that meets his or her needs and preferences.

Mechanisms to assist with managing budgets and paying or employing providers. Methods for giving consumers functional control of funds include: contract systems where providers are paid based on individual costs of consumers who choose their services; voucher systems; checking systems; debit card systems; and cash reimbursement of consumers. Consumer control of funds does not require that the consumer have the skills or make the commitment to carry out fiscal management. Fiscal intermediaries and employment services are made available to handle payment of providers, pay taxes and benefits, or act as employer of record for providers chosen by the consumer.

Methods to ensure quality, health and safety. The support coordinator remains responsible for ensuring that plans ensure consumer health and safety. Protective systems for prevention of abuse and neglect remain in place and are implemented. Outcome-based evaluation is applied to measure the level of consumer control, consumer satisfaction, and achievement of both consumer goals and system quality outcomes.

Appendix 5: Composition, Appointment, and Roles of State and Local LTC Councils and Governing Boards

State LTC Council

Composition and appointment:

- The Council will have 25 members. At least 51 percent of the Council's members will be elderly people, people with physical disabilities, people with developmental disabilities, and their family members, guardians and other advocates, proportional among the three target groups. Of these consumer representatives, at least two-thirds must be elderly people, people with physical disabilities and people with developmental disabilities; not more than one-third may be family members, guardians or other advocates. Consumer members will be appointed by the Governor from a pool of nominations solicited by the Secretary of the Department of Health and Family Services and submitted by consumers, family members, guardians, and organizations representing older people and/or people with disabilities. Consumer representatives will be trained and supported to enable them to participate effectively in the deliberations of the Council, and reimbursed for reasonable expenses associated with participating.
- The chair of the Council will be appointed by the Governor.
- The balance of members will be county and tribal representatives, service providers, state officials and other community leaders, appointed by the Governor from pools of nominations solicited by the Secretary and submitted by respective stakeholders.

Roles:

- Assist the Department in developing broad policy issues related to long term care services and systems.
- Assist the Department to develop, implement, coordinate and guide the state's LTC system, including review and recommendations on the Department's standard contract provisions for Resource Centers and CMOs, the new Family Care benefit (including per person rate structure), and, for as long as they are a part of the system, the Community Options Program, the Community Integration Program and other Medicaid Home and Community-Based Waiver Programs, and the Medicaid fee-for-service system.
- Review, at the request of counties, tribes, local LTC Councils, or applicant organizations, Department decisions regarding how many CMOs should operate in a given geographic area, which organizations should receive CMO contracts from the Department, and whether specific contracts should be terminated. The Council will review disputed decisions in light of materials presented by the applicant organization, any affected CMO already operating in the same geographic area, any affected local LTC Council and the Department. The State LTC Council will review these cases within established guidelines and make recommendations to the Department. The final

Department decision on the matter must include consideration of the Council's recommendations; if the Department's final decision does not agree with the Council's recommendations, it must explain in writing its reasons for not doing so.

- Monitor patterns of complaints, grievances and appeals across the state to identify issues that need state level attention.
- Monitor the number of people on waiting lists and the level of their functional needs.
- Review the utilization of various types of services by CMOs.
- Monitor the statewide pattern of enrollments and disenrollments in CMOs.
- Review annual reports submitted by local LTC Councils and other information and report annually to the Governor and the Legislature on the status, significant achievements and problems in the statewide LTC system, including people served, costs, the number and service areas of Resource Centers and CMOs, waiting list information, and results of quality reviews. Make recommendations for system changes as indicated by these findings.

County[7] LTC Council

Composition and appointment:

- The Council will have an odd number of members, not to exceed 21. If the Council serves a multi-county area, it may have up to 25 members.
- At least 51 percent of the Council's members must be elderly people, people with physical disabilities, and people with developmental disabilities or their family members, guardians or other advocates, proportional among the three target groups. Of these consumer representatives, at least two-thirds must be elderly people, people with physical disabilities and people with developmental disabilities; not more than one-third may be family members, guardians or other advocates. Consumer members will be appointed by the County Board(s), or County Executive(s) if applicable, from a pool of nominations submitted by consumers, family members, guardians, and local organizations representing older people and/or people with disabilities. Consumer representatives must be trained and supported to enable them to participate effectively in the deliberations of the Council, and reimbursed for reasonable expenses associated with participating.

[7] Requirements for tribes cannot be exactly the same as those for counties; for example, the state cannot dictate that tribes establish tribal LTC Councils. However, if a tribal organization wishes to apply to be certified as a Resource Center or CMO, it must demonstrate that a similar process for involving consumers and other tribal members was used in making this decision and developing the application. Tribal LTC Councils must include representatives of affected counties.

- If tribal lands are included in the area covered by the Council, at least one member from each affected tribe will be appointed by the governing body of the tribe(s). The balance of the members of the Council will be appointed by the County Board(s), or County Executive(s) if applicable. Members will include up to four County Board Supervisors, service providers, and other residents of the county(ies) with demonstrated ability and demonstrated interest in the needs of people with developmental disabilities, people with physical disabilities, and elderly people, and services that address those needs.

Roles:

- Develop initial plan for local LTC system structure, to include recommendations on: whether and how the county should exercise its option to operate Resource Center(s) and/or CMO(s); what non-county organizations should be considered to serve in these roles as an alternative or addition to county-run entities; and, if applicable, how county-operated functions should interact with any planned tribal Resource Center(s) and/or CMO(s).
- Advise the County Board, and if applicable, the County Executive as they make decisions regarding county applications for Resource Center and/or CMO certification.
- Provide recommendations on applications for initial or renewal certification of Resource Centers and CMOs in the area, which the organization will attach to its application; assist the Department in its review and evaluation of all applications to operate a Resource Center or CMO in the Council's geographic area.
- Receive and monitor concerns from CMO consumers about the adequacy of the CMO's network. Review initial plans and existing provider networks of local CMOs , to assist CMOs in developing a sufficient number of accessible in-network providers to ensure that its members can choose, without waiting, from among a broad array of providers with characteristics that their members, as a group, find convenient and desirable. Any application for initial or renewal certification as a CMO must include attached recommendations from local LTC Council(s) in the CMO's service area regarding its proposed or existing provider network.
- Make recommendations to local CMOs regarding whether the CMO should offer optional acute and primary health care services and if so, how these benefits would be offered to members. Each application for initial or renewal certification that proposes to include these services must include attached relevant recommendations from local LTC Council(s) in the CMO's service area.
- Review the utilization of various types of services by CMOs.
- Monitor the pattern of enrollments and disenrollments in local CMOs.
- Identify gaps in services, living arrangements and community resources and develops strategies to build local capacity to serve elderly and disabled people, especially those with long term care needs.
- Perform long range planning for elderly and disabled citizens locally.

- Review and make recommendations as appropriate on the interaction among Resource Centers and CMOs in an area, to assure a coordinated overall LTC system for consumers, including annual review of required interagency agreements.
- Review the number and types of complaints and grievances from customers of Resource Centers and CMOs to determine whether patterns of complaints and grievances indicate the need for system changes; recommend system or other changes when appropriate.
- At local option, may be part of local grievance process (i.e., review and act on grievances from individual consumers).
- Identify potential new sources of funding for Resource Center(s) and CMO(s)
- Participate in monitoring and evaluations of Resource Center(s) and CMO(s)
- Advocate for local system improvements that will improve overall service to elderly people and people with disabilities and their families.
- Report annually to the Department and to the State LTC Council on significant achievements and problems in the local LTC system.

Governing Board of CMO or Resource Center

Composition and appointment:

- Each board will have not less than 10 nor more than 20 members.
- Each board's membership will have a minimum of 25 percent consumer representation, of which at least two-thirds are members of the target group(s) served by the Resource Center or CMO (elderly people, people with physical or developmental disabilities); the remaining one-third may be family members or guardians. Each target group served by the Resource Center or CMO must be represented. Consumer representatives will be appointed from a pool of people nominated by consumers, family members, guardians, and local organizations representing older people and/or people with disabilities. Consumer representatives must be trained and supported to enable them to participate effectively in all aspects of the deliberations of the board, and reimbursed for reasonable expenses associated with participating.
- If a county or tribal agency, at least one-third, but not more than two-thirds, of each governing board's members will be elected county or tribal officials.
- The balance of members will be citizens of the county(ies) or tribal members not connected to organizational providers of services within the purview of the Resource Center or CMO.

- Board membership must be reflective of the ethnic and economic diversity of the community.
- If a county or tribal agency, governing boards will be appointed by the County Board(s) of Supervisors or the elected tribal governing body(ies). In counties with a County Executive or Administrator, the board members will be appointed by the Executive or Administrator, subject to confirmation by the County Board(s).

Roles:

- Be accountable for the mission and goals of the organization.
- Oversee development of a mission statement for the organization that is consistent with the goals of the statewide LTC redesigned system.
- Determine the structure, policies and procedures of the organization, within state guidelines and local governance structure.
- Oversee the implementation and operation of the Resource Center or CMO to ensure compliance with:
    - state CMO or Resource Center contract requirements,
    - applicable statutes, guidelines and procedures.
- Ensure the Resource Center or CMO has a viable plan for implementation and operation, which addresses:
    - Program priorities and policies.
    - Budget and fiscal solvency.
    - Contracting, accounting and procurement policies.
    - Which services should be provided directly and which should be purchased.
    - Quality assurance and improvement activities.
    - Personnel functions.
    - Client rights protections.
    - Civil rights compliance.
    - Complaint, grievance and appeal mechanisms.
    - Adequate information technology and other resources.
    - Human resource development, including training in the organization's mission, skills training for both its own staff and contracted providers.
    - Cultural competency of the organization and its contracted providers.
    - Maintenance of formal linkages with other service networks.
    - Consumer and family education and training.
- Identify unmet needs and prepare plans to meet them.

- If a county agency and the county has a County Executive or Administrator:
  - Advise the County Executive or Administrator on the appointment of the director of the organization.
  - Recommend program priorities.
  - Prepare a proposed budget for submission to the County Executive or Administrator and approve final budget for submission to DHFS.
  - Advise the director of the organization on purchasing and providing services.
- If a county agency and the county does not have a County Executive or Administrator:
  - Govern the Resource Center or CMO, assuming all powers and duties of the Resource Center or CMO.
  - Appoint the director of the organization, subject to County Board confirmation.
  - Prepare proposed budget for submission to the County Board and approve final budget for submission to DHFS.
  - Determine whether services are provided or purchased.
- If a private agency:
  - Govern the Resource Center or CMO, assuming all powers and duties of the Resource Center or CMO.
  - Appoint the director of the organization.
  - Prepare and monitor the agency's budget.
  - Determine whether services are provided or purchased.

Appendix 6: Efficient management of public resources

Managing financial risk

In the redesigned system both authority and responsibility would move closer to the individuals being served. The intent of such movement is to improve responsiveness to consumers, provide a better quality of life, and increase cost-effectiveness.

Moving responsibility and authority toward consumers means that consumers and organizations dedicated to managing their services have more discretion to make important decisions. They have more flexibility to use funding where it makes the most sense for the consumer.

With increased authority comes increased responsibility to manage spending within acceptable limits, to be cost-conscious, and to get the maximum value for each dollar spent. Accepting increased responsibility for spending involves certain risks. One risk is that service expenses will exceed the revenues from the average monthly payment per person.

Counties and other organizations manage some financial risk now. They have developed many techniques to protect themselves against unexpected expenses and to "smooth out the ride" when expenses are high in one year but much less in other years. In our redesigned system we will make additional tools available which do not require reliance on the property tax.

The state will assure that all CMOs have the tools necessary to manage the risk inherent in increased responsibility. The state will also continue to share risk with CMOs. Risk and responsibility will be phased-in over time (3-5 years) until the appropriate balance between state and CMO responsibility is reached. The rate at which this happens will depend on the extent to which needed tools are available, the desire of the CMO for more responsibility and the capability of that CMO to manage more authority and more responsibility.

It is useful to think of three sets of tools:

- **On-Going:** Tools available during the course of each year to protect against high cost situations as they occur.
- **Risk Reserve**: The CMO's own financial reserve available during or after the end of the contract year.
- **End-of Year Settlements**: Risk-sharing or other means which can be invoked after a final accounting of the years expenses and revenues.

On-Going Protections Available During Each Contract Year

The state will make several financial management tools available to assist the CMO in managing these costs, including:

Outlier Protection is typically an allowance in the contract that permits higher expenses to be billed on fee-for-service basis for certain very unusual diagnoses or conditions when costs significantly exceed the average, such as higher costs usually associated with ventilator dependency.

High Cost Reinsurance is additional insurance that pays for individual or aggregate costs above a certain level. A premium is paid depending on the amount of coverage and the deductible the CMO will pay if it needs to collect the insurance payment. For example, the CMO might purchase reinsurance to protect against the possibility that more than X percent of its members would require 24-hour home health coverage or nursing home care.

Program Reserve Fund

The purpose of a Reserve Fund is to protect (a) consumers, (b) providers, (c) the public, and (d) the CMO against the potential that expenses may exceed revenues in a given year. Ensuring that there are sufficient funds available in a special account to cover unpaid bills in case a CMO decides to end its services protects consumers and providers. This is particularly important in the redesigned system where neither county nor private agencies would be mandated to be a CMO. Gaining authority to keep a reserve fund that can even out expenses and revenues from year to year protects the CMO. The Reserve Fund is also essential for ensuring that the CMO is able to meet its financial obligations under any risk-sharing agreements.

All CMOs (public or private) must have a Program Reserve Fund used only for the adult long term care services it provides as a CMO. The funds may be available throughout the year or at year-end to cover any shortfall if total costs exceed total revenues. Prior to signing a contract with the state, each organization will be required to establish *an initial risk reserve* at least equal to 5-10 percent of the Family Care revenues expected in the first year of the program's operation. In subsequent years the Reserve Fund must equal 5-15 percent of annual Family Care program revenues. The Reserve Fund must be established in an escrow account in a financial institution that meets state specifications, such as a state or Federally chartered bank.

The CMO will be allowed to *build up the Reserve Fund over time. The required minimum grows only with the growth in census. The CMO might, for example, make annual deposits into a reserve, or it might make monthly deposits during the course of the year*

At the end of each year, the CMO will be permitted to keep audited savings from the average per person payments, providing that (a) the CMO can document that the savings are used to pay for additional services or are placed in the Program Reserve Fund, and (b) the unspent funds are not owed to the department as part of the risk-sharing agreement. The CMO must establish a separate account to receive contributions to the Reserve. Funds in this account are not to be intermingled with other funds of the organization and are subject to special reporting requirements. The *minimum amount of the Reserve Fund* will be calculated based on expected total enrollment. For example, enrollment of 300 people would require a smaller risk reserve than enrollment of 3000 people. Several sources of solvency protection may be used together to meet this requirement, e.g., cash reserves, a bank line of credit, reinsurance or stop/loss protection that together add up to the amount of the minimum reserve requirement.

The *Reserve* Fund is *used **after** outlier protection and high cost reinsurance payments* are obtained, and ***before** risk sharing* with the state. Whenever the CMO withdraws more than $10,000 from the risk reserve during the contract year, the CMO will notify the Department with information about the amount of the withdrawal and a plan for replenishing the risk reserve, which must be approved by the Department. The CMO will discontinue withdrawals when the risk reserve fund balance is equal to 25 percent of the minimum required risk reserve, unless Department approval is obtained.

If the CMO decides to discontinue as a Care Management Organization under contract with the Department, ***all moneys*** in the Program Reserve Fund revert to the Department for the exclusive use of any successor agency (ies) in the same geographical area or for payment to creditors.

After the End of the Contract Year

Depending on how monthly rates are structured, a case-mix adjustment may be negotiated as part of the contract between the CMO and the state. If a CMO receives a consolidated rate (e.g. one average monthly payment for all levels of care) then a case-mix adjustment will be required. If the CMO receives multiple payment rates based on sufficiently distinct levels of care, an optional case-mix adjustment will be made available at CMO request.

If this adjustment is used, the CMO's enrollment will be reviewed at the end of the year to see if there is any significant difference between the characteristics of people actually served and the assumptions originally used to set the average monthly payment levels. If there is a significant difference in important factors such as age, sex, or level of care, payment rates are adjusted retrospectively to reflect actual enrollment experience. Such an adjustment can be an important part of CMO risk management because it protects the CMO from the fiscal impact that can result if high quality services attract voluntary enrollment on the part of more people with significant disabilities or conditions than was expected.

Once a case-mix adjustment is completed, it is appropriate to calculate end-of-year savings or (losses) and then determine the amount which might be shared between the Department and the CMO, based on the terms of the contract.

Risk Sharing Between the CMO and Department. At year-end, after any case-mix adjustment, after the CMO has used any existing outlier protections and high cost reinsurance and, in the case of a loss, after the CMO has used 75 percent of the Program Reserve Fund, the state will share in the CMO's savings or (losses). There are three steps to this process:

- Net Savings or (Loss): Determine the amount of total savings or loss, including revenues available through high cost reinsurance, outlier protection, risk-sharing agreements with other parties, and required payments from the Reserve Fund (up to 75 percent of Fund), etc.
- Shared Savings or (Loss): Subtract administrative costs which exceed the agreed-upon levels, and the historic level of past county contributions or matched charitable donations.
- Allocating the Shared Savings or (Loss): Calculate the amount owed to or from the CMO and the Department, based on the agreed formula.

Step 1. Determine the Net Amount of Savings or (Loss).

What is the savings or (loss), if any, after adding the revenue from outlier protections and high cost reinsurance available during the contract year?

a. Initial Savings or (Loss)

Revenues From All Sources
\+ Outlier Protection, Reinsurance Payments
\- Expenses
= **Initial Savings or (Loss)**

If there is a (loss), what funds are available from the risk reserve to cover the (loss)? And, what is the remaining program deficit, based on a certified audit?

b. Net Program (Loss)

Initial (Loss)
\- Funds from Reserve (up to 75 percent of Fund)
= **Net Program (Loss)** (from certified audit)

Once the net program savings or (loss) for the year is determined, what is the amount for which the state will be responsible? *The sharable savings or (loss)* will be calculated as the

total program savings or loss (determined through an audit) minus administrative expenses that will not be included in risk sharing and any historic contributions from property taxes or matched charitable sources.

Step 2: Determine the Sharable Loss or Savings

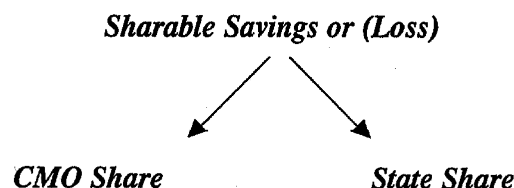
Savings	**Net Program Loss**
	- Disallowed Administrative Costs
- Current County/Charitable Contributions	- Past County/Charitable Contribution Level
= **Savings**	= **Sharable Loss**

To account for high start up costs, a higher level of administrative expenses will be allowed in the first years of implementation; i.e., a percentage of revenues will be allowed for administrative costs in the first year of implementation, with the allowable percentage of administrative expenses decreasing each year to seven percent in the third year of implementation. The percentage will be higher in smaller CMO's in the first two years than in larger ones (e.g., 25 percent in the first year in smaller CMOs). Administrative costs that exceed the designated amount will not be included in risk sharing.

Some counties have contributed considerable overmatch to the system in the past. The Department's risk sharing will not extend to amounts which counties have contributed in the past. Therefore, amounts which counties have contributed in the past (plus any charitable contributions that have counted toward match for Community Aids) will be excluded from risk sharing.

Step 3. Allocating the Shared Savings or (Loss)

Once the sharable savings or (loss) is determined, a formula will be used to determine how much each entity - the CMO and the state - will retain from savings or contribute toward the loss.



Prevention of cost shifting between systems

The LTC system will be designed to ensure efficient and appropriate use of federal funding. This includes structuring the system so that Family Care is the payer of last resort, following Medicare and private insurance, when available. Services will be structured to ensure Medicare payment when Medicare-funded services are appropriate under the person's service/care plan. In addition, CMOs and other providers will be expected to assist people in accessing Medicare benefits when this is appropriate.

Of particular concern is that Medicare beneficiaries can use their Medicare benefit for short-term nursing home stays for recuperative or rehabilitative care if they choose. To address this concern, the Department proposes the following special consideration **for short term nursing home care**:

- For people not already enrolled in a CMO:
    - Hospitals and nursing homes must provide information about Resource Center services immediately, and consumers or their families can request a screen and counseling at any time.
    - Within 14 days of admission, the nursing home must send data (MDS, PPOC, and/or other) to the Resource Center, which will determine whether a functional/financial screen is warranted.
    - If the Resource Center determines that conducting a screen is not warranted, or the screen indicates that the person does not meet eligibility for the long term care benefit, the nursing home bills Medicare, Medicaid or other sources under fee-for-service.
    - If the Resource Center determines that the person has long term care needs, he/she will be referred to a CMO for an assessment and service/care plan. If the person chooses to enroll in a CMO, and for as long as his/her nursing home stay is Medicare-covered, the nursing home bills Medicare directly. The CMO will receive a reduced monthly payment amount for that person to cover care management costs, other ongoing costs, and any Medicare co-pays for Medicaid-eligibles, either concurrently or through a year-end adjustment. If the person is still in the nursing home when Medicare stops coverage, the monthly payment amount to the CMO is reinstated or increased to the full level consistent with person's level of care, and the CMO is responsible for payment to the nursing home.
- For people already enrolled in a CMO, the nursing home must seek CMO approval prior to admission for a short-term stay. For the period that any stay is covered by Medicare, the nursing home will bill Medicare directly. During this period, the CMO's monthly payment amount for that person will be handled in the same manner as described above.

Other Medicare providers will also be able to bill Medicare directly when appropriate.

To counter the potential for **cost shifting from the LTC system to the acute/primary health care system**, some combination of the following strategies will be employed:

- **Care management requirements.** Protocols will be in place for the management of acute/primary health care services (for example, to assure that CMO members get appropriate immunizations and routine physicals, see their primary physicians as needed). Quality of care indicators will be specified in the CMO contract and physical health outcomes will be part of the state's quality assurance strategy.

- **Share in fee-for-service savings/excess costs.** Focused incentives could be established to encourage appropriate use of acute care over which the Care Management Organization has some influence through its advice, referral, and health monitoring. For example, a baseline could be determined of expected fee-for-service (FFS) costs for hospitalizations of elderly people due to falls, lack of alternate care, malnutrition, skin breakdowns, or misuse of medications. If the FFS costs for hospitalizations of a CMO's elderly members for these reasons are lower than the baseline, a portion of the savings would be returned to the CMO. If FFS costs exceeded the baseline, the CMO would be billed for a portion of the costs.

  Any CMO financial responsibility in this area will be relatively small. The purpose is simply to ensure that there are incentives in place with sufficient prominence to assure that care management systems pay attention to health care outcomes and prevention and cost-shifting incentives are countered. The financial linkages will be phased in over time. The first phase-in year will consist only of tracking, monitoring, and providing statistical feedback as a means of preparing for later limited financial responsibility for outcomes which can be affected by long term care practice.

- **Monitoring of major health care events.** The Department will monitor and analyze the causes and frequency of acute care events related to the adequacy of long term care, such as hospital admissions or emergency room visits for CMO members. If such service utilization by a CMO's members is outside of normal expectations (adjusted for the ages and conditions of those members as a group), an external quality review organization would review the CMO's practices to determine why this has occurred. If problems are found in the CMO's practices, corrective measures can then be taken.