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May 27, 2015 Joint Committee on Finance Paper #357

# ADRCs and Long-Term Care Advisory Councils (Health Services -- Medical Assistance -- Long-Term Care Services)

[LFB 2015-17 Budget Summary: Page 211, #1]

## CURRENT LAW

Aging and disability resource centers (ADRCs) serve as a gateway for individuals who need, or expect to need, long-term care services, including publicly-funded services available through Family Care, IRIS (Include, Respect, I Self-Direct), PACE (Program for All-Inclusive Care for the Elderly), and Partnership. ADRCs were created to serve as a "one-stop shop" for individuals seeking long-term care services, and are tasked with providing information regarding available programs, facilities, and other long-term care-related resources, as well as administering the long-term care functional screen to determine eligibility for and assist with enrollment in long-term care programs. Information and assistance are available in-person at an ADRC, over the phone, and in an individual's home.

ADRCs have a governing board that is responsible for overseeing the operations of ADRCs and providing certain quality assurance functions related to ADRC operations. Long-term care advisory committees are statutorily responsible for similar quality assurance functions related to the operations of ADRCs and MCOs providing Family Care, PACE, and Partnership.

## GOVERNOR

Permit the Department of Health Services (DHS) to contract with entities other than ADRCs to perform the duties of ADRCs. Permit DHS to specify in a contract with an ADRC or agency acting as an ADRC that the entity provide any of the following services or functions: (a) information and referral services and other assistance at hours that are convenient for the public; (b) a determination of functional eligibility for Family Care; (c) within the limits of available

funding, prevention and intervention services; (d) counseling concerning public and private benefits programs; (e) a determination of financial eligibility and of the maximum amount of cost sharing required for a person who is seeking long-term care services, under standards prescribed by the Department; (f) assistance to a person who is eligible for Family Care with respect to the person's choice of whether or not to enroll in an MCO and, if so, which available MCO would best meet his or her needs; (g) assistance in enrolling in an MCO; (h) transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system; and (i) a determination of eligibility for state supplemental payments, MA benefits related to the receipt of certain Social Security, Medicare, or BadgerCare Plus benefits, or for FoodShare benefits.

Repeal all statutory provisions relating to ADRC governing boards. Repeal statutory provisions relating to regional long-term care advisory committees.

## DISCUSSION POINTS

### Aging and Disability Resource Centers

1. Under current law, ADRCs are responsible for providing the following services: (a) information and referral services and other assistance at hours that are convenient for the public; (b) a determination of functional eligibility for Family Care and other long-term care programs; (c) within the limits of available funding, prevention and intervention services; (d) counseling concerning public and private benefits programs; (e) a determination of financial eligibility and of the maximum amount of cost sharing required for a person who is seeking long-term care services, under standards prescribed by the Department; (f) assistance to a person who is eligible for Family Care with respect to the person's choice of whether or not to enroll in an MCO and, if so, which available MCO would best meet his or her needs; (g) assistance in enrolling in an MCO; (h) transitional services to families whose children with physical or developmental disabilities are preparing to enter the adult service system; and (i) a determination of eligibility for state supplemental payments, Medical Assistance (MA) benefits related to the receipt of certain Social Security, Medicare, or BadgerCare Plus benefits, or for FoodShare benefits.

2. As of August, 2014, there were 41 ADRCs operating in Wisconsin, including 28 single county ADRCs and 13 multi-county/tribe regional ADRCs, serving all 72 counties and 11 tribes. The attachment provides a list of the ADRCs currently in operation.

3. In calendar year 2013, ADRCs had a total of 484,290 contacts, which includes any individual interaction or conversation that occurs between ADRC staff and a person who contacts the ADRC. In that same year, ADRCs conducted 209,857 activities related to individuals under 60 years old, 473,924 activities related to individuals over 60 years old, and 32,561 activities related to individuals whose ages were unknown, for a total of 718,478 activities. (The number of activities exceeds the number of contacts because more than one activity may occur during a contact.)

4. As a part of the statutorily-defined responsibilities, ADRCs administer the functional screen. The functional screen was developed to provide an automated and objective way to

determine the long-term care needs of the elderly and individuals with disabilities, as well as how much assistance is required to address those needs. The process for a functional screen includes a face-to-face interview, as well as collection and verification of functional, medical, and behavioral information from the applicant, family, guardian, caregivers, medical providers, therapists, and educators, among others. It assesses the following: (a) an individual's ability to complete activities of daily living (ADLs), including bathing, dressing, eating, mobility in home, toileting, and transferring; (b) an individual's ability to complete instrumental activities of daily living (IADLs), such as meal preparation, medication administration and management, money management, use of a telephone, and transportation; (c) an individual's needs related to health-related services tasks, such as skilled nursing; (d) an individual's needs related to diagnoses; (e) an individual's needs related to behaviors; (f) an individual's needs related to memory and cognition; and (g) an individual's needs related to specific risk factors.

5. In calendar year 2012, ADRCs administered a total of 20,123 long-term care functional screens, including 7,955 functional screens for individuals under 60 years old, 12,059 functional screens for individuals 60 years old and over, and 109 functional screens for individuals whose ages were not reported. The functional screens represented approximately four percent of the total number of activities reported by ADRCs in calendar year 2013.

6. The information collected through the functional screen is inputted to a web-based application, known as the Functional Screen Information Access (FSIA), which contains logic that interprets data to determine an individual's level-of-care and functional eligibility for long-term care programs. In addition to determining level-of-care and eligibility, results from the functional screen are used to inform rate setting for MCO capitation payments. Certain aspects related to assessing an individual's needs are handled outside of the FSIA system, such as determining to which target group (physically disabled, developmentally disabled, or elderly) the individual should be assigned. For assessments and determinations conducted outside of FSIA, there are DHS procedures and guidelines provided to screeners.

7. Individuals who administer the functional screen must meet the following requirements: (a) minimum education and experience criteria, which includes holding a Bachelor of Arts or Science degree, preferably in a health or human services-related field, and at least one year working with frail elderly, physically disabled, or intellectually/developmentally disabled population, prior approval from DHS based on a combination of post-secondary education and experience or on a written plan prepared by the agency for formal and on-the job training to develop the required expertise, or experience in home and community-based waiver agencies screening people with intellectual or developmental disabilities; (b) training requirements specified by DHS, which generally consists of completion of a web-based certification course; (c) have at least one year of experience working in a professional capacity with long-term care consumers; and (d) successfully complete all mandatory certification courses, exams, refresher courses, and continuing skills testing required by DHS, which includes regular continuing skills tests.

The continuing skills tests are administered every other year, and screeners are required to pass with a score of 80% or higher to be considered to have passed without any further conditions. Individuals who receive a score ranging from 65% to 79% are considered to have passed subject to

a plan of correction, which must be completed with 90 days of receipt of the test results. Individuals who receive a score below 65% are decertified, and must retake the test and comply with a plan of correction to be considered for recertification. According to DHS, in 2014, the average continuing skills test score was 84%, and 78% of screeners passed, 19% of screeners were subject to a plan of correction, and approximately 3% were decertified.

8. In 1999, DHS conducted a study to test the inter-rater reliability of the long-term care functional screen. This study found that the long-term care functional screen is a valid method, in that the screen will produce similar results when it is administered to similar individuals within a short time period.

9. In addition, during the April, 2011, Legislative Audit Bureau audit of the Family Care program, the auditors compared the results of the approximately 30,500 functional screens conducted in fiscal year 2009-10 with the requirements in administrative code. The audit found that most eligibility determinations were correct, but that 87 individuals (0.003%) were found eligible for an intermediate level of care, rather than the more extensive comprehensive level of care. The same audit also compared the assessment results of the functional screen conducted by ADRCs with those results from screens conducted by MCOs. The audit found that, of the 9,304 participants whose first functional screen was conducted in fiscal year 2009-10, 103 individuals had increased levels of care at the second assessment and 275 individuals had decreased levels of care at the second assessment. The audit indicates that the second assessment occurred approximately 7.5 months later, on average.

10. ADRCs are also responsible for enrollment counseling. Each ADRC creates an enrollment plan that describes how the ADRC will coordinate with partner agencies, such as income maintenance consortia, managed care organizations, and the IRIS consultant agency, to assist individuals who may need to access the Medicaid system. ADRC staff work with potential enrollees in accordance with the enrollment plan to assist those enrollees in choosing long-term supports and services through enrollment counseling. Enrollment counseling is intended to provide unbiased assistance to individuals who are eligible for publicly-funded long-term care to assist those individuals in making the choice between enrolling in a managed care organization, IRIS, the PACE or Partnership program, if available in that county, or utilizing Medicaid card services only. The ADRC staff member is intended to serve as an unbiased resource, and will engage in activities such as preparing an enrollment packet that shares information regarding the state's long-term care programs and services that may be available to the individual, as well as discuss with the individual the various options that are available in the individual's geographic region.

11. In addition to enrollment counseling and functional screens, primary activities conducted by ADRCs include information and assistance, options counseling, benefits counseling (elder and disability), and prevention, information, and related activities. According to 2013 data regarding ADRC activities, approximately 76% of the activities conducted by ADRCs involve providing information and assistance.

12. Currently, the contract between an ADRC and DHS allows the ADRC to be reimbursed for its costs in carrying out required functions, up to a limit based on the estimated size of the population served in each area. ADRCs are not permitted to charge for services, and counties

are not expected to contribute to the cost of operating ADRCs. State funding to support ADRCs is allocated based on the number of activities performed and the estimated amount of time required to carry out the ADRC functions. If actual costs exceed this limit, the ADRC is responsible for those costs. Because ADRCs provide services to, and respond to, inquiries from individuals and their families regardless of MA eligibility, federal cost sharing for their operations is limited to the amount that can be documented as supporting services for MA-eligible individuals. DHS estimates that approximately 65 percent of ADRC expenditures were eligible for federal MA administrative matching funds between July 1, 2014, and October 29, 2014, meaning that approximately 32.5 percent of ADRC expenditures are currently paid by federal matching funds.

13. Under the bill, approximately $56.7 million ($38.3 million GPR and $18.4 million FED) in 2015-16 and $59.0 million ($39.8 million GPR and $19.2 million FED) in 2016-17 would be budgeted to support ADRCs.

14. Under the bill, DHS would be permitted to contract with any entity, including for-profit entities, to provide any of the services that are currently the responsibility of ADRCs to a geographic region specified by the Department. Additionally, the list of services that ADRCs must provide would no longer be requisite of an ADRC, and the Department would be authorized to choose which, if any, of these services would be offered by entities fulfilling ADRC functions.

The bill would permit (but not require) DHS to contract to provide certain ADRC functions on a statewide basis. The administration argues that providing ADRC services through a single vendor could improve the consistency of the services offered by these entities. In particular, some have expressed concern regarding the consistency of functional screens and enrollment counseling throughout the state, citing anecdotal evidence that certain ADRCs are more likely to find individuals functionally eligible, or to counsel individuals into certain long-term care programs over others.

15. However, providing ADRC services on a statewide basis runs counter to a central feature of the current mission of ADRCs, which is to provide reliable information on locally-available long-term care services. Further, claims of inconsistency in the results of functional screens or directing individuals to specific programs or providers appear to be unsubstantiated or anecdotal.

16. Additionally, concerns have been expressed that this provision could lead to the Department contracting with for-profit entities that may have financial incentives relating to the services they perform. Currently, the governmental bodies and non-profit agencies that serve as ADRCs have no financial stake in the outcome of an individual's functional screen or any other services an individual may be seeking.

It has also been argued that contracting with a vendor for some of the current responsibilities of ADRCs could put current ADRCs at risk financially, due to the funding structure of ADRCs. ADRCs currently receiving funding reimbursement based on the activities they conduct. While functional screens represent only a small percentage of the activities conducted by these entities, ADRCs receive significant funding related to this work due to the time-intensive nature of these screens. Therefore, some argue that if the Department contracts these activities to other entities, the

ADRCs will lose a significant funding source, even though these activities only comprise a fraction of the total activities conducted by ADRCs.

As previously indicated, this provision would not require the Department to contract with a for-profit entity, but instead permits DHS the flexibility to provide ADRC services in a manner that it sees fit. If the Committee wishes to allow DHS flexibility with respect to what type of entity provides ADRC services and which ADRC services are offered, the Committee could adopt the Governor's recommendation (Alternative A1).

17. If the Committee wishes to allow DHS flexibility with respect to what type of entity provides ADRC services, but require that all of the statutorily-required services currently provided by ADRCs continue to be offered, the Committee could modify the bill to require that all of the current statutory responsibilities of ADRCs be conducted by any entity with which the Department wishes to contract to provide those services, such that all services currently provided by ADRCs continue to be available to residents of all 72 counties (Alternative A2).

18. If the Committee wishes to maintain the current functioning of ADRCs, but has concerns related to the reliability of the functional screen and enrollment counseling, it could delete the Governor's recommendations related to ADRCs and instead require the Department to conduct a study of the reliability of these activities (Alternative A3).

19. Finally, the Committee could make no changes to the current functions and responsibilities of ADRCs by deleting the Governor's recommendations related to ADRCs (Alternative A4).

**ADRC Governing Boards**

20. Under current law, ADRCs have a governing board that is responsible for determining the structure, policies, and procedures of, as well as overseeing the operations of, the ADRC. In addition, the governing board is responsible for gathering information regarding the ADRC's activities, including identifying gaps in services and reporting findings to the regional long-term care advisory committee. Further, the governing board is responsible for recommending strategies for building local capacity, identifying new sources of community resources and funding, appointing members to the long-term care advisory committee, reviewing interagency agreements between ADRCs and MCOs, reviewing the number and types of grievances and appeals related to long-term care in the area served by the ADRC, and recommending system changes as appropriate. Membership of the governing board is required to be reflective of the ethnic and economic diversity of the geographic service area served by the resource center, including members, family members, guardians, or advocates of individuals who may be served by the ADRC.

21. Under the Governor's recommendation, ADRC governing boards would be eliminated by June 30, 2017, and all statutory references to these entities would be deleted.

22. According to one advocate, ADRC governing boards are actively involved in ADRC functions and oversight. They provide guidance to ADRC directors or managers, and most ADRCs meet monthly with these boards to review ADRC activity reporting, financial reports, program

updates, complaints and appeals, enrollment in long-term care programs, quality reports related to facilities and ADRC services, and ensure that all responsibilities specified within the ADRC contract are being completed. In addition, the ADRC board must authorize any policy changes related to the operation of the ADRCs.

23. Under current law, ADRC governing boards play an active role in overseeing and providing review of the state's long-term care programs. The review provided by the ADRC governing board may be valuable, in that the governing boards are disconnected from DHS and have no financial stake in program operations. If the Committee believes that the ADRC governing boards should continue to provide review and oversight of the state's long-term care programs, the Committee could delete the Governor's recommendation to eliminate ADRC governing boards (Alternative B4).

24. However, there may be certain duplicative tasks performed by both ADRC governing boards and DHS. For instance, both entities are required to monitor the quality of the long-term care system. However, ADRC governing boards have limited access to data that may inform these efforts, and do not have authority to enforce any changes related to poor quality or performance, whereas DHS has more formal monitoring and compliance processes related to the provision of long-term care.

25. If the Committee believes that these boards serve a useful purpose, but that the responsibilities of ADRC governing boards and DHS may be duplicative, the Committee could delete the Governor's recommendation to eliminate ADRC governing boards, but require the Department to assess which responsibilities of ADRC governing boards are duplicative with current Department procedures, and to propose changes to the statutory requirements of these boards that remove duplication to the relevant standing committees of the Legislature no later than July 1, 2016 (Alternative B3).

26. Alternatively, the Committee could adopt the Governor's recommendations for the following reasons: (a) these entities have limited access to data with which to assess the state's long-term care programs; and (b) these entities do not have any authority with respect to implementing changes to the state's long-term care system (Alternative B1).

27. If the Committee believes that most responsibilities of ADRC governing boards are duplicative with respect to the responsibilities of the Department, but wishes to require the Department to continue to fulfill the responsibilities of these boards, it could adopt the Governor's recommendations, but modify the bill to assign the current statutory responsibilities of the ADRC governing boards to the Department (Alternative B2).

**Long-Term Care Regional Advisory Councils**

28. Under current law, ADRC governing boards appoint a regional long-term care advisory committee, whose responsibilities include: (a) evaluating the performance of MCOs offering Family Care, PACE, and Partnership with respect to responsiveness to enrollees, choices provided to enrollees, and other issues affecting recipients of services, and making recommendations to the Department and to MCOs as appropriate; (b) evaluating the performance of

ADRCs operating in that region and, as appropriate, making recommendations concerning their performance to the Department and the ADRCs; (c) monitoring grievances and appeals made to MCOs operating Family Care, PACE, or Partnership; (d) reviewing utilization of long-term care services in the committee's region; (e) monitoring enrollments and disenrollments in MCOs that provide services in the committee's region; (f) identifying gaps in the availability of services, living arrangements, and community resources, and developing strategies to build capacity to provide those services, living arrangements, and community resources in the committee's region; (g) performing long-range planning on long-term care policy for individuals belonging to client groups served by the resource center; and (h) annually reporting to the Department regarding significant achievements and problems related to the provision of long-term care services in the committee's region.

29. Under the Governor's recommendation, long-term care advisory councils would be eliminated by June 30, 2017, and all statutory references to these entities would be deleted.

30. A long-term care advocate indicates that the regional long-term care advisory committees have only met once, and, as such, do not play an active role in reviewing long-term care programs or policies related to the Family Care program and ADRC operations.

31. Because long-term care advisory committees, while established in statute, are not active participants in the state's long-term care system, the Committee may wish to eliminate these committees. If the Committee wishes to eliminate long-term care advisory committees, it could do one of the following: (a) the Committee could adopt the Governor's recommendation to eliminate long-term care advisory committees (Alternative C1); or (b) the Committee could eliminate long-term care advisory committees, and require the Department to reassign the responsibilities of the committees that DHS does not already conduct within the Department, if any (Alternative C2). Alternatively, the Committee could delete the provision related to the elimination of long-term care advisory committees (Alternative C3).

## ALTERNATIVES

### A. Changes to ADRCs

1. Adopt the Governor's recommendation to modify the statutory requirements of ADRCs, including the types of entities that may provide services and which services must be provided.

2. Adopt the Governor's recommendation to allow the Department to contract with any entity to fulfill the responsibilities of ADRCs. Modify the bill to require that all of the current statutory responsibilities of ADRCs continue to be provided to residents of all 72 counties of the state.

3. Delete provision. In addition, require DHS to evaluate the functional screen and options counseling for reliability and consistency among ADRCs, and to provide a report regarding these activities by January 1, 2017.

4. Delete provision.

### B. ADRC Governing Boards

1. Adopt the Governor's recommendation to eliminate ADRC governing boards.

2. Adopt the Governor's recommendation to eliminate ADRC governing boards. In addition, assign DHS all of the current statutory responsibilities of ADRC governing boards.

3. Delete the Governor's recommendation to eliminate ADRC governing boards. In addition, require the Department to assess which responsibilities of ADRC governing boards are duplicative with current Department procedures, and to propose changes to the statutory requirements of these boards that remove duplication to the Committee no later than July 1, 2016

4. Delete provision.

### C. Long-Term Care Advisory Committees

1. Adopt the Governor's recommendation to eliminate long-term care advisory committees.

2. Adopt the Governor's recommendation to eliminate long-term care advisory committees. In addition, assign DHS all the current statutory responsibilities of long-term care advisory committees.

3. Delete provision.

Prepared by: Stephanie Mabrey
Attachment

## ATTACHMENT

## Aging and Disability Resource Centers (ADRCs)
## As of August, 2014

**Single County or Tribe ADRCs**

Bad River Tribe
Brown
Chippewa
Columbia
Dane
Dodge
Door
Douglas
Dunn
Eau Claire
Florence
Fond du Lac
Ho Chunk Nation
Jefferson
Kenosha
Lac Courte Oreilles
Marinette
Milwaukee (Aging Resource Center and Disability Resource Center)
Menominee Tribe
Oneida Nation
Ozaukee
Pierce
Portage
Racine
Red Cliff
Rock
Sheboygan
St. Croix
Trempealeau
Walworth
Washington
Waukesha
Winnebago

**Multi-County or Tribe ADRCs**

Adams - Green Lake - Marquette - Waushara
Ashland - Bayfield - Iron - Price - Sawyer
Barron - Rusk - Washburn
Buffalo - Clark - Pepin
Burnett - Polk - St. Croix Chippewa Indians of WI
Calumet - Outagamie - Waupaca
Crawford - Juneau - Richland - Sauk
Forest - Forest County Potawatomi - Lac du Flambeau - Oneida - Sokaogon Chippewa - Taylor - Vilas
Grant - Green - Iowa - Lafayette
Jackson - La Crosse - Monroe - Vernon
Kewaunee - Manitowoc
Langlade - Lincoln - Marathon - Wood
Menominee - Oconto - Shawano - Stockbridge Munsee