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**Annual  
Report of the  
Wisconsin  
Council on  
Long Term  
Care**

**May, 2001**

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# Wisconsin Council on Long Term Care

## Annual Report

### I. EXECUTIVE SUMMARY

*The Council has reviewed Wisconsin's long term care system and makes the following observations and recommendations.*

- The State needs to continue its commitment to realign long term care systems so that people have access to a range of options, including home and community care.
- The Family Care pilots are on target. As of March 31<sup>st</sup>, 2001, 2,875 people were enrolled in the five Family Care benefit counties: Fond du Lac, Portage, La Crosse, Richland and Milwaukee.
- Three of the counties have now been in operation for a year. Those three counties have reported that they have cleared their waiting lists for Family Care target populations.
- Resource Center outreach has been effective. Resource Centers served over 61,500 people in calendar year 2000.
- Preliminary figures show that the waiting lists in non-Family Care counties continue to grow. In light of the recent U.S. Supreme Court *Olmstead* decision regarding the rights of persons to be served in the most integrated setting appropriate to their needs, the Council believes that Wisconsin needs to continue to provide additional resources for home and community based care for people as outlined below.

#### **Recommendations Regarding Family Care**

1. **Fully Fund Existing Family Care Pilots.** Include resources beyond the Governor's budget for the following: 3% inflationary increase for Resource Centers (\$577,251 GPR) and the restoration of Independent Advocacy (\$525,000 GPR) with a cost of \$1.1 million new GPR for the biennium.
2. **Expand Family Care Pilot Sites Beyond Governor's Budget.** Add Kenosha County Care Management Organization (CMO) services by July 1, 2002. Provide resources to plan for additional pilot sites for the next biennium that would expand pilot sites to the level currently authorized in the Family Care statute with a cost of \$5.7 Million new GPR for the biennium.
3. **Maintain Non-Medicaid Enrollees in Family Care Benefit.** Fund at the Governor's budgeted level. The Department of Health and Family Services (DHFS) should review current eligibility to determine if modifications may be needed to assure the state maximizes its ability to capture federal funding and serve those most in need.

4. **Delay the Sunset of the Council on Long Term Care.** Continue the Council until the end of the next biennium to allow for continued oversight of the implementation of long term care redesign, including Family Care and the final development of the Americans with Disabilities Act (ADA) Title II recommendations. Expand membership on the Council from 15 to 17 members to add stakeholder representation for children and individuals with mental health needs. Fund Council activities by providing \$10,000 GPR for the biennium.
5. **Family Care Policy Recommendations:**
  - **Replicate Prevention Programs That Are Effective.** To reduce future long term care needs and improve quality of life, prevention projects found effective should be replicated.
  - **Conduct an Evaluation of the Pre-Admission Consultation.** Draft recommendations for any future changes needed to current legislation and/or administrative rules.
  - **Resolve Conflict Of Interest Issues.** Before expanding Family Care beyond the pilots, a cost-effective and consumer-centered solution should be found.
  - **Evaluate the Adequacy of Funding for Economic Support Functions.** To assure timely enrollments, adequate funding must be provided for Economic Support workers.

### ***Recommendations Regarding Current Long Term Care System***

1. **Develop New Budget Methodology.** For future budgets, develop a new long term care budget methodology that aligns budgeting and policy across the spectrum of long term care services that promotes cost-effective options and consumer choice of care setting.
2. **Maximize Federal Revenue to Pay for New Community Care Capacity.** Direct the Department of Health and Family Services to develop new options to generate federal revenue no later than 6/30/02 by capturing additional Medicaid funding for home and community based care programs. These options should include investigating an option related to an “Intergovernmental Transfer Program (IGT)” for Community Care (or by using the county Community Aids overmatch as leverage).
3. **Expand Community Care Capacity.** In the upcoming biennium for non-Family Care counties and population groups, fund as follows:
  - COP/COP Waiver—Add 1,400 new slots for the expected demographic growth and another 1,200 slots to reduce the waiting lists at a cost of \$19.1 Million new GPR for biennium.
  - CIP II—Add 1,600 new CIP II slots at an increased rate of \$45 a day with a cost of \$10.9 Million new GPR for biennium. For 800 of these new slots, priority would be given to the relocation of individuals identified as *Olmstead* clients.

- CIP 1B—Add 500 new slots at the current actual cost of \$74.70 a day with a cost of \$5.6 Million new GPR for biennium;
- Brain Injury Waiver—Add 100 new slots at the current rate of \$184 a day with a cost of \$2.8 Million new GPR for biennium.

4. **Maintain Existing Community Care Capacity through Rate Increases.** In future budgets cost of living increases for home and community based care should be tied to an agreed upon measure of inflation. For this coming biennium, the following rate increases are proposed to bring these programs more in line with the actual costs:

- CIP II--Increase rate from \$40.78 a day to \$45 a day; with a cost of \$3.5 Million new GPR for the biennium.
- CIP 1A--Increase rate from \$190 a day to \$300 a day. Separate this rate increase from the State Center’s “drop rate” in order to preserve quality care for individuals who remain in the Centers and to maintain adequate staffing to meet Medicaid certification standards, with a cost of \$1.7 Million new GPR for biennium.
- CIP 1B--Increase rate from \$49.38 to actual average rate of \$74.70 a day with a cost of \$20.3 Million new GPR for the Biennium. Although it is important to assure that the rates paid for community services accurately reflects actual costs, if resources are not available, this item would be of secondary importance because counties are already providing support for these costs at the present time.

5. **Transition Institutional Capacity To Community Care, Where Appropriate.**

- The state should develop a protocol in which anyone receiving institutional care in Wisconsin and who qualifies under the new U.S. Supreme Court *Olmstead* decision, should be entitled to have the money for institutional care “follow them” to pay for community care.
- Direct DHFS to maximize all current options that allow funding to follow clients (including CIP II, CIP 1A, CIP IB programs) to allow “*Olmstead* Clients” to move to more integrated settings. Further direct DHFS to develop additional or new options no later than 6/30/02 for consideration by the Governor and Legislature in the next biennial budget process.
- Provide \$66,000 new GPR for the biennium to provide resources to contract for community assessments and care plans for residents when nursing homes close, especially in the area of individuals with multiple conditions.

6. **Make Improvements In The Mental Health Long Term Care System.**

- Provide \$2.25 Million in new GPR funding for the biennium to pay for the State assumption of the responsibility for the state share of Medicaid (MA) funding for Community Support Programs for all new persons to be served in the upcoming biennium. Currently, counties provide the state match for this Medicaid benefit. The state is required to assure that this MA

benefit is available statewide. State and Counties should negotiate an agreement regarding the current resources used by counties to provide match for this benefit.

- Direct the Department to develop proposals no later than 6/30/02 in the following areas:
  - Explore how this population can be served through a new “CIP II-like” Waiver.
  - Develop financing mechanisms to relocate youth at the state mental health institutes who could be served in community settings (include in the options moving state GPR spent in institutions to community services, EPSDT, the Children’s Redesign Waiver).
  - Review the current PASARR (Preadmission Screening and Resident Review) and other processes to develop budget and policy recommendations for improvements to the screening of all individuals entering institutions and on an ongoing or annual basis.
  - To improve data collection in institutional settings for individuals with mental health and/or behavioral needs.

## **7. Support the Care of Children with Disabilities at Home.**

- The Council recommends that an additional \$3.5 Million in new GPR be allocated for the biennium to serve an additional 778 children in the Family Support Program.
- Request that the Legislature keep in the budget the Governor’s proposal that directs DHFS to develop a new Medicaid Children’s Home and Community Based Waiver. In addition, DHFS should be directed to submit to the Governor no later than 9/30/02 a budget proposal for the Children’s Waiver that will better use existing federal and state programs (including the Family Support Program) to draw down additional federal resources for children’s long term care services. The new Waiver should serve children with a range of physical, developmental and mental health needs.
- The Department should further be directed to explore federal, as well as state statutory changes, needed to assure children are supported in their homes as a first priority as opposed to out of home placements.

## **Wisconsin's Vision for Long Term Care Redesign**

*“Foster the statewide development of comprehensive long term care and support systems that maximize independence, recovery and quality of life, while recognizing the need for interdependence and support.*”

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

### **Goals**

- Increase Consumer Choice
- Improve Access to Services
- Create a comprehensive and flexible long term care system
- Improve quality through a focus on health and social outcomes
- Create a cost-effective long term care system for the future.

## ***II. Background on the Council on Long Term Care***

### **Council Creation**

The Wisconsin Council on Long Term Care was created by the state legislature in 1999 with the passage of Wisconsin Act 133. The Council is administratively attached to the Wisconsin Department of Health and Family Services (DHFS), Office of Strategic Finance.

### **Council Membership and Duties**

Governor Thompson appointed the 15-member Wisconsin Council on Long Term Care on July 26, 2000. They serve at the pleasure of the Governor (See Appendix 1 for membership list). Governor Thompson also designated Tom Rand, of La Crosse, as the Chair of the Council. Carol Eschner of Milwaukee was elected Vice Chair and Charles Wilhelm of the DHFS, was designated as Secretary. Council membership includes a majority who are consumers or consumer representatives. All the members were previously appointed by Secretary Joe Leann to the Secretary's Interim State Long Term Care Advisory Committee. That Committee operated from January 2000 until their July 2000 appointment to the Council.

The Council is legislatively scheduled to sunset on July 1, 2001 or on the day after publication of the 2001-03 Biennial Budget.

The Council advises the Governor, the Legislature and DHFS. The Council is responsible for reviewing the entire long term care system and guiding development of the state's redesign of that system. Their specific responsibilities include (see Appendix 2):

- Advising the State on general long term care policy.
- Guiding the State on Family Care implementation policy.
- Monitoring Family Care complaints system and statewide long term care wait lists.
- Reporting annually to the Governor and Legislature.

The Council has been active in all areas of long term care policy. They believe that the state needs to have some policy coordinating body, such as the Council, to review how the policies work together for all target groups in need of long term care. The Council's current fifteen-member make-up does not adequately reflect representation for children or individuals with mental health needs. They recommend that two positions be added to the 15 required members in the current statute to bring their membership to 17. The two additional members should be appointed to represent children and mental health issues.

## Major Activities

Over the past year, the Council reviewed the progress of the Family Care pilots. This review included visits to four of the five counties that offer the full Family Care program: Fond du Lac, Portage, La Crosse and Milwaukee Counties. The Council worked through a number of committees that developed recommendations for this report. Highlights of the Council's major activities include (see Appendix 3 for a full description of these activities):

- **Mediated Family Care Administrative Rules.** The Council's successful mediation of stakeholder concerns is a key outcome of the Council's activities in the last year.
- **Met with Local Long Term Care Councils.** Received input from local councils on the status of their local long term care systems.
- **Reviewed Status of Statewide Long Term Care System.** Developed initial recommendations to address Americans with Disabilities Act (ADA) Title II issues arising from the U.S. Supreme Court *Olmstead* decision.
- **Developed Budget Recommendations.** The Council met with staff from the Governor's Office and the Department of Administration to discuss their recommendations and priorities in the area of long term care for the upcoming budget.

### ***III. Family Care Overview***

#### **The Family Care Benefit**

The benefit package in Family Care is comprehensive and flexible. By including all the long term care services in one payment system with a broad array of services available, depending on the individual's needs and choices (see Appendix 4), the institutional bias of the current Medicaid system will end. With options counseling provided by the resource centers and the comprehensive and flexible benefit offered by the care management organizations, the overall system is structured to offer people informed choice of services and service settings.

#### **Service Areas for Family Care Pilots**

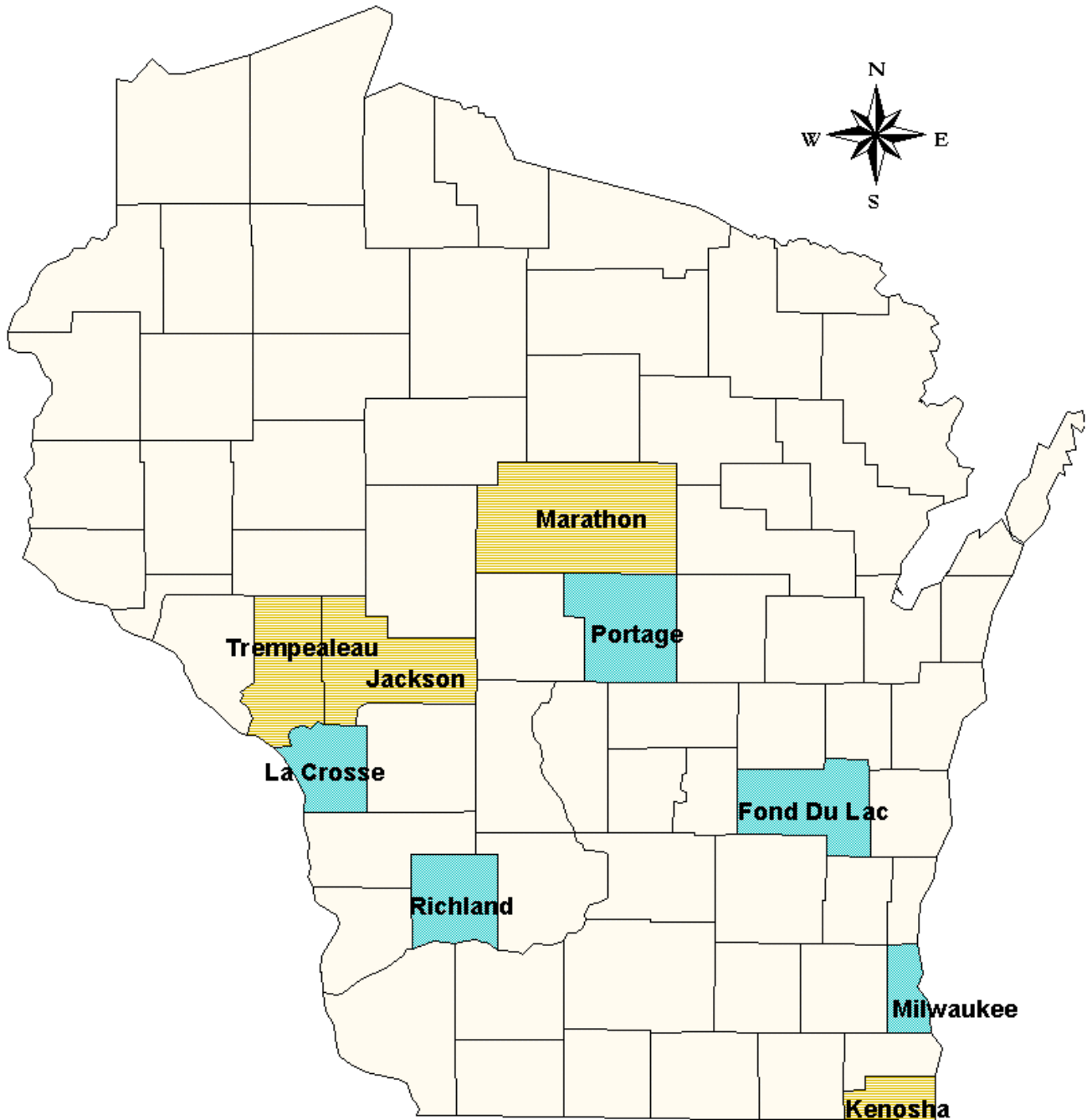
In addition to the comprehensive flexible benefit, there are two major components of Family Care: resource centers (RCs) and care management organizations (CMOs). There are nine counties with resource centers, including Milwaukee, Kenosha, Fond du Lac, Richland, Portage, La Crosse, Trempealeau, Jackson, and Marathon Counties (see map of Family Care pilot sites on next page).



Of these counties, five provide the full range of Family Care services, including resource centers and enrollment into CMOs. Those five counties are Milwaukee, Fond du Lac, Portage, La Crosse and Richland. The remaining four counties do not have CMOs, and their RCs do not provide enrollment counseling and access to the Family Care benefit.

Milwaukee County targets their Family Care services to people aged 60 and over. Kenosha County has two resource centers, one site primarily serves older people and persons with disabilities and another site targets persons with developmental disabilities. All the other counties have one resource center and one CMO serving all target groups included in Family Care—frail elders, adults with developmental and/or physical disabilities.

# Wisconsin Family Care Pilots

Resource Centers and Care Management Organizations (CMOs)



-  Resource Center and CMO Pilot
-  Resource Center Pilot Only

## **Access to Benefit: Statewide and Family Care County Wait Lists**

Improving access to long term care services is a key Family Care goal. Across the state counties have reported waiting lists for COP and COP Waiver services for many years. Individuals on “waiting lists” must first be found financially and functionally eligible for COP or waiver services. Being on “a waiting list” does not mean a person is entitled to COP or COP Waiver services, has an imminent need for such services, or is not receiving other services. It means only that a person is financially eligible and meets applicable level of care requirements.

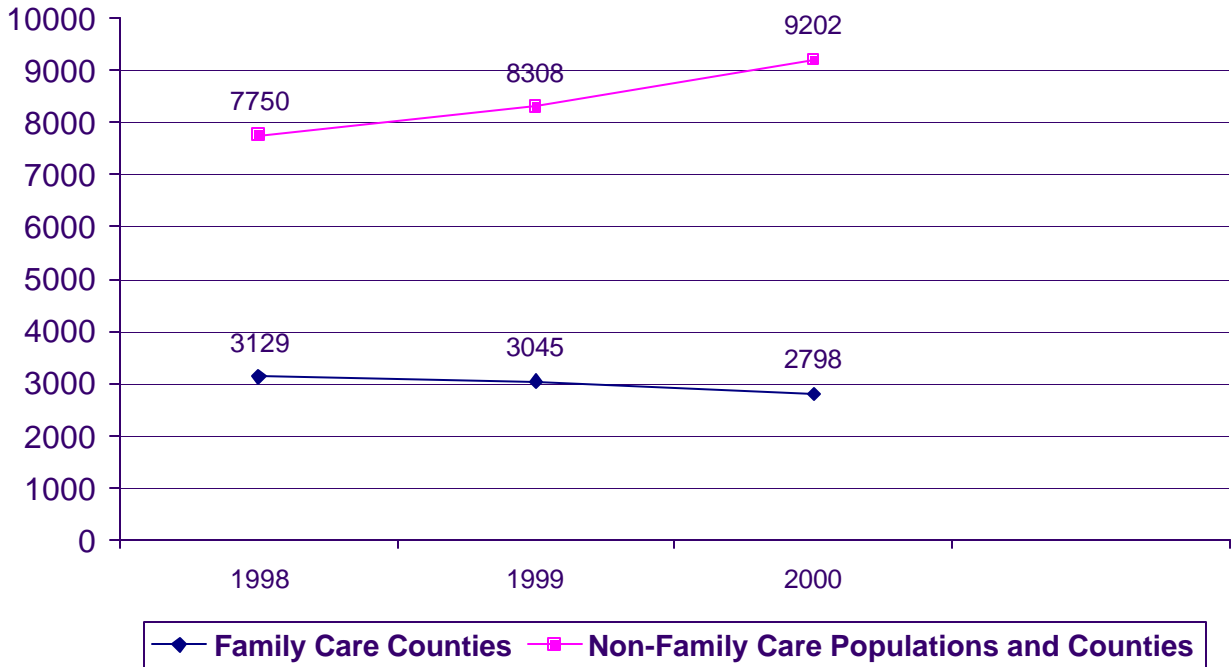
Counties are required to report to DHFS annually in their County COP Plans, the number of people who are financially and functionally eligible for, but are not yet receiving COP or Waiver services as of December 31. The COP Wait lists include some population groups that are not covered under Family Care—children under age 18 and individuals who may have only mental health or substance abuse needs (see Appendix 5 for Information on Individuals Reported Waiting for Long Term Care Services in non-Family Care counties by Target Group and County).

In Family Care counties with the full Family Care benefit, individuals are assured of access to services two years after the CMO begins operation in that county. In Family Care counties within two years, any waiting list that exists may not contain names of people who are entitled to the Family Care benefit. As a part of planning to assume this responsibility, DHFS provided counties that would soon offer the Family Care benefit (Fond du Lac, Portage, La Crosse, Milwaukee, and Richland) funding to begin reducing their wait lists in 1998 and 1999. The CMOs began operation in the years 2000 and 2001.

On December 1998, all five of the full-benefit Family Care counties reported a total of 3,129 people (including all Family Care and non-Family Care target groups) waiting for COP or COP Waiver services. As of December 31, 2000, these Family Care counties reported that 2,806 people were waiting. Of those still on waiting lists, 2,727 are in Milwaukee County alone and they have a plan to serve all individuals by the end of December, 2001. In addition, two counties—Portage and La Crosse—reported eliminating their wait lists for all Family Care target groups by December 31, 2000. As of April 1, 2001, Fond du Lac County reports that they have also eliminated their wait list for Family Care target populations.

Between December 1998 and December 2000 there has been a 10% decrease in the number of people waiting for long term care services in Family Care counties. In comparison (see chart on next page), during this same time period, the non-Family Care counties reported a total of 7,750 people waiting as of December 31, 1998 which had risen to 9,202 persons by December 31, 2000. This is slightly more than an 18% increase. The data shows that the additional resources made available in Family Care counties has resulted in a reduction in the number of people waiting for home and community based services.

## Family Care and Non Family Care Populations and County COP Waitlist Trends



## Workforce Issues

Having access to services depends not only on having access to the funding for services, more and more it also hinges on having an adequate array of trained workers to provide those services. In the last few years this has become increasingly difficult for providers. A critical element to attracting a trained workforce is finding ways to elevate the status and value of the care-providing role. This is an area that needs more attention and creative solutions.

## Utilization of Services in Family Care Counties

Fond du Lac County was the first to offer the comprehensive benefit on February 1, 2000. The other four counties followed in 2000 and 2001. It is too early to form a complete picture of what is happening in the use of long term care and other services in the Family Care benefit counties. However, the Department is monitoring the use of institutional services in the pilot counties and statewide on a

quarterly basis. In the first three quarters of the year 2000 (as the pilots began) the data shows that in Family Care counties, the number of Medicaid patient institutional days is slightly less than the statewide average. The most recent information is shown in the chart that follows.

It is too early to attribute this decline to Family Care. But it is safe to say that Family Care did not increase the use of nursing home days in the first three quarters of the year 2000.

### **Institutional Services Utilization Reported to Date in the Family Care Pilot Counties**

<b>FC Pilots</b>	<b>CY 2000, 1st Quarter</b>	<b>CY 2000, 2nd Quarter</b>	<b>CY 2000, 3rd Quarter</b>
Actual Patient Days	604,111	591,740	588,167
Patient Days % Change	-2.8%	-2.0%	-0.6%
<b>State Minus Pilots</b>			
Actual Patient Days	1,917,620	1,913,011	1,923,479
Patient Days % Change	-2.9%	-0.2%	0.5%

### **Complaints and Grievances**

From February 1, 2000 to February 22, 2001 the Department received eleven complaints regarding Family Care. Of those, five were older people, three were persons with a developmental disability, and three were from persons with a physical disability. Of those 11 complaints, four were withdrawn with the complainant satisfied. The status and outcome of the remaining eight cases is as follows:

- Four were resolved by DHFS with three of those to the complainants' satisfaction and one formal decision where the complainant was partially satisfied.
- Two are eligibility related and are being resolved by the fair hearing process.
- One is a new complaint still being investigated.
- The issues involved included three provider complaints, reconsideration of service authorizations, choice of enrollment, protective services and guardianship, denial of eligibility and one alleging that a consumer was treated disrespectfully.

## Independent Advocacy Program

Consumer and Advocacy organizations wanted assurance that as Wisconsin reshaped the long term care system using a managed care model, that there would be an independent organization consumers could seek help from to advocate on behalf of their concerns. The Family Care Independent Advocacy Program was created as a part of the negotiation with the Governor to provide consumers with impartial assistance with grievances, appeals and the fair hearings process.

The contracting responsibility for the Independent Advocacy Program was given to the Wisconsin Board on Aging and Long Term Care, which also operates the long term care ombudsman program. The Board is administratively attached to the Department of Administration (DOA). Consequently, DOA issued the Request for Proposals. DOA awarded the contract to the Wisconsin Coalition for Advocacy (WCA), who in turn contracted with a number of local advocacy organizations.

During the year 2000, 18 individuals were provided advocacy assistance. In addition, they provided information and assistance, training and technical assistance to 180 people. As of March 31<sup>st</sup> the Advocacy Program reports that they had 65 total advocacy cases reported to date.

The top advocacy system concerns reported:

- Many counties “rolled over” their current Medicaid Waiver clients into Family Care and there have been complaints that some people did not made an informed decision regarding enrollment.
- Some family members have expressed concern that they have not yet had the benefit of the full interdisciplinary team assessment and planning process required in Family Care.
- Some reports have been made that not all of the staff in pilot counties are aware of, or have the information they need to help people. In one case, the client reported that they had difficulty working with the county staff to find a Complaint and Grievance form. In another incident, staff reportedly didn’t tell someone of all the possible options available to them.
- In some cases it was reported there was a lack of reassessments for people who had unmet needs or significantly changed circumstances, or who asked for significant changes in their care plan, such as a community placement.
- Local advocates reported that they felt the Local Long Term Care Councils were slow to develop and that they needed to include adequate representation of people with disabilities as required by statute.

## Family Care Recommendations

The Council believes that the state should continue its commitment to pilot a redesign of the long term care system in Wisconsin. Many hundreds of older people, people with disabilities, counties, providers and advocacy groups worked for five years to develop Family Care. In the last biennium, Family Care legislation authorized pilots in up to 29% of the state's elderly and adult disabled population. The last budget funded sites in five counties, which make up approximately 17%. The Council would like the Legislature to provide resources to expand into more sites and continue its commitment to pilot Family Care in up to 29% of the state's adult long term care population.

- **Fully Fund Existing Family Care Pilots by Adding \$1.1 Million New GPR for the Biennium to the Governor's Budget.** The pilots should remain a priority and fully funded. The Council would oppose any funding diversion from the proposed Family Care budget to fund community care in non-Family Care counties. The Council would supplement the Governor's Family Care budget in the following areas:

- Restore Independent Advocacy at a cost of \$525,000 GPR;
- 3% RC inflationary increase at a cost of \$577,251 GPR.

- **Provide an additional \$5.7 Million GPR for the Biennium to Expand Family Care.** The Council supports expansion of the CMO and the Family Care benefit into Kenosha County (\$5 Million GPR) by July 1, 2002 and to include planning funds (\$699,765 GPR) for additional sites that would begin in the next biennium.

- **Maintain Non Medicaid Enrollees in Family Care.** Family Care was structured to be inclusive of people who do not yet meet Medicaid eligibility, but who have needs at the institutional level of care. These individuals pay a cost share for their services on a sliding fee basis. At this time, only a few non-Medicaid individuals (120) have enrolled. The Council supports the continued assurance of services to this group. It is very important to use a sliding scale and not have a cliff or cut off for income eligibility. However more study is needed on the current eligibility structure to determine if any modifications may be needed prior to expansion of Family Care. It will be important to assure that the state maximizes its ability to capture federal funding and appropriately serves those most in need.

The Council also recognizes the need to carefully budget for this population and supports the extension of the deadline to reach entitlement for two years—if needed—to gather the data to appropriately budget for this group. The Council supports the Governor's budgeted funding level of \$12.4 Million GPR.

- **Provide \$10,000 in GPR for the Biennium to Fund the Council on Long Term Care.** In order to continue to carry out the role of advising the department on the development of the pilots, we recommend that the role and funding for the Council continue through the next

biennium. The sunset provision should be delayed and the Council should remain as a statutory Council with the requirement to report annually to the Legislature and Governor. As noted previously, the Council membership should be expanded from 15 members to 17 to assure representation for issues related to children and mental health.

- **Conflict of Interest.** It is imperative that conflict of interest issues in Family Care are resolved prior to expanding Family Care beyond the pilots. Because Family Care is using a managed care model to create a cost-effective integrated and flexible benefit, the federal government requires separation between the organization that provides enrollment counseling and functional eligibility (the Resource Center), and the organization that receives the funding to provide the care (the CMO). Counties currently provide both functions—often in the same agency. Some of the pilots see the requirement to restructure county government as unreasonable in a pilot program.

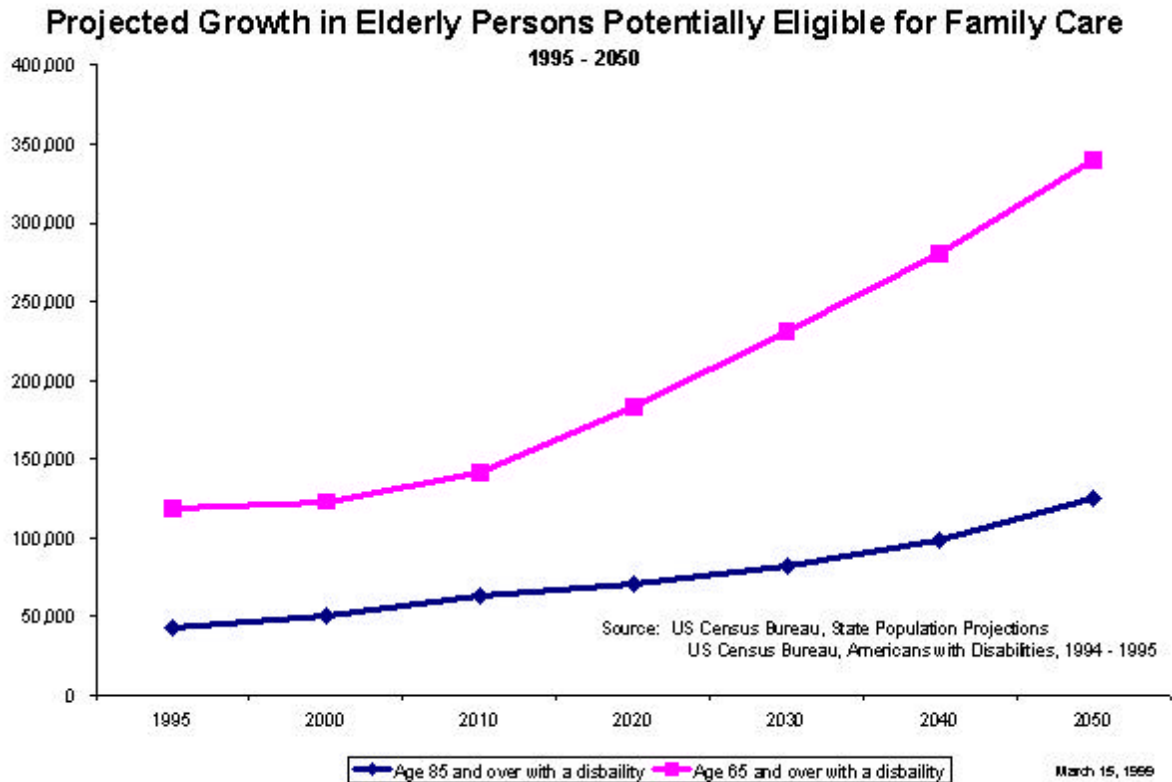
## ***IV. Aging and Disability Resource Centers Achievements and Challenges***

**Overview: Improving Access to Long Term Care.** One of the goals of the long term care redesign process was to improve access to long term care services. The Aging and Disability Resource Centers were created to accomplish that vision through "one-stop shopping" for the general public on issues affecting older people, people with disabilities, or their families. Resource Centers are welcoming and convenient places to get information, advice and access to a wide variety of services. As a clearinghouse of information, they are also available to physicians, hospital discharge planners, and other professionals. Services are provided through telephone contacts or in-home visits. As pressure increases to prioritize the functions, it is important to assure that resource centers continue to be visible and easy to locate community information and outreach centers.

### **Resource Center Duties and Services**

- **Information and Assistance.** Providing information to the general public about services, resources and programs in areas such as: disability and long term care related services and living arrangements, health and behavioral health, adult protective services, employment and training for people with disabilities, home maintenance, nutrition and Family Care. Resource Centers also connect people with services. They may help people apply for SSI, Food Stamps and Medicaid.
- **Pre-Admission Consultation.** The Family Care legislation requires that hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF-MRs), Community Based Residential Facilities (CBRFs), Residential Care Apartment Complexes (RCACs), and adult family homes (AFH) refer admissions for long term care services to the resource center in their area for pre-admission consultation. Resource centers are required to offer these individuals an in-home visit to discuss their situation and the options that might be available to them. The goal is to provide neutral information so that people can make informed decisions about the services that will best meet their needs.
- **Long Term Care Options Counseling.** In addition to referrals from residential providers, Resource centers provide consultation and options counseling to anyone who contacts them. This consultation will include a discussion of the factors to consider when making long term care decisions and to provide objective information about the cost-effective options available.
- **Benefits Counseling.** Providing accurate and current information on private and government benefits and programs. This includes assisting individuals when they run into problems with Medicare, Social Security, or other benefits.

- **Emergency Response.** The Resource Center will assure that people are connected with someone who will respond to urgent situations that might put someone at risk, such as a sudden loss of a caregiver.
- **Access to the Family Care Benefit.** In the five counties with the full Family Care benefit, Resource Centers conduct a functional and financial eligibility determination to assess an individual's functional eligibility for Family Care. The Resource Center then provides enrollment counseling regarding the options available including, enrolling in Family Care, staying in the Medicaid fee-for-service system (if eligible), or privately paying for services. If the individual chooses Family Care, the Resource Center will enroll that person in the Care Management Organization (CMO). The CMO then arranges and pays for their needed services. The care level determined by the Resource Center also triggers a monthly payment to the CMO for that person.
- **Prevention and Early Intervention.** The vision for the future of long term care must include prevention. The number of people in need of long term care will continue to increase due to the steady increase in the number of older people as shown in the chart that follows. Additional resources will be needed to provide support for this growing population. However, research is showing that society can shape its future through changes in individual behavior. More people need to know about, and participate in, activities that will reduce their chances for entering the long term care system—through exercise, nutrition, and proactive health care. In addition, preventative health care for people already in the long term care system needs to be a priority for primary care physicians and other care providers.



## Prevention Activities

In order to demonstrate effective prevention practices, funds were available for 2000 and 2001 through a competitive process to four resource centers. The Resource Center pilots are documenting outcomes for consumers that will be reported when the projects are completed. The effectiveness of these research-based projects will be studied to determine the future focus areas for resource centers (see Appendix 6 for a more complete description of these projects). The four projects include:

- **Jackson County: Falls Prevention.** An intervention effort to prevent falls in older adults through exercise and safety education.
- **Marathon County: In Home Preventative Health Care.** Provides health assessments and telephone monitoring of older adults.
- **Milwaukee County: Changing Health Related Behaviors.** Targets minority elders to help improve health through risk assessments and fitness programs.
- **Trempealeau County: Nutritional Risk Identification and Intervention.** Provides nutritional risk assessment and support services.

## Number of Persons Served

The Resource Centers served a total of 61,526 people with a variety of services from January 2000 to December 2000. People initiate contact with resource centers in one of two ways. They can contact the resource centers themselves or on behalf of a friend, client, or family member. They can also be referred to the resource center for pre-admission consultation (that is, by a hospital, nursing home, CBRF, AFH, or RCAC).

The contacts for the year 2000 are broken out by resource center in the chart below. For information on monthly contacts broken out by target groups, see Appendix 7.

### Resource Center Contacts January 1 – December 31, 2000

Resource Center	Total Contacts 2000
Fond du Lac	2,123
Jackson	604
Kenosha Aging & PD	6,177
Kenosha DD	743
La Crosse	3,097
Marathon	3,233
Milwaukee	37,439
Portage	6,913
Richland**	49
Trempealeau	1,148
State Totals	61,526

\*\*Richland County RC began operations in November 2000, thus their totals reflect contacts for November and December only.

These numbers contain some duplication (one person may make more than one contact in a year), however, other single contacts assisted more than one person.

As expected, Milwaukee County had far and away the bulk of the contacts (61%). Richland County was not one of the original resource center pilots that began in 1998. They opened their resource center in November of 2000. They reported their first 49 contacts in November and December.

Resource centers report that the four areas most frequently asked about include: information on basic needs such as Medicaid and food stamps; disability and long term care related services; long term care living arrangements and health care issues (see Appendix 8).

**Outcome of Resource Center Contacts.** The outcome of the contacts with the resource centers are tracked and reported to the Department. Resource Centers reported that from June until December of 2000, 53% of the resource center contacts resulted in giving individuals information about long term care. Another 15% received other information, and 13% of the contacts continued to see if they were functionally in need of public long term care services. (See the chart in Appendix 9 which summarizes the outcomes for the contacts during that time.)

## **Pre-Admission Consultation**

Pre-admission Consultation (PAC) referrals were not made for a full year during 2000 and data reporting has been inconsistent to date. However, the Department reports that the current rate of referrals across all resource centers is approximately 350 per month. It has been reported that some facilities, especially CBRFs, are not consistently complying with the PAC referral requirement. The resource centers are working with their local facilities to improve voluntary compliance and the DHFS Bureau of Quality Assurance is working on a strategy to assure appropriate PAC referrals.

The resource centers appear to be responding to referrals with timely offers of consultation services, as reported by Department staff. (All PAC referrals received in January 2001 for 2 of the 9 resource centers have been reviewed at the time of this report. The Department will complete all resource center site reviews of the PAC process by the end of April.)

## **Long Term Care Functional Screening**

Another duty of the Resource Centers is to complete a Long Term Care Functional Screen that gathers information on an individual's level of functioning and health care needs. The functional screen determines an individual's nursing facility level of care and Family Care functional eligibility. During the past year, approximately 3,600 new people were provided functional screening services. On an annual basis all Family Care CMO enrollees are re-screened and their functional eligibility redetermined. During the course of the year, some individuals may experience a significant change in their condition and the CMO or the individual may request another screen. The chart that follows breaks out the activity of the resource centers for the year 2000.

**Functional Screens Completed  
January 1 – December 31, 2000**

	<b>Initial &amp; Facility PAC Screens</b>	<b>Annual &amp; Change-in- Condition Screens</b>	<b>Total Screens</b>
Fond du Lac	461	101	562
Jackson	29	0	29
Kenosha	341	2	343
La Crosse	514	358	872
Marathon	203	10	213
Milwaukee	1,520	491	2,011
Portage	309	28	337
Richland	127	40	167
Trempealeau	96	0	96
<b>TOTAL</b>	<b>3,600</b>	<b>1,030</b>	<b>4,630</b>

*NOTE: Data includes both Version I and Version II Screens.*

**Family Care Eligibility Levels.** The Long Term Care Functional Screen determines a nursing home level of care and one of three Family Care eligibility levels—Intermediate, Comprehensive, or Not Eligible. The screener can also indicate if the individual was grandfathered into the program. If an individual had been previously served by the Community Options Program, one of the Medicaid Waivers, institutional services or other county long term care program, and did not score at least at the Intermediate Level they can be “grandfathered” into the program. Based on a review of the eligibility level for 4,630 screens reported, around 89% of the screens scored at the comprehensive level, 9% at the intermediate level, and about 2% scored as not eligible for a Family Care level of care.

### **Cost of Services**

During the calendar year 2000, the Department contracted with the nine resource centers for a total of \$4.78 million (includes prevention funding). The resource centers submit annual fiscal reports. Those reports have not yet been fully analyzed. The resource centers have told the Department that they have been financially stretched to keep up with the demand for their services. At this time, the Department and the resource center pilots have begun a joint review of the resource center activities. This review will look at all the required activities in the legislation, administrative rules, and their contract. They will identify areas they believe are priorities for resource centers and for ways to streamline current practices.

## Quality of Services

Each resource center site went through a certification review by DHFS prior to assuming certain functions as a resource center (i.e. functional screening, pre-admission consultation, enrollment counseling). In addition, each resource center has developed a quality assurance and quality improvement plan that has been submitted to the state. In the last two years, state staff conducted site reviews for all sites. A new round of resource center site monitoring visits is planned in the spring and summer of 2001. A report is planned for September 2001.

## Resource Center Accomplishments

- **Resource Center Outreach Has Been Effective.** All the resource centers have made great strides in implementing the vision of increasing access to long term care information. They have developed the full spectrum of services as outlined in their contracts with the Department. In particular their outreach efforts have been exemplary, with the resulting number of information and assistance contacts exceeding the Department's expectations.
- **New Long Term Care Functional Screen Approved by Federal Government.** The Department, in cooperation with the resource centers, has completed the validity and reliability testing of a new screening instrument that was designed to take the place of the current Community Options Program Screening tool and to standardize the nursing facility level of care determination process. This new computerized screening instrument provides a way to record information that does not presuppose eligibility based on where the individual happens to be—in a nursing home, hospital or home environment. The federal Health Care Financing Administration has approved the tool as a valid and reliable tool for determining institutional levels of care.
- **Resource Centers Report Diversions from Institutional Services.** The resource centers are becoming well known and are offering pre-admission consultation and options counseling services to individuals looking for long term placements in residential settings. There are some preliminary numbers that show a slight reduction in the number of nursing home days in Family Care counties. Whether this can be attributed to resource center activities or Family Care in general is too early to tell. However, resource centers do report successful individual cases of institutional diversions.

## Resource Center Stories

A few stories can illustrate how the resource centers are intervening before individuals make major life decisions. These stories show the ability of resource centers to divert people from more expensive services that may provide more than they really want or need. The following example shows how one resource center was able to help someone conserve their private resources.

*In Kenosha County, a 43 year-old woman was referred for a pre-admission consultation prior to nursing home placement. As a result of that discussion, she decided to move to a CBRF instead. This allowed her to stretch her private funds to pay for her own care in a more integrated setting. Because Kenosha County is not yet a Family Care benefit county, the only program that she would be eligible for was the Alzheimer's Family Caregiver Support Program. She is on a waiting list for that service.*

In other cases, the resource centers intervene in crisis situations and have been successful at providing support to keep people in their homes, as illustrated in the following story.

*An 81 year-old male had had several strokes, heart failure, dementia and uses a walker. He was caring for his 79 year-old wife who had been confined to a wheelchair for more than three weeks. The Resource Center called the county nurse to evaluate the condition of his wife. She was found to be weak, malnourished, and dehydrated. She went to the hospital by ambulance. Emergency services were arranged for the husband, including a juvenile court offender program to provide snow shoveling. Bathing services, adaptive equipment, housekeeping services and home delivered meals were also arranged. The husband then enrolled into Family Care for ongoing support.*

Sometimes people use the information and assistance provided by the resource center to help them resolve their current situation, without enrolling in Family Care or other long term care program, as illustrated in this story.

*A 35 year old female, who is deaf, was referred to the resource center. She was diagnosed with a post traumatic stress disorder after undergoing an unexpected eye surgery. Before the surgery she had been independent and outgoing. Now she refused to sleep in her bedroom, cried and accompanied her elderly parents 24 hours a day. The family was looking for a psychologist who could sign. The family was referred to Services for the Deaf and Hard of Hearing to find an appropriate provider. Because the family had no insurance coverage, they were referred for Medical Assistance. The family was given information about Family Care—but they were not interested in having a functional evaluation at that time.*

## Resource Center Challenges and Opportunities

As is often the case, when success is achieved, it can also create challenges. The following are some challenges faced by the resource centers:

- **Resource Center Resources are Stretched.** Because the response to the resource centers has been so positive and the need for their services has been so great, this has led to concerns by the resource centers that the resources available to them are not adequate to fulfill all the functions in their contracts. The Resource Centers are budgeted with a fixed amount and that amount does not vary with actual caseload trends, as is the case with CMOs.
- **Eligibility Challenges.** County Economic Support Units are often still separate from resource centers. The original vision for resource centers was to have Economic Support functions co-located with the Resource Center staff using a streamlined eligibility process. This vision has yet to be accomplished.

In counties that offer the full Family Care benefit, the economic support units have had a large number of cases as counties converted their existing Waiver clients into the Family Care program. As counties enter into their second year of eligibility for clients, the annual re-certification of these cases causes a similar increase in cases. These are complex cases, requiring specialized expertise in the area of the waiver and long term care financial issues.

On occasion, the processing of Family Care financial eligibility for new cases takes longer than was expected. As a result, resource centers continue to provide short-term care management and gap filling services until the individual's financial eligibility is completed and they are enrolled in the CMO.

After the Economic Support Specialist completes the financial eligibility process, the CARES computer system generates multiple eligibility notices to consumers. The notices are confusing and easily misunderstood by the consumer as well as generating additional phone calls and extra work for both the Economic Support Worker and the consumer. The Department is working on a redesign of the eligibility notices.

- **Pre-Admission Consultation.** The pilot counties have begun identifying areas where they felt they could be more cost-effective. In the area of pre-admission consultation, the pilots found that some hospitals sent all their discharges of older people and people with disabilities to the Resource Center. They were not screening out those without long term care needs. This resulted in a deluge of referrals to the resource centers with a large number of people who were not appropriate for long term care. As a result, the Department waived the penalty for hospitals for not referring hospital discharges and submitted a proposal to the Governor's Office to change the legislative language deleting the penalties on hospitals for not making referrals. The Resource Centers are working with hospitals to develop better protocols to make appropriate referrals for pre-admission consultations.

The pilots also reported that pre-admission consultation prior to admission to CBRFs seemed to be an area where they felt some study was needed regarding the cost-effectiveness of these referrals.

- **Resource Centers Should Remain Visible and Easy To Find.** As enrollment and eligibility duties of the resource center consume an ever-increasing share of the resource center resources, it is important that they continue to carryout outreach activities. The initial success of the resource centers is a direct result of the excellent work they have done to make themselves visible in their local communities.
- **Consumer Friendly “One Stop Shopping” Threatened.** The vision of the resource center as a customer friendly, “one stop shop” for information, assistance and eligibility may be threatened in those counties that offer the full Family Care benefit. A consumer may encounter many different people through the resource center and the CMO before they begin receiving services. Although, consumers have reported that they receive services quicker through the RCs and CMOs than in the old Waiver-based system, they still often encounter up to five or more individuals in that process. This can be confusing to people who may be experiencing difficulty.
- **Conflict of Interest.** The federal government has notified Wisconsin that if it wants to receive a new combination 1915(b)(c) waiver, the CMO pilot counties must assure that there is no conflict of interest between the entity that provides the functional eligibility and enrollment counseling (the RC) and the CMO. This new waiver is needed to eliminate duplicative waivers, streamline financial accounting and increase the ability to earn federal revenue. Current state statutes require the RCs and CMOs to be structurally separate.

The federal government wants to assure that the organization doing the functional eligibility determination and enrollment counseling does not have any real or perceived conflicts that could raise concerns about the accuracy of the functional eligibility levels or the neutrality of the enrollment counseling. When both the RC and CMO report to the same county board, the potential exists for the county to influence decisions so that higher functional eligibility levels result in more people enrolled at higher reimbursement levels tied to those determinations. In the area of enrollment counseling, the concern is that the Resource Center could steer more expensive people away from their CMO towards the fee-for-service system, or in the future, to a different CMO.

One means to provide for the needed separation is to create a Family Care district that is a part of the Family Care statute. The federal government has asked for changes to that statute to assure adequate separation. Those changes are included in the Governor’s budget. Another option under discussion is to separate out the functional screening and/or enrollment counseling and have another agency, under a separate contract perform those functions. This would add yet another individual in the entry point process for consumers. Council members feel this would increase consumer confusion and increase the costs for these functions at a time when the resources are already stretched.

## Council Resource Center Recommendations

- **Conduct an Evaluation of the Pre-Admission Consultation Process and Outcomes.** An in-depth look at the requirements for pre-admission consultation should be undertaken to determine what has been effective and what has not. Recommendations should be developed for any future changes needed to the current Family Care legislation and administrative rules.
- **Resolve Conflict of Interest.** The counties and the Department should consider the impact on consumers in all proposals for separation of functions of the RC and CMO. The Council recognizes the potential for conflict of interest when counties do not restructure their systems to allow for adequate separation of the functional screening and enrollment counseling functions from the CMO. If at all possible, cost-effective and consumer centered solutions should be found.
- **Assure Adequate Funding for Economic Support Functions.** The state should review the budget requirements for the economic support responsibilities for long term support programs and request adequate resources from the legislature to assure that the resources appropriated match the responsibilities and caseload mix of the workers.
- **Replicate Prevention Programs That are Effective.** The results of the prevention projects should be studied and those methods shown to be effective should be replicated in other areas. The future of long term care lies in prevention. Effective prevention methods can reduce the future need for long term care services and results in better quality of life. Although there will be an increasing need for additional budgetary resources to fund long term care services due to the growth in the elderly population, prevention has the potential to reduce the rate of future expenditure growth.

## **V. Care Management Organizations Achievements and Challenges**

### **Overview of Duties**

In addition to increasing access to services, a major goal of Family Care is to create a single flexible benefit for all long term care (LTC) services. Care Management Organizations must provide the range of long term care services currently offered by Medicaid fee-for-services, as well as the services in the Home and Community-Based Waivers and the flexible Community Options Program.

CMOs receive a per person per month payment to manage and pay for care for members who live in their own homes, group living situations, or nursing facilities. They are responsible for:

- Developing and managing a comprehensive network of long term care services and supports. They deliver some services directly through CMO staff.
- Conducting a comprehensive assessment of individual's needs, abilities, preferences and values with the consumer and family/guardian. The Care Management Team, consisting of at least a social service coordinator and registered nurse, and the member jointly complete a comprehensive assessment which looks at: activities of daily living, physical health, nutrition, autonomy and self determination, communication, mental health and cognition.
- Designing a care plan in partnership with the consumer, which is based on information gathered during the assessment and is tailored to the individual's needs, preferences and outcomes.
- Monitoring and continually improving the quality of care and services consumers receive.

### **Status of CMO Pilot Sites**

All five of the planned Care Management Organizations are now in place. Fond du Lac County's Creative Care Options was the first to begin enrolling people in the new Family Care benefit as of February 1, 2001. Portage and La Crosse County came on line in March 1, 2000, and Milwaukee County Department on Aging on July 1, 2000. Richland County began enrolling in their CMO on January 1 of 2001.

## Number of Persons Served by CMOs

Since February 2000 when Fond du Lac began enrollment, there has been a gradual steady increase in the number of people enrolled in Family Care, as additional counties began offering the benefit.

**Enrollment Data for the Year 2001.** As of March 31, 2001, 2,875 people were enrolled in Family Care. The breakout by county and target group is shown in the chart below. The data includes Richland county enrollments for their first three months.

### CMO Enrollment by County and Target Group as of March 31, 2001

	<b>Elderly</b>	<b>Disabled</b>	<b>Total Enrollment as of March 31, 2001</b>	<b>Members Enrolled at Any Time From Feb. 2000 Thru March 31, 2001</b>
Fond du Lac	287	336	623	685
Portage	159	226	385	429
La Crosse	345	463	808	851
Milwaukee	911	0	911	983
Richland	80	68	148	151
<b>TOTAL</b>	<b>1,782</b>	<b>1,093</b>	<b>2,875</b>	<b>3,099</b>

## Disenrollment Information

Family Care is a voluntary program. Individuals can choose to enroll in Family Care or stay in the Medicaid fee-for- service system. One of the responsibilities of the Council is to monitor the disenrollments from Family Care. As of March 31, 2001, 224 individuals had disenrolled from Family Care since Family Care began (from February 2000). The chart that follows shows the break out by county, target group and by primary category of disenrollment.

**Family Care CMO Disenrollments – Cumulative from February 2000  
As of March 31, 2001**

County	Deceased		Pending* or Lost Eligibility		Voluntary Disenrollments		CMO Totals		Totals
	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	Elderly	Disabled	All
<b>Fond du Lac</b>	29	7	8	3	11	4	48	14	<b>62</b>
<b>Portage</b>	22	4	5	3	7	3	34	10	<b>44</b>
<b>La Crosse</b>	28	6	2	4	2	1	32	11	<b>43</b>
<b>Milwaukee</b>	34	0	26	0	12	0	72	0	<b>72</b>
<b>Richland</b>	2	0	0	1	0	0	2	1	<b>3</b>
<b>State Total</b>	<b>115</b>	<b>17</b>	<b>41</b>	<b>11</b>	<b>32</b>	<b>8</b>	<b>188</b>	<b>36</b>	<b>224</b>

Source: Totals drawn from Recipient ODS on 4/11/01 and accurate as of 3/31/01.

*NOTE: \*This column will identify individuals who appear to have lost MA eligibility, therefore, they appear to have disenrolled. However, in some cases, their re-certification for MA is simply in a “pending re-certification” status. Over time this problem will be rectified in the data system, as these persons are re-certified. This column also likely includes some people who appear to have disenrolled but are still receiving services under state funded Family Care while they await their re-certification.*

**Analysis of Family Care Enrollments and Disenrollments.** From February 2000 to March 31, 2001 3,099 people have been enrolled in Family Care over that time period. Of those 224 have disenrolled for a variety of reasons, with over half of those due the death of the member. Forty people (1.3%) have reportedly left the program voluntarily.

### **Quality and Consumer Outcomes**

The Department developed a multi-faceted approach to monitor the quality of services in the CMOs. This includes an initial certification of the CMO and its proposed network of providers, staff capacity, protocols and procedures. In addition, the Department assures that there is a review of the CMO care plans, an annual site review of the CMO with a review of a sample of CMO clients. The CMOs are required to develop their own quality assurance and quality improvement plans and submit them to the Department. These plans are then monitored as a part of the site review process.

Finally, the Department has implemented a new vision of outcome-based monitoring. This new monitoring system will be used to measure the program's progress towards achieving the client outcomes. A workgroup of consumers and other stakeholders identified 14 personal outcomes (see Appendix 10) that Care Management Organizations will help members achieve.

From November 2000 through January 2001, the Department conducted in-home interviews with a sample of 355 CMO members. They were asked about their individual preferences related to these 14 outcomes. Their care managers were also interviewed about how the member was being supported while making service choices.

These interviews are the initial baseline measurement of CMO enrollees. Because the CMOs generally began by enrolling their existing COP and Waiver caseloads, the baseline could be seen as a picture of how enrollees experienced the system before Family Care. The results show that the consumers felt the existing system scored high in assuring that people are safe from abuse and neglect, had privacy, fair treatment, choice of their routines and are generally satisfied with their services. However, other areas did not score as high, including having a limited choice of their services and providers. The Department published a report on their findings in March 2001, *Family Care Quality. CMO Member Outcomes: The Baseline Assessment*. This report can be found at the DHFS website:

<http://www.dhfs.state.wi.us/LTCare/pdf/MemberOutcomesReport.pdf>

Appendix 11 shows a summary of the fourteen outcome baseline results across all CMOs.

## Cost Of Services: CMO Rates

The only information available to date about the cost of services for the CMOs, are the rates shown in the chart that follows. CMO rates were developed in conjunction with the actuarial firm of Milliman and Robertson, which specializes in managed care for Medicaid populations. The prospective rates are based on the historical costs of those individuals likely to enroll in the CMO. Then on a retrospective basis the rates are adjusted based on who actually enrolls.

Initially, CMOs had concerns about whether or not the rates picked up all the historical costs from all the state and local programs that supported people with long term care needs. Changes were made and at this point, two counties have felt comfortable enough with the rates to discontinue the risk sharing option with the state. So for the calendar year 2001, the state will not share in any losses or profits in those two counties. Since the final review of the CMO audits and fiscal reports for the year 2000 are not yet complete, more time is needed to analyze the results of the last contract period.

### CMO Retrospective Rates CY 2000

CMO County	Casemix			
	Current Retro Rate	Enrolled Days	% of Enrolled Days	Weighted PMPM*
Fond du Lac (Draft)	\$1,634	123,982	30.9%	\$504
LaCrosse (Final)	\$1,584	109,474	27.3%	\$432
Milwaukee (Final)	\$1,467	92,642	23.1%	\$338
Portage (Draft)	\$2,434	75,520	18.8%	\$458
<b>TOTAL</b>		<b>401,618</b>	100.0%	<b>\$1,732</b>

\*Per Member per Month

## CMO Accomplishments

**Waiting Lists Are Being Eliminated.** One of the goals of Family Care is to improve access to a comprehensive long term care benefit. That is becoming a reality in the CMO pilot counties. As of March 15<sup>th</sup>, LaCrosse, Fond du Lac and Portage counties have eliminated waiting lists for the Family Care target populations. People also report that the process is much quicker getting into Family Care as opposed to the Waiver process.

**CMOs Report that People are Being Relocated.** CMOs are beginning to relocate individuals into more integrated and less costly settings appropriate to their needs. The following story illustrates one success:

*Mr. B., 68 years old, was referred to the Resource Center for possible assistance with nursing home relocation, because his nursing home was due to close by Christmas. Mr. B. suffered from depression, hypertension and other health problems. He was determined eligible for Family Care and enrolled. The care manager and Mr. B developed a plan of care that included a CBRF. Although he believes the five years he spent at the nursing home had been helpful to improve his health and ability to socialize, he recognized that he no longer needed the nursing home to provide that care. He moved to his new home before the Christmas deadline.*

**The Department Has Developed and Implemented an Outcome-Based Monitoring System for CMOs.** This major shift in measuring quality will allow the Department to move towards one of its five major goal areas for Family Care—to improve quality through a focus on health and social outcomes.

**CMOs Creating Interdisciplinary Teams of Nurses and Social Workers.** The sharing and cross training of skills has been beneficial to clients and care managers report this has been a favorable experience. Consumers now have access to a health professional to help coordinate their long term care services with their acute and primary care providers.

*The team, including a social services coordinator and registered nurse, evaluated the health care needs of one of the members. As a result, a number of over-the-counter pharmacy items were recommended and authorized. These items were necessary to prevent some health problems. The member and his family noted that this intervention helped and his health has improved.*

**Consumer Outcomes at the Center of Decisions on Cost-Effective Services.** The Department has developed and implemented a new Resource Allocation Decision-Making Methodology which structures decision-making for care planning. The team, which includes the consumer, begins the decision-making process with the consumer's desired outcomes, then seeks the most cost-effective methods to meet those outcomes. CMOs and consumers who are using this approach seem to like it, although there is still considerable learning to be done by many care managers and consumers.

The following story illustrates this method:

*A 90-year-old man was discharged from the hospital after suffering a stroke. He and his wife of 63 years lived independently in their own apartment until the husband's illness. He needed personal care, but not a lot of nursing care, although he met the nursing home level of care. Because the team knew that the couple had expressed a strong preference to stay together—their desired outcome—the care plan was developed whereby the couple moved to an assisted living apartment. His wife can provide most of his personal care, while the facility provides meals and supervision. They are together and have enough income to pay the room and board costs for both of them.*

If the man in this story had entered a nursing home, his wife would have needed most of the family income to support her apartment, and the CMO or MA fee-for-service would have paid the entire cost of the nursing home. The cost to the CMO is less than half of what the nursing home costs would have been. The CMO and the state saved money and a married couple of 63 years stayed together and allowed a wife to continue to care for her husband.

**Site Visits Show Care Management Organizations Have Major Components in Place.** The Department reports that based on their site reviews, CMOs appear to have developed, or are on target to have in place the major components of Family Care. Because Family Care includes a tremendous amount of change in doing business, it is expected that change will happen gradually.

**Two Counties Have Opted Out of Risk Sharing with the State.** Although counties initially had concerns about entering into a risk-based system, at this time, two of the five CMO counties feel confident enough and have opted out of risk-sharing with the Department. These counties, Portage and Fond du Lac, are two years ahead of the projected three-year time period of risk sharing that was available to them.

**State Support for the CMOs in Place.** The level of state support through technical assistance, training, and the provision of information in regular conference calls and meetings have produced a high level of cooperation essential to the CMOs early success.

**CMOs are Collaborating.** The CMOs have shared with each other their best practices. This has helped CMOs who have come on later to not “re-invent the wheel.” As an example, Richland County used an information system developed by Portage County.

**Flexible Benefit Allows Services to Reflect Cultural Differences.** CMOs are beginning to use the flexibility of the new benefit, including the use of alternative providers. In the current Medicaid fee-for-service system this would be difficult to do. The following story illustrates how this happened in one situation.

*The father of a large and multi-generational Hmong family suffered a stroke. He was enrolled in Family Care and lived at home with support, including traditional physical therapy. The family wanted to use a Hmong therapist to help him regain strength in his arms. The CMO decided after looking into the treatment that they would authorize a trial of the therapy. The nurse measured the member's strength and flexibility prior to treatment and after the trial. As improvement was noticed, the team authorized additional treatments.*

## **CMO Challenges and Opportunities**

All new programs bring challenges and opportunities to improve. Family Care is no different. The following are some areas that the Council wanted to highlight:

- **Kenosha Expansion on Hold.** Kenosha County has been the recipient of a planning grant to build the infrastructure needed to pilot the care management organization in the next biennium. They have done considerable work and are poised to reap the benefit of that hard work. However, the Governor's biennial budget did not include an expansion into Kenosha County. Kenosha County has reported 428 people waiting for home and community based care. The Council is concerned that this will result in a loss of momentum and the learning and development of special expertise. The individuals who need help in that county will not receive services while at the same time the resources used for this planning and development will have been wasted.
- **Benefit Package Initially Confusing for Providers.** Because Family Care pays for some services and certain medical supplies and equipment and not others, this has caused confusion for some providers in the transition period. Electronic billing methods are important to providers and have established methods and need to retool to bill the CMO. Counties and the state held multiple information and training sessions for providers as well as providing written information and clarification in the Medicaid Provider Updates.
- **Worker Shortages are a Challenge.** Having sufficient staff to assure that people have cost effective options is a challenge due to the shortage of workers, especially direct care workers. This may have resulted in care plans that include services that are not the first choice of the individual.

- **Occasional Enrollment Delays Have Occurred.** As a part of the initial phase-in of the CMOs, the state has two years before the counties enter the entitlement phase. When county pilots eliminated their waiting lists, they still encountered times when they experienced enrollment delays as they processed larger than expected number of referrals and as CMOs converted their existing COP and Waiver caseloads to Family Care. It is imperative that counties have the flexibility to add the needed staff in a timely way as caseloads increase. This may be an expected phenomenon of new program growth versus a mature program.
- **Service Authorizations by CMOs Can Be Labor Intensive.** Some of the CMOs developed service authorization procedures that are labor intensive for care managers. This seemed to result in staff having less time available to spend with consumers. This will hopefully improve as new business functions are standardized and as CMOs learn to rely on aggregate utilization data, instead of individual care plan information to assure cost-effectiveness.

### **Council CMO Recommendations**

- Expand Family Care Pilots. Add the Kenosha CMO in the FY 2001-03 Biennial Budget.
- Restore the Independent Advocacy Program. As in any program, disagreements may occur; an objective third party may help resolve them and could help ensure consumer rights are protected.

## **VI. Americans with Disabilities Act (ADA) Title II Issues**

**Background.** In July 1999 in the *Olmstead vs. L.C.*, the U. S. Supreme Court affirmed the requirement in the Americans with Disabilities Act (ADA) Title II Regulations that public entities must serve individuals in the most integrated setting appropriate to their needs when the following is true:

- The State’s treatment professionals determine that such placement is appropriate,
- The affected persons do not oppose such treatment, and
- The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

The *Olmstead* case was brought by two Georgia women whose disabilities include mental illness and mental retardation who lived in state-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The *Olmstead* decision interpreted Title II of the ADA and its implementing regulation, which oblige States to administer their services, programs, and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” (28 CFR 35.130(d)).

*Olmstead* applies to individuals with disabilities protected from discrimination by Title II of the ADA. Although *Olmstead* involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of *Olmstead* limited to Medicaid (MA) beneficiaries or to services financed by the MA program. In addition, it is the Council’s belief, that the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

**ADA Title II Advisory Committee Formed.** The Council formed a committee jointly with the Secretary of DHFS to review Wisconsin’s long term care system in light of the ADA, Title II and the possible ramifications of the *Olmstead* decision. The Committee is made up of over 40 individuals representing the major stakeholders in the area of long term care (see Appendix 12 for Committee Charge and Membership). The committee make-up is broader than the Council to include representation of target groups beyond Family Care, including mental health and children.

**Interim Report.** The Committee is due to complete its final report on their final recommendations by the end of 2001. The ADA Title II Advisory Committee found that there were a number of areas where additional data is needed to find out who may be affected by ADA Title II. The Council reviewed the Committee’s interim proposals and they are included in the Council’s budget recommendations that follow.

## VII. Other Long Term Care Recommendations

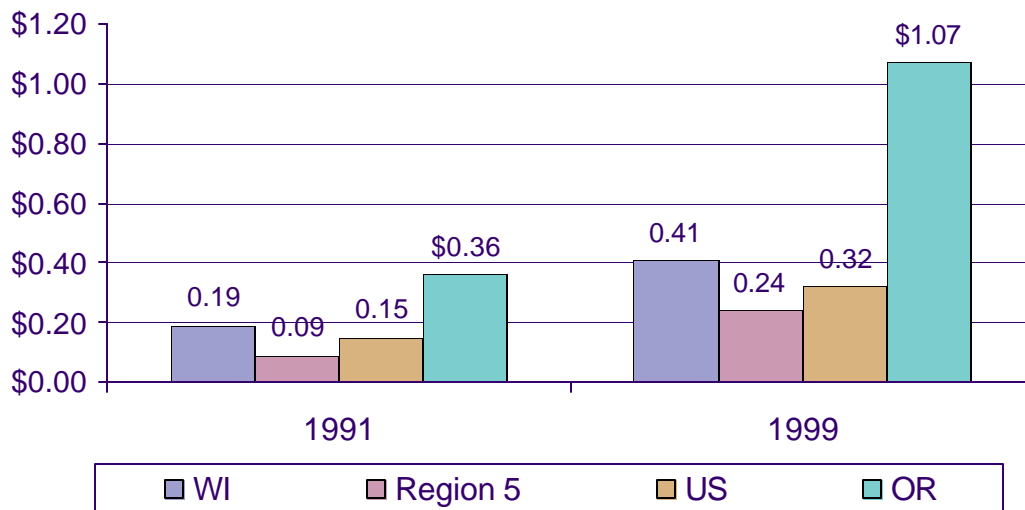
### Wisconsin's Long Term Care Expenditures

Wisconsin's total per capita Medicaid long term care expenditures in 1999 were \$266 a year. That was higher than those of the average of the other states surrounding Wisconsin in the federal Department of Health and Human Services Region 5, which was \$246 and the U.S. average of \$242 per capita. Often Wisconsin is compared to Oregon, another leading state in providing long term care services to older people and people with disabilities, which spent \$209 per capita (see chart in Appendix 13). However, the average rate of growth of the total long term care expenditures between 1991 and 1999 has been lower in Wisconsin than the region or the U.S. average.

Looking at the breakout of the total Medicaid long term care costs, Wisconsin's ratio of per capita home care to institutional care expenditures is higher than the Region 5 states and the U.S. averages, but lower than Oregon's in both 1991 and 1999 (see chart below). For example, in 1991 Wisconsin spent 19 cents in Home Care for every one-dollar spent on institutional care. By 1999, it increased to 41 cents for every one dollar of institutional care. In 1999, Oregon spent more on home care than on institutional care programs.

This shows Wisconsin is making progress, but more can be done.

**Ratio of Home Care to LTC Institutional Medicaid Expenditures, 1991 and 1999**



## Council Community Care Budget Recommendations

In light of the *Olmstead* decision and the Council's review of the current state of the long term care system in Wisconsin, the state needs to continue its commitment to realign systems so that there is access to a range of options, including home and community based care. In order to improve access to home and community based care for the 9,202 people waiting for services in non-family care target groups and counties, Wisconsin needs to allocate additional resources in the 2001-2003 state budget. The Council recommends the following items:

- **A New Long Term Care Budget Methodology is Needed.** With the future growth in people needing long term care, the state needs to adopt a new budgeting system for long term care that supports a consistent policy and vision. The current system of budgeting program by program or service by service does not show the overall impact of these discreet budget decisions and how they impact on the entire system. Policy and budgeting need to be aligned towards a vision of cost-effective long term care options, which promote consumer choice of care setting. This approach is especially needed in light of the recent *Olmstead* ruling.
- **Maximize Federal Revenue Sources.** The state should develop new ways to generate additional federal revenue to pay for the expansion of community programs. Direct the DHFS to develop new options no later than 6/30/02 to generate federal revenue by capturing additional federal Medicaid funding for home and community based care programs. These options should include investigating an option related to a new "Intergovernmental Transfer Program (IGT)" for Community Care or by using the county Community Aids overmatch as leverage.
- **Expand Community Care Capacity.** The population in need of long term care continues to increase. The state needs to provide resources to expand the capacity of the various community programs that serve the long term care populations in non-Family Care counties and populations as follows:
  - **\$8.7 Million GPR for the Biennium to Fund Demographic Growth in Non-Family Care Counties for COP and COP Waiver.** The Council recommends that the state fund 700 new COP slots as of Jan. 2002 and an additional 700 slots as of Jan. 2003 to pay for the expected demographic growth in the non Family Care counties and non Family Care populations. This will provide areas of the state outside Family Care counties with resources to continue the state's commitment to community based care. The cost of funding 700 new slots each year, using 30% COP-Regular slots and 70% COP-Waiver slots, is \$2,443,800 GPR and \$1,343,600 FED in FY 02 and \$6,367,300 GPR and \$3,890,500 FED in FY 03.

- **\$10.4 Million GPR for the Biennium to Fund COP/Waiver Wait list Reduction.** These funds should be targeted to fund COP services or as match for COP Waiver programs in non-Family Care counties and for non-Family Care populations to reduce waiting lists. This would provide approximately 1,200 additional slots over the biennium assuming services for 18 months starting January 2002, using a split of 30% COP and 70% COP Waiver funding.
  - **\$10.9 Million GPR for the Biennium to fund CIP II Slots.** *At a minimum*, the Council strongly recommends the addition of 1,600 new CIP II slots, with 800 in FY 02 and 800 in FY 03 at a rate of \$45/day. For 800 of these new slots, priority would be given to the relocation of individuals identified as *Olmstead* clients.
  - **\$5.6 Million GPR for the Biennium to fund 500 CIP 1B Slots.** Fund 500 new slots at the current actual cost, \$74.70/day with 250 new slots each year of the biennium.
  - **\$2.8 Million GPR for the Biennium to fund 100 new Brain Injury Waiver (BIW) Slots.** – Fund these slots at the existing rate of \$184/day at the rate of 50 each year.
- **Maintain Existing Community Care Capacity with Rate Increases.** In future budgets, annual cost-of-living increases for home and community care (e.g., COP and CIP) should be included that are tied to an agreed upon measure of inflation such as the consumer price index. As any other commodity, long term care services cost more each year. To ignore this inflation results in the erosion of the capacity of the existing programs. Counties have to choose between allocating additional county tax levy or serving fewer people. For this biennium, the following rate increases are proposed to bring these programs more in line with the costs currently incurred by programs across the state:
    - **Provide \$3.5 Million new GPR for the Biennium to Increase the CIP II Rate.** Increase the rate for CIP II to \$45 a day (from existing rate of \$40.78), beginning on January 1, 2002. This will provide a higher average CIP II rate that will help pay for the increased costs associated with the relocation of nursing home residents who may have more significant needs. Experience has shown that to be successful at making placements, the average cost of CIP II would need to increase to pay for these individuals with increased needs.
    - **Provide \$1.7 Million new GPR for CIP IA above the Governor’s Budget** – Increase rate to \$300.00/day (existing rate is \$190/day and the Governor’s budget increases the rate to \$200/day in 2002 and \$225/day in 2003). Separate this rate increase from the State Center’s “drop rate” in order to preserve quality care for individuals who remain in the Centers and to maintain adequate staffing to meet Medicaid certification standards. The de-coupling of the drop rate adds increased costs reflected in this recommendation.
    - **Provide \$20.3 Million GPR for the Biennium to Fund CIP IB Rate Increase** - Increase rate to current actual average cost of a slot \$74.70/day (current average rate is \$49.38).

Although it is important to assure that the rates paid for community services accurately reflects actual costs, if resources are not available, this item would be of secondary importance because counties are already providing some support for these costs at the present time.

- **Transition Institutional Capacity to Community Care.** The Supreme Court’s *Olmstead* decision provides yet another reason for Wisconsin to recognize the need to transition the existing system towards community care. As the number of nursing homes in financial trouble increases, it is likely that there will be an increasing number of nursing home closures. The Council recommends that the state use this as an opportunity to proactively budget for the resources needed to relocate individuals into the community when that is appropriate.
  - **\$66,000 new GPR for the Biennium to fund Community Assessments.** When a nursing home closes, a quick response is needed to assess the needs of residents and develop a care plan for those appropriate for relocation into the community. When an entire nursing home closes, counties are not able to process that volume of referrals in a short period of time. The Council proposes that the state recognize the costs of these assessments and care plans as a part of a nursing home phase down and increase its capacity to assure that these assessments are completed in a timely manner. Experience has shown that this is essential, especially for individuals with multiple conditions, in order for successful community transitions and placements. The Council proposes that funds be set aside that have the flexibility to pay for either additional county care manager time to perform these tasks—when that is possible—or to enter into contracts with independent organizations to complete these assessments and care plans. We estimate the annual cost of this proposal to be approximately \$66,000 a year (\$33,000 GPR and \$33,000 FED) —the estimated cost of one full time contracted nurse consultant.
  - **Money Follows Person.** The state should develop a protocol in which anyone receiving institutional care in Wisconsin and who qualifies under *Olmstead* guidelines should be entitled to have the money for institutional care "follow them" to pay for home and community care. Direct DHFS to maximize all current options that allow funding to follow clients (including CIP II, CIP 1A, CIP IB programs) to allow “Olmstead Clients” to move to more integrated settings. Further direct DHFS to develop additional or new options no later than 6/30/02 for consideration by the Governor and Legislature in the next biennial budget process.
- **Mental Health System Improvements to Address ADA Title II.** Improve funding in mental health long term care as follows:

- Provide **\$2.25 Million in new GPR for the Biennium** to pay for the State assuming the responsibility for the state share of MA funding for Community Support Programs. Currently counties provide the state match for this Medicaid benefit. The state is required to assure that this benefit is available statewide. The state and counties should work towards a mutually agreed upon method for transitioning this fiscal responsibility to the state, including the most equitable way to allocate these funds and serve all people waiting or will be in need of services over the biennium.
  - Direct the Department to develop options in the following areas no later than 6/30/02:
    - Explore how this population can be served through a new “CIP II-like” Waiver.
    - Develop financing mechanisms to relocate youth at the state Mental Health Institutes into community services. Explore options including: moving the state GPR dollars from the hospital to the community for youth at the state mental institutes, EPSDT, and a new Children’s Waiver.
    - Improvements for the screening of individuals entering institutional settings and the on-going or annual review of those individuals. Review the current PASARR (Preadmission Screening and Resident Review) and other processes that already exist and develop budget and policy recommendations to improve existing processes.
    - Improve the data collection in institutional settings, especially for individual’s mental health and behavioral health needs (includes exploring modifications to state module for the Minimum Data Set).
  - The Department should allocate a portion of the recent Mental Health Block Grant to develop the community services capacity for kids, such as further developing integrated services programs and other services and models.
  - The Department should also allocate a portion of the new Mental Health Block Grant funds to provide consultation support to the Division of Supportive Living, Bureau of Community Mental Health to assist in the development of these options by 6/30/02.
- **Children’s Long Term Care.** As the adult redesign efforts continue in the pilot stage, it is important that the efforts to redesign children’s long term care services also moves forward. The *Olmstead* decision, affects all ages and target groups and none should be left behind, especially the children of Wisconsin.
    - **Keep Children’s Redesign Waiver in the Budget.** The Council supports the Governor’s Budget proposal, which requires DHFS to develop and submit to the federal government a new Children’s Redesign Waiver. This new home and community based services Waiver would include services more appropriate for children and families. The new Waiver would target children in need of long term care across the spectrum of disabilities, including children with developmental, physical and emotional disabilities. Using the current GPR funded Family Support Program as match for those families who voluntarily enroll, Wisconsin could expand the Federal resources available. DHFS should be directed to submit no later than 9/30/02 a budget proposal for the Children’s Waiver to the Governor that will better utilize the federal and state

programs (including the Family Support Program) to draw down additional federal resources for children's long term care services.

- The Council recommends that \$3.5 million in new GPR be allocated for the upcoming biennium to begin servicing an additional 778 children in the existing Family Support Program while awaiting the new Children's Waiver.
- Direct the Department to explore federal and state statutory changes needed to assure that long term care services support *children* in their homes as a first priority as opposed to out of home placements.

## ***VIII. Appendices***

## APPENDIX 1

### Wisconsin Council on Long Term Care Membership

(Agendas and minutes of all meetings can be found on the Council's Internet site at:  
[www.wcltc.state.wi.us](http://www.wcltc.state.wi.us))

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## APPENDIX 2

### Duties of Council

Legislation gave the State Council on Long Term Care the following specific responsibilities:

- **Broad Policy Development.** Assist the department in developing broad policy issues related to long term care services.
- **Implementation Policy and Coordination.** Assist the department in developing, implementing, coordinating and guiding long term care services and systems, including reviewing and making non-binding recommendations to the department on all of the following:
  - The department's standard contract provisions for Resource Centers and Care Management Organizations.
  - The Family Care benefit, including the per person rate structure for the benefit.
  - The long term support Community Options Program under s. 46.27.
  - The Community Integration Programs under ss. 46.275, 46.277 and 46.278.
  - Other programs that provide home and community-based services.
  - The provision of medical assistance services under a fee-for-service system.
- **Monitoring and Review.** Monitor patterns of complaints, grievances and appeals related to long term care in order to identify issues of statewide importance.
  - Monitor the numbers of persons on waiting lists.
  - Review patterns of utilization of various types of services by care management organizations.
  - Monitor the pattern of care management organization enrollments and disenrollments throughout the state.
- **Reporting.** Report annually to the legislature under s. 13.172 (2) and to the governor on the status, significant achievements and problems of Resource Centers (RCs), Care Management Organizations (CMOs) and the Family Care benefit, including all of the following:
  - Numbers of persons served.
  - Costs of long term care provided under the family care benefit.
  - The number and service areas of resource centers and care management organizations.
  - Waiting list information.
  - Results of reviews of quality of services provided by resource centers and care management organizations.

## APPENDIX 3

### Major Activities of the Wisconsin Council on Long Term Care

In order to efficiently carry out their responsibilities, the Council developed a number of Committees to address issues that arose and to develop specific recommendations for this report. The Council Committees included:

- Budget Recommendations Committee
- Resource Center Administrative Rules Committee
- Consumer Awareness Committee
- Resource Center (RC) Committee
- Care Management Organization (CMO) Committee
- ADA Title II Advisory Committee

Over the past year the Council and its predecessor were involved in the following key activities:

- **Mediation of Family Care Administrative Rules.** The Wisconsin State Senate Committee on Human Services and Aging and the Assembly Health Committee referred concerns raised by stakeholders in the Family Care Administrative Rules process to the Council for their input and advice. They were asked to involve concerned stakeholders in the resolution of the issues. The concerns centered around the need for more specific standards in the rule for Resource Center and Care Management Organizations.

In August, the Council met with concerned stakeholders including providers, county pilots and the department and developed more specific CMO and RC standards which all parties agreed upon that were included in the permanent Administrative Rule.

The Council was able to provide support to the Legislature by avoiding a protracted debate on the rules. The Council's successful mediation of stakeholder concerns is a key outcome of the Council's activities in the last year.

- **Met with Staff from the Governor’s Office and the Department of Administration (DOA) Budget Office.** The Council met with staff from the Governor’s Office and the DOA Budget Office on December 1, 2000. They discussed their recommendations and priorities in the area of long term care for the upcoming biennial budget.
- **Met with Local Long Term Care Councils.** The Council invited input from the nine Local Long Term Care Councils. Eight of the nine local long term care councils were represented at the State Council at its February 23, 2001 meeting. They reported on the significant achievements and challenges in the implementation of Family as well as the status of their local long term care system.
- **Review of State-Wide Issues in Long Term Care.** The Council also reviewed the status of the statewide long term care system in Wisconsin. The major issues explored on a statewide basis included: status of the home and community based services wait lists; data on persons served and the history of funding levels; and the need for providing cost of living increases to existing community care clients.
- **ADA Title II Advisory Committee.** In 1999 the U.S. Supreme Court ruled in *Olmstead vs. L.C.* that under T. II of the Americans with Disabilities Act (ADA) that public entities must provide services to persons with disabilities in the most integrated setting appropriate to their needs. The Council created a committee jointly with the Secretary of DHFS to review the current long term care system in light of the ADA Title II and the *Olmstead* decision. The ADA Title II Advisory Committee (see Appendix 10 for Committee Charge and Membership) submitted interim recommendations to the Council. The Council reviewed their initial report and recommendations are included in this report to address ADA Title II issues.

## APPENDIX 4

### Family Care Benefit Services

Members receive services in the long term care benefit package where they live, including:

- Member's own home, including supported apartments;
- Nursing Facilities or ICFs/MR.
- Alternative residential settings:
- Residential Care Apartment Complex (RCAC)
- Community Based Residential Facility (CBRF)
- Adult and Family Homes;

CMOs provide members a package of long term care and health care services. These services are tailored to meet the individual member's needs identified during a comprehensive assessment. The specific services a person will receive are included in the member's individualized care plan, which is developed in consultation with the member, the member's authorized representatives and informal supports, and that incorporates the member's choices and preferences. The following is a list of the minimum services that a CMO must develop and have available.

- Adaptive Aids
- Adult Day Care
- AODA Day Treatment (all settings)
- AODA Services (except inpatient or physician provided)
- Case Management (includes Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Community Support Program
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment (except hearing aids and prosthetics)
- Home Health
- Home Modifications
- Meals (home delivered and congregate)
- Medical Supplies
- Mental Health Day Treatment (all settings)
- Mental Health Services (except inpatient or physician provided)
- Nursing Facility (includes ICF/MR and IMD)
- Nursing Services
- Occupational Therapy (except inpatient hospital)
- Personal Care
- Personal Emergency Response System Services
- Physical Therapy (except inpatient hospital)
- Prevocational Services
- Protective Payment/Guardianship Services
- Residential Services (RCAC, CBRF, Adult Family Home)
- Respite Care
- Specialized Medical Supplies
- Speech and Language Pathology Services (except inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation (except ambulance)

The CMO is not restricted to providing only the services in the LTC benefit package listed above. In developing service plans, the CMO case management team may decide that other services, treatments or supports are more appropriate or likely to result in better outcomes than the services in the LTC benefit package (e.g., exceptional housing needs, acupuncture, membership in a fitness club). The per member per month payments made to the CMO will not be increased or decreased when additional or alternative services are provided.

## **Medicaid Services “Carved Out” or Not Included in Family Care**

- Alcohol and Other Drug Abuse Services provided by a physician or in an inpatient setting
- Audiology
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital: Inpatient and Outpatient, including emergency room care (except as indicated in list of covered services above)
- Independent Nurse Practitioner Services
- Lab and X-Ray
- Mental Health Services provided by a physician or in an inpatient setting
- Optometry
- Pharmaceuticals
- Physician and Clinic Services (except as indicated in list of covered services above)
- Podiatry
- Prenatal Care Coordination
- Prosthetics
- School-Based Services
- Transportation: Ambulance and transportation by common carrier

## APPENDIX 5

### Individuals Reported Waiting for Long Term Care Services by Target Group and County (Non-Family Care Counties)

(Data Current as of 12/31/00)

County	Elderly	D.D.	CMI	P.D.	AODA	Total
Adams DHSS	0	0	0	33	0	33
Adams DCP	0	18	1			19
Ashland	69	48	19	40	1	177
Barron	55	36	4	31	0	126
Bayfield	31	5	0	11	0	47
Brown	319	214	42	156	1	732
Buffalo	0	0	0	0	0	0
Burnett	14	7	7	14	0	42
Calumet	0	0	0	0	0	0
Chippewa	0	0	0	0	0	0
Clark	11	0	6	0	0	17
Columbia	103	155	14	60	3	335
Crawford	9	4	0	0	0	13
Dane	615	192	75	391	239	1,512
Dodge	17	64	0	24	0	105
Door Dss	6	0	0	0	0	6
Door Dep	0	73	8	0	0	81
Douglas	4	58	8	33	0	103
Dunn	0	57	0	0	0	57
Eau Claire	13	10	5	27	0	55
Florence	0	0	0	0	0	0
Fond du Lac (Non FC Eligibles)	N/A	N/A	8	N/A	0	8
Forest	0	7	0	3	0	10
Grant	28	17	2	5	0	52
Green	20	7	5	24	0	56
Green Lake	9	4	3	0	0	16
Iowa	5	0	0	12	0	17
Iron	18	1	0	4	0	23
Jackson	17	8	0	8	0	33
Jefferson	14	0	2	2	0	18
Juneau	16	11	0	30	0	57
Kenosha	284	24	2	118	0	428
Kewaunee	20	0	1	10	0	31
Lafayette	16	10	1	18	0	45

<b>County</b>	<b>Elderly</b>	<b>D.D.</b>	<b>CMI</b>	<b>P.D.</b>	<b>AODA</b>	<b>Total</b>
Langlade	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0
Manitowoc	45	23	15	61	0	144
Marathon	143	171	23	50	1	388
Marinette	49	23	2	21	0	95
Marquette	30	10	2	11	0	53
Menominee	0	0	0	0	0	0
Milwaukee	0	583	5	777	0	1,365
Monroe	24	3	3	5	0	35
Oconto	23	35	3	14	1	76
Oneida	0	18	0	0	0	18
Oneida Tribe	12	2	0	0	0	14
Outagamie	43	12	0	57	0	112
Ozaukee	69	23	0	19	0	111
Pepin	4	9	0	1	0	14
Pierce	0	21	0	0	0	21
Polk	0	32	1	25	0	58
Price	0	13	4	0	0	17
Racine	104	74	9	70	0	257
Rock Hsd	118	0	37	36	0	191
Rock Dd Bd	0	129	0	0	0	129
Rusk	47	12	3	16	1	79
St Croix	32	90	11	10	0	143
Sauk	41	52	1	13	0	107
Sawyer	28	14	1	17	0	60
Shawano Dss	0	0	0	0	0	0
Shawano Dcp	0	44	1	0	0	45
Sheboygan	12	136	0	1	0	149
Taylor	13	0	0	0	0	13
Trempealeau	2	17	0	8	0	27
Vernon	8	1	1	1	0	11
Vilas	21	24	4	30	0	79
Walworth	16	75	12	53	0	156
Washburn	18	1	11	24	1	55
Washington	8	10	5	28	0	51
Waukesha	173	0	38	133	0	344
Waupaca	55	58	4	46	0	163
Waushara Dhs	79	4	1	22	1	107
Winnebago	65	16	6	23	0	110
Wood	71	40	1	39	0	151
<b>TOTALS</b>	<b>3,066</b>	<b>2,805</b>	<b>417</b>	<b>2,665</b>	<b>249</b>	<b>9,202</b>

## APPENDIX 6

### Resource Center Prevention Research Projects

- **Jackson County: Falls Prevention.** Jackson County's project is an intergenerational effort, which collaborates with the high school, hospital rehabilitative services, Western Dairyland Economic Opportunity Council (EOC), Inc., and the physical therapy department at the UW La Crosse. The project has two components. In the first component, 59 adults age 75 and over have been evaluated for balance, muscle strength and walking speed. Home safety evaluations were completed for all 59, and 40 homes are having needed home modifications completed by the Western Dairyland EOC, Inc. High school seniors and healthy older adults have been trained to help the 59 people complete a basic in-home daily exercise program to increase leg strength and overall stability. The second part of the project is an exercise and safety education program for 92 active adults 55 and older living independently in the community. Pre and post testing for risk of falls is being analyzed for twenty participants.
- **Marathon County: In Home Preventive Health Care.** Marathon County's project is a replication of a California project that reduces rates of daily disability and use of the nursing homes. The project includes in-home assessments by a gerontological nurse practitioner for participants 75 and over who reside at home, have no significant physical or cognitive disorder and are not terminally ill. Follow-up visits and assessments are dependent upon assignment to a control or intervention group. The research project is being conducted in collaboration with North Central Health Care and Dr. Mark Sager, UW Madison, Medical School. The Resource Center will strengthen the model by adding telephone monitoring and linkage to Resource Center services. The project is expected to enroll 430 participants over three years.
- **Milwaukee County: Changing Health Related Behaviors.** Milwaukee County Department on Aging, in collaboration with UW Milwaukee, is targeting people age 60 and over who are African American, Southeast Asian, Hispanic or Native American, and seniors over 70, to assess the effectiveness of three interventions in motivating people to lead healthier lives. The interventions include: a computer-based health risk assessment and internet-based health and fitness education; individual fitness assessments by a trained exercise physiologist and access to equipment and structured workout time; and print information such as pamphlets, booklets and newsletters. A control group that receives no intervention will also be measured. Actual change in physical fitness and feelings about fitness and functionality will be assessed.
- **Tempealeau County: Nutritional Risk Identification and Intervention.** Trempealeau County's project identifies individuals at high or moderate nutritional risk and provides nutritional counseling and personal health planning. The United Volunteer Caregivers, Inc. is recruiting and training volunteers to provide support services such as friendly visitors, transportation and meal preparation. In addition to a dietician's evaluation of the nutritional health of service recipients, this project will measure the benefits of meaningful volunteer activities for individuals participating in the volunteer program.

## APPENDIX 7

### Resource Center Monthly Contact Information by Target Group

On a monthly basis, the resource centers report approximately 4,800 contacts a month.

Below is a chart that shows the demographics of the Resource Center contacts by site for the month of December 2000. This shows that older people (63% of the state contacts) and their families especially have found resource centers to be a good place to get information.

<b>Resource Center Contacts by Target Group December 2000</b>											
<b>Target Group</b>											
<b>Resource Center</b>	<b>65+</b>	<b>(%)</b>	<b>60-64*</b>	<b>(%)</b>	<b>DD</b>	<b>(%)</b>	<b>PD</b>	<b>(%)</b>	<b>Other</b>	<b>(%)</b>	<b>Totals</b>
Fond du Lac	71	58%			12	10%	15	12%	24	20%	<b>122</b>
Jackson	38	66%			2	3%	12	21%	6	10%	<b>58</b>
Kenosha Aging & PD	293	55%			-	0%	19	4%	220	41%	<b>532</b>
Kenosha DD	-	0%			-	0%	-	0%	43	100%	<b>43</b>
La Crosse	99	41%			6	3%	16	7%	118	49%	<b>239</b>
Marathon	268	82%			-	0%	22	7%	35	11%	<b>325</b>
Portage	117	22%			7	1%	16	3%	387	73%	<b>527</b>
Richland	14	54%			4	15%	2	8%	6	23%	<b>26</b>
Trempealeau	36	40%			-	0%	-	0%	53	60%	<b>89</b>
<b>Total Non-Milwaukee</b>	<b>936</b>	<b>48%</b>			<b>31</b>	<b>2%</b>	<b>102</b>	<b>5%</b>	<b>892</b>	<b>45%</b>	<b>1,961</b>
Milwaukee*	2,099	73%	50	2%	3	0%	26	1%	698	24%	<b>2,876</b>
<b>State Totals</b>	<b>3,035</b>	<b>63%</b>	<b>50</b>	<b>1%</b>	<b>34</b>	<b>1%</b>	<b>128</b>	<b>3%</b>	<b>1,590</b>	<b>33%</b>	<b>4,837</b>
Source: Resource Center I & A Data.											
Percentages represent the percentage of the <b>Totals</b> in the far right hand column (number in the cell directly to the right of the percentage divided by the RC Total for that row).											
*Only Milwaukee County reports elderly as 60+ years of age.											

## APPENDIX 8

### Resource Center Information Most Frequently Requested

For the time period of July to December 2000, over 44,000 requests were made to the resource centers. The areas of information most frequently requested are shown in the following table. They include requests for information about basic needs and financial issues, disability and long term care related services, long term care living arrangements, and health care needs. One client contact with the resource center may include requests for information in a number of areas.

<b>Resource Center Information Requested July - December 2000 (Cumulative)</b>		
<b>Type of Information</b>	<b>Requests</b>	<b>Percent</b>
Basic needs & financial-related (MA, Food Stamps, etc.)	8,556	19%
Disability & LTC-related services (home care, respite, etc.)	8,018	18%
LTC living arrangements (home accessibility issues, etc.)	6,037	14%
Health* (recuperative care, diseases, dementia, etc.)	5,148	12%
Transportation	3,371	8%
Paying for disability and LTC-related services	2,906	7%
Nutrition (home-delivered meals, nutrition counseling, etc.)	2,732	6%
Home maintenance (repairs, yard work, safety, etc.)	2,349	5%
Legal (taxes, complaints, guardianship, advocacy, etc.)	1,607	4%
Life enhancement (socializing/recreation, volunteers, etc.)	1,191	3%
Adult Protective Services (abuse, neglect, etc.)	1,159	3%
Behavioral Health (mental health or substance abuse)	1,060	2%
Employment & training (vocational rehabilitation, jobs, etc.)	341	1%
<b><i>State Total</i></b>	<b><i>44,475</i></b>	<b><i>100%</i></b>

## APPENDIX 9

### Outcome of Resource Center Contacts

The outcome of the contacts with the resource centers was tracked and reported to the Department. Resource Centers reported that from July till December of 2000, 53% of the resource center contacts resulted in giving individuals information about long term care. Another 15% received other information and 13% were referred on for a long term care functional screen to see if they were functionally in need of public long term care services. The chart below summarizes the outcomes for the contacts during that time.

<b>Resource Center Outcome of Contacts July - December 2000 (Cumulative)</b>		
<b>Outcome</b>	<b>Frequency</b>	<b>Percent</b>
Information on LTC	18,132	53%
Other information	5,071	15%
Referral to FC screen	4,612	13%
Referral to other services	1,761	5%
Needs short term services	1,623	5%
Follow up contact	1,411	4%
Referral to APS	826	2%
Referral to private LTC services	802	2%
Referral to emergency services	212	1%
<b><i>State Total</i></b>	<b><i>34,450</i></b>	<b><i>100%</i></b>

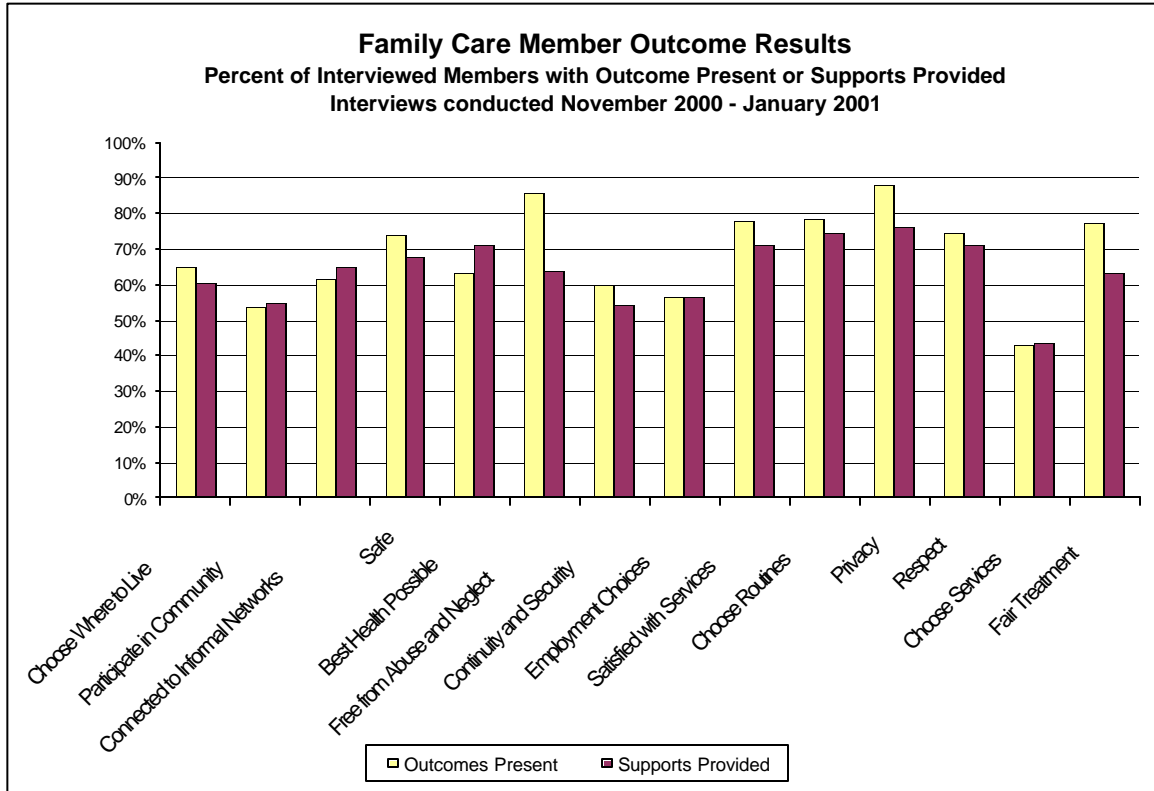
*Source: Resource Center I & A Data.*

## APPENDIX 10

### Family Care Member Personal Outcomes:

1. People choose where and with whom they live.
2. People achieve their employment objectives.
3. People are satisfied with services.
4. People choose their daily routine.
5. People have privacy.
6. People participate in the life of the community.
7. People have personal dignity and respect.
8. People choose their services.
9. People remain connected to informal support networks.
10. People are safe.
11. People are treated fairly.
12. People have the best possible health.
13. People are free from abuse and neglect.
14. People experience continuity and security.

## APPENDIX 11



Source: "Family Care Quality, CMO Member Outcomes: The Baseline Assessment,"  
 March 2001.

## APPENDIX 12

### Advisory Committee on ADA Title II Issues

12/1/00

#### Advisory Committee Charge:

This Committee is appointed by the Chair of the Wisconsin Council on Long Term Care and the Secretary of the Department of Health and Family Services under s. 15.04(1)(c), Wis. Stats., to review Wisconsin's long term care system in light of Title II of the Americans with Disabilities Act (ADA). The Committee will review statutes, rules, programs, policies, funding systems and practices affecting long term care in Wisconsin as they relate to ADA Title II. The Committee will advise the State Council on changes that could be made in these areas to help ensure the state's public system meets the requirements of ADA Title II. The Council may direct that the Committee advise them on particular issues, such as whether proposed changes should be incorporated into a formal written plan, or that the Committee provide advice or information to other public officials or groups with responsibilities relating to long term care. The Council will consider the Committee's advice in carrying out its statutory responsibility under s. 46.282(1), Stats., to assist the Department in developing broad policy issues related to long term care services and in developing, implementing, coordinating and guiding long term care services and systems.

#### Timeframe:

The Committee is expected to complete its task by September 1, 2001, but may submit interim reports or advice to the Council at the Committee's discretion or the Council's direction.

#### Advisory Committee Membership:

George Potaracke, (**Committee Chair**), Wisconsin Board on Aging & Long Term Care and Member of the Wisconsin Council on Long Term Care  
Dale Block, Member, Wisconsin Council on Long Term Care  
Chuck Wilhelm, Director, DHFS Office of Strategic Finance (**Committee Secretary**)  
Sinikka McCabe, Administrator, Division of Supportive Living, DHFS  
Peggy Bartels, Administrator, Division of Health Care Financing, DHFS  
Laura Flood, Interim Administrator, Division of Care and Treatment Facilities, DHFS

#### *Representatives from:*

AARP  
Aging Advisory Committee  
Americans with Disability Act Partnership Committee  
ARC of Wisconsin  
Area Agencies on Aging  
Children's Long Term Support Redesign Committee  
Coalition of Wisconsin Aging Groups

Department of Administration—Division of Housing (Invited)  
Department of Workforce Development  
Governor’s Committee for People with Disabilities  
Governor's Office (Invited)  
Grass Roots Empowerment Project  
Medicaid Advisory Committee or Medicaid Home Health Advisory Committee  
Mental Health Association in Milwaukee County  
Mental Health/AODA Pilots Implementation Committee  
National Alliance for the Mentally Ill of Wisconsin  
People First of Wisconsin  
State Independent Living Council  
WHEDA  
Wisconsin ADAPT  
Wisconsin Assisted Living Association  
Wisconsin Association of Homes and Services for the Aged  
Wisconsin Association of Residential Facilities  
Wisconsin Coalition for Advocacy  
Wisconsin Coalition of Independent Living Centers  
Wisconsin County Human Services Association  
Wisconsin Council on Developmental Disabilities  
Wisconsin Council on Mental Health  
Wisconsin Council on Physical Disabilities  
Wisconsin Counties Association  
Wisconsin County Nursing Home Association  
Wisconsin Department of Administration (Invited)  
Wisconsin Department of Veteran’s Affairs  
Wisconsin Family Ties  
Wisconsin Health Care Association  
Wisconsin Homecare Organization  
Wisconsin Hospital Association  
Wisconsin Parents Association  
Wisconsin Personal Services Association  
Wisconsin State Employees Union

**Advisory Committee Facilitator:**

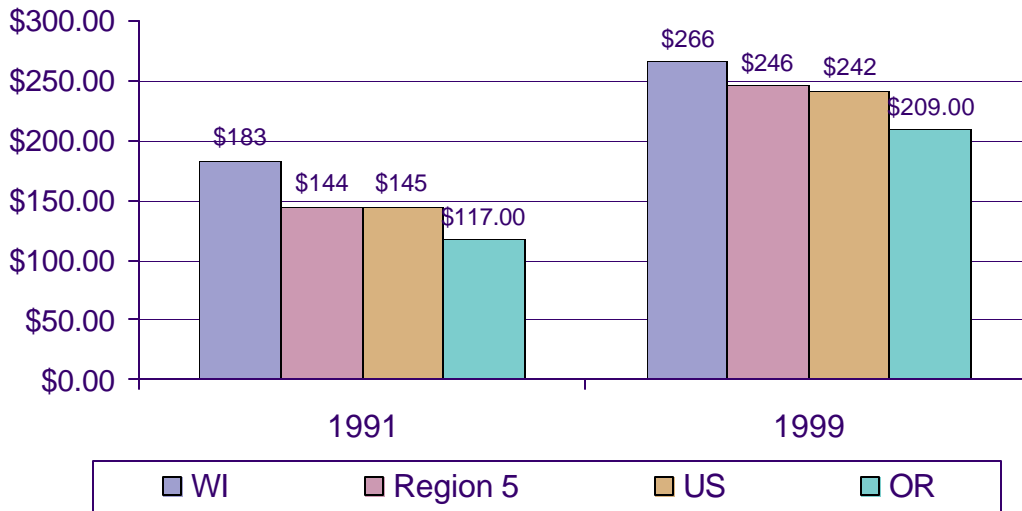
Gladis Benavides—DHFS Director of Affirmative Action/Civil Rights Compliance Office

**Staff:**

Joyce Allen, DHFS, Office of Strategic Finance  
Neil Gebhart, DHFS, Office of Legal Counsel  
Sandra Hammer, Affirmative Action/Civil Rights Compliance Office

## APPENDIX 13

### Total Per Capita Long-Term Care Medicaid Expenditures, 1991 and 1999



Total Long Term Care expenditures include both Home Care and LTC Institutional Care.

Home Care includes Home and Community Based Waivers, Personal Care and Home Health Care.

Long Term Care Institutional expenditures include Mental Health Facility Services, Skilled Nursing Services, and Intermediate Care Facilities for the Mentally Retarded.

Region 5 states include Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

Wisconsin's per capita Total Long Term Care expenditures were higher than those of Region 5, the U.S., and Oregon for both 1991 and 1999.

The rate of growth of Total Long Term Care expenditures from 1991 to 1999 was lower for Wisconsin than for Region 5, the U.S., or Oregon.

To receive a copy of the Annual Report of the Wisconsin Council on Long Term Care please contact Susan Grosse at 608/267-8909. This report is also available on the web site at:

[www.wcltc.state.wi.us](http://www.wcltc.state.wi.us)