

**Dane County Department of Human Services  
Planning for Change in Long-Term Care  
in Dane County**

**I. Issues:**

What are the risks and benefits to Dane County and its consumers if Dane County operates Family Care? Similarly, what are the risks and benefits if Dane County opts out of Family Care?

**II. Recommendations**

The Department recommends using the remainder of the Family Care expansion planning process to develop and further research the viability of a county operated CMO model for the implementation of Family Care in Dane County.

**III. Background**

Long-term Care programs: Community Options Program and Medicaid Waivers

The Community Options Program (COP) was introduced in 1982 as an alternative to nursing home care. This long-term care program provided community-based services as an alternative to the traditional nursing home care for persons who were functionally eligible for nursing home care. The program originally piloted in 8 counties and within 4 years the program had expanded to include all 72 Wisconsin counties. At the same time COP was enacted, a moratorium was placed on the construction of new nursing home beds in an effort to control increasing costs of providing nursing home care to MA recipients. In 1987 the COP-Waiver Program was approved by the federal government to allow for federal Medicaid funding for community-based services as an alternative to nursing home care. There are currently 7 waiver programs that serve adults in Dane County in addition to the original State funded COP program. Each of these waiver programs has similar financial and functional eligibility requirements but targets different client populations or differs in the way the program funds are allocated.

In 2006 in Dane County, 1,842 adults received services through the waiver programs at a total cost of \$79.6 million. Due to the popularity of these programs waiting lists of eligible persons interested in receiving community-based services instead of institutional care were quickly established since funding for these programs is sum certain. Historically, available resources have not been adequate to serve everyone who is eligible for services. Additionally, allocations have not been indexed to inflation. As participants age and become more frail, service needs increase, but program per diems are largely stagnant. Increases in funding over the last 12 years for the waiver programs are summarized below:

- There has been one increase in the per diems of the CIP1B (7/1/2000; program has 306 participants) and CIP1I (7/1/2002; program has 324 participants) programs. The increases were 2.8% and 2.6% respectively.
- The Brain Injury Waiver (BIW) Program began in 1995 and serves a much smaller population (16 served in Dane County in 2006). The per diem for this program started at \$150/day and by 1998 increased to \$180/day. The per diem has not changed since 1998. In 2006, Dane County's costs for services per day in the Brain Injury Waiver Program were \$253.26.
- The CIP 1A program funds persons relocating from State centers and has a tiered rate setting mechanism. In 1996 the base rate for persons in the program prior to July 1, 1995 increased to \$125/day. There are currently 6 separate payments tiers or per diems for participants in this program that are based on the person's enrollment date. The last payment tier, \$325/day was established in July 2003 for persons enrolled in the CIPA program after July 1, 2003. Dane County currently serves 89 people in the CIP1A program; 53 of those slots were established prior to July 1, 1995. There has been no rate increase on those initial slots in the last 12 years.
- The largest waiver program, in terms of enrollment, is the CIP1B local match program that served 685 participants in 2006. There is a Brain Injury local match program as well that had 32 participants in 2006. Locally matched programs have no State contribution in them. The county provides the entire match to federal funds in locally matched programs. CIP1B and BIW are the only Home and Community Based Waiver programs for adults with locally matched slots.

Over the years, some counties increasingly began to add local funding, sometimes referred to as "local match" or "overmatch", to these programs to fill the gap, and this is certainly true in Dane County where we have chosen to invest significant resources to provide better services. In 2006 our local match in these programs totaled \$19.5 million.

	Number Served`	Total Cost of Waiver Participants	Local GPR
Devel. Disabled	1,143	\$65,779,157	\$19,542,103
Frail Elderly	476	\$8,752,965	\$0
Phys. Disabled	223	\$5,120,289	\$0
Total	1,842	\$79,652,411	\$19,542,103

#### Managed Care Pilot Programs

The State piloted two managed care programs in the 1990's, the Partnership Program and Family Care.

A. The Partnership program provides long-term care services as well as acute and primary care to frail elders and adults with physical disabilities. In the

Partnership model, multi-disciplinary teams include a Nurse Practitioner. This program was piloted in 3 areas of the State including Dane County, Milwaukee County and a regional program serving Chippewa, Dunn and Eau Claire Counties. In Dane County, Care Wisconsin (formerly ElderCare of Wisconsin) and Community Living Alliance (CLA), two local not for profit agencies, became licensed HMO's in the 1990's to operate the Partnership managed care programs for older adults and people with physical disabilities. CLA will be closing its Partnership Program April 30, 2008. They no longer meet risk reserve minimums required under their licensure and thus will no longer hold an HMO license. The Partnership programs are expected to expand to other counties along with Family Care expansion.

B. Family Care, a new managed long-term care program for frail elders, adults with physical disabilities and adults with developmental disabilities was developed by the State in 1997 and piloted in 5 counties. Family Care eliminates the fragmentation of funding from 8 different long-term care programs, operates on a capitated rate for each enrollee and creates an entitlement for long-term care services in counties that have the program. There are no waiting lists for long-term care services in Family Care counties. The intent of entitlement for long-term care services for eligible persons is to give all adults with disabilities a real choice between nursing home care or community based long-term care services. In the Request for Interest/Proposal for Long-term Support and Health Care Reform, the State reports that Family Care (and other managed care models: SSI and Partnership) have "achieved improved outcomes for consumers, high consumer satisfaction, and lesser tax payer costs relative to other MA service delivery systems in the State, using valid consumer comparison groups." Members make better use of their primary care physicians, stay healthier, and require less specialist visits. With the growth in program funding, provider networks have expanded in the pilot counties offering more choices of providers and services for consumers.

#### Request for Interest/Proposals: Long-Term Support and Health Care Reform

In 2005, the State released a Request for Interest (RFI) and a Request for Proposal (RFP) to expand Family Care statewide. The State indicated its goal is to roll out Family Care statewide over a 5-year period replacing the existing long-term care programs (COP and Home and Community Based Waivers) for adults, and asked that parties let their interest be known with a response to the RFI. Grant funds were also available for regional planning efforts. Those interested in grant funds could apply for the RFP. The State promoted regional collaboration to meet minimum risk pool requirements, create efficiencies, and ultimately simplify the State's administration of this program by limiting the number of contracts statewide. Three years into the process, it appears it may take longer than 5 years to implement Family Care statewide.

Dane County partnered with Care Wisconsin and CLA to develop a proposal in response to the RFP. Two grant proposals were developed. One proposal, a

request to plan for implementation of managed long-term care for frail elders and adults with physical disabilities; and a second proposal, a request for planning to plan long-term care services for adults with developmental disabilities. Since the Partnership programs have been operating in Dane County for many years providing managed long-term care services to frail elders and adults with physical disabilities, it was felt that this experience would expedite planning for Family Care for those target populations. CLA will no longer serve as a planning partner with Dane and Rock Counties since they no longer operate as an HMO or serve as a Partnership Program site. There are no managed long-term care services for adults with developmental disabilities in Dane County. The County is heavily invested in the existing program for adults with developmental disabilities and given the size of the existing budget (excess of \$65.4 million in 2006) transitioning this system to a managed care long-term care model was expected to take more time and research. The experience in existing Family Care counties is that it costs more to provide services to the DD population. The regression model used to develop the capitation rate averages costs across the 3 target populations and because the DD population is more expensive the difference between the capitation rate and spending is most significant in DD. This will be very significant in Dane County as a result of the extensive programming and services that Dane County has developed in this program area over time. Thus the planning to plan request for adults with developmental disabilities.

Dane County did receive a planning grant in February 2006. The allocation of \$100,000 was to develop a plan for Family Care for frail elders and adults with physical disabilities. We were the only county or region that was not planning for all 3 target populations at the start, but the State acknowledged the uniqueness of Dane County's developmental disabilities services system and permitted the Department to begin planning for 2 of the 3 target populations. Shortly into our planning process we were informed that developmental disabilities services would need to transition to Family Care within a year of the other target populations. It made sense at that time to bring DD services into the planning process, since we are developing a model of managed long-term care services that will eventually serve all 3 target populations.

In June 2006 Rock County joined Dane County in its planning process. Rock County's \$30,000 State grant allocation was awarded with the expectation that the county would join with another planning consortium, since they did not meet the State's criteria for planning as a single county. Dane and Rock County have partnered successfully on initiatives in the past. Our proximity and the fact that we both use contracted service systems, meaning we have established provider networks for services, made this an easy partnership at the start. Rock County contracts for most of their services to the DD population and is a provider of many services to the frail elderly and physically disabled populations. Dane County primarily contracts for services for all 3 target populations. The planning process will provide an opportunity for both Dane and Rock Counties to explore

the potential for a partnership or other options for managed long-term care in their counties.

Our planning grant requires that planning activities result in the development of a comprehensive written plan for managed long-term care. That intensive planning includes planning for one or two (one in each county) operational Aging and Disability Resource Centers (ADRCs) and must address the following topics:

1. Implementation and management plan for care management provision
2. Provider network development
3. Administrative and financial systems
4. Information technology and reporting systems
5. Consumer and stakeholder participation
6. Quality management systems
7. Eligibility and enrollment systems
8. Establishment of a risk reserve and business solvency plan
9. Coordination or integration with acute and primary health care
10. Legal and operational platform for regionalized governance
11. Coordination with adult protective services
12. Conversion of the present Home and Community Based Waiver caseload

Upon completion of the planning process it is expected that the grantee will either achieve readiness to respond to a Request for Proposals (RFP) to operate/implement managed long-term care or choose not to proceed with a proposal.

#### Financing of Family Care

Family Care is a Medicaid managed care program. The federal government, Centers for Medicaid and Medicare Services (CMS), requires Wisconsin to use actuarially sound rates. The established Family Care rates are based on client acuity, regional differences in labor rates and service costs and include administrative costs. Unlike the current waiver programs' per diems that do not change for many years, Family Care rates are reviewed and adjusted annually up or down. The State contracts with an actuary to develop the rates.

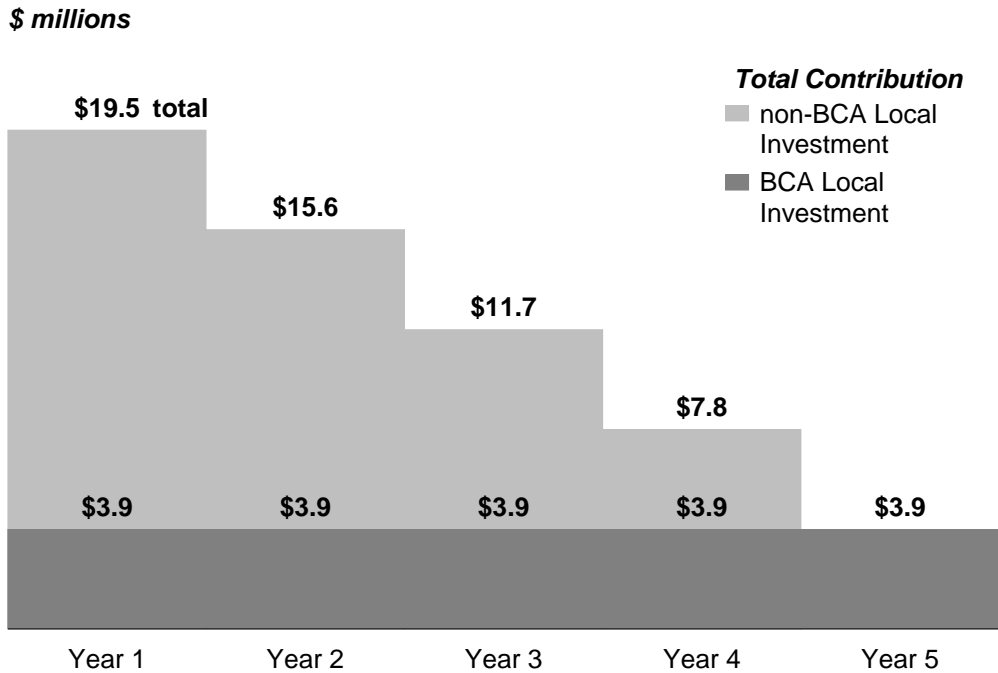
In 2005 when DHFS Secretary Helene Nelson announced the State's plans for Family Care expansion, it was noted that cost projections indicated that the program could expand statewide at the level of funding (including State, federal and local match from counties) that was currently invested in the system. This proposal would be in effect budget neutral. The State could not afford to expand the program to the remaining 67 counties without the county funding that was currently being invested in long-term care services. Statewide, local county investment in 2005 totaled approximately \$100 million. Dane County's investment was the largest single county investment at a total of \$20.2 million. Milwaukee County was the next largest with \$7 million. At the time the original

pilot counties implemented Family Care, the State estimated that counties used roughly 22% of their Community Aids (CA) or Basic County Allocation (BCA) on long-term care services. As a result, those original counties were required to make an annual investment of 22% of CA to the Family Care program. The State's original proposal for Family Care expansion was to freeze county investment at the 2005 level, meaning counties would continue to contribute on an annual basis the same level of funds it invested in 2005 and that would not increase over time.

The disparity in the amount of local investment statewide is a significant issue for many counties. Through the State's 2007 – 2009 biennial budget process an alternative proposal was developed. Local investment would be based on calendar year 2006 rather than 2005, and the State would buy down a county's contribution (if it were in excess of 22% of its Community Aids) over a 5-year period. Counties that contribute less than 22% of their Community Aids allocation would be held harmless. In Dane County that means our first year contribution would be approximately \$19.5 million and that would reduce by roughly \$3.9 million per year until the 5<sup>th</sup> year when our contribution would be \$3,893,126, which reflects 22% of Dane County's Community Aids. We would continue to invest \$3,893,126 annually for Family Care barring any legislative change to the contrary.

The following chart illustrates the effect of the buy down over the first 5 years of Family Care in Dane County. Once Family Care is implemented, Dane County taxpayers would need to give more than \$39 million in local contributions over 4 years in addition to the required annual contribution equal to 22% of the County's CA (\$3.9 million). There is the unstated risk that the funding requirements for this program could change at some time though it is currently fixed at the 2006 level of BCA. Our experience with the State in other program funding such as Community Aids, Youth Aids, and W-2 does not bode well with regard to consistency of funding arrangements in the long run.

## Dane County's Family Care Contribution



### Family Care Models

Counties were invited to be creative in their planning, developing the best program for their communities within the structure of Family Care. To date the models that have emerged through this Family Care expansion planning process include the following:

A. Counties operate the Family Care program. The county is the Care Management Organization (CMO, a single county operation) or Managed Care Organization (MCO, a multi county regional operation) and holds the contract with the State. The county would then, either directly or through sub-contracts, manage the program to provide care and services for enrollees. As of this writing, the regional governance models being considered by counties include formation under authority granted in section 66.0301 of WI Statutes (known as a 66.0301 agreement) or creation of a Long-term Care District as authorized by WI Statute 46.2895. It is anticipated that 32 counties will have county operated Family Care programs by the close of 2009.

B. Private Corporation operates the Family Care program. During the 2007-2009 biennium a number of counties will be expanding to Family Care with a private HMO model. To date, the HMOs that have been awarded the RFP for Family Care currently operate Partnership programs. Family Care Plus (includes acute and primary care) is being piloted in West Central Wisconsin (Chippewa, Dunn, Eau Claire, Pierce and St. Croix Counties). The HMO is the MCO and holds the contract with the State. Counties in that region make their local

contribution to the State and operate the ADRCs in their region. The MCO may contract with counties for care management or other county provided services. This contractual arrangement may be temporary existing only through the transition period from waiver programs to Family Care or it may be a longer-term arrangement. Some counties plan to stay involved, forming committees to provide a program oversight role. It is anticipated that 19 counties will have privately operated Family Care programs by the close of 2009<sup>1</sup>.

### Family Care Expansion Organizations Pending Certification as Family Care MCOs

Proposing Organization	Governance Structure	Counties Identified in Proposal	Anticipated Start of Enrollments*
Community Care of Central Wisconsin	Counties will form a Long-Term Care District, MCO will incorporate.	Marathon, Portage, Wood	Family Care in 2008
West Central Consortium for Long-Term Support and Health Care Reform	Counties will form a Long-Term Care District, MCO will incorporate	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon	Family Care in 2008
Partnership Health Plan, Inc. and Community Health Partnership, Inc.	HMO will hold contract with State. MOUs with participating counties.	Chippewa, Dunn, Eau Claire, Pierce, St. Croix	Family Care Plus in 2008
Community Care, Inc. and Community Care Health Plan, Inc.	HMO will hold contract with State. MOUs with participating counties to include an Operations Council.	Ozaukee, Sheboygan, Walworth, Washington, Waukesha	Family Care in 2008 Family Care Partnership in 2008
Care WI (formerly Elder Care of Wisconsin, Inc. and Elder Care Health Plan, Inc.)	HMO will hold contract with State. MOUs with participating counties to include an Operations Council.	Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waushara, Waukesha	Family Care in 2008 Family Care Partnership in 2008

\* Enrollments may be phased-in by county, target group or program type over the course of 2008 and 2009.

### Self-Directed Supports (SDS) Waiver

The State is creating the SDS Waiver to provide an alternative to the Family Care program and its availability will be coordinated with Family Care expansion. Although this waiver is similar in program design to the one currently operating in Dane County, it is a different waiver and will not be funded at the same level. SDS Waiver participants will be given a fixed budget based on the results of their individual Long-term Care Functional Screen and the Family Care cost experience for people with like needs. These individual allocations could be higher or lower than the Family Care capitation rates, depending on each individual's level of service need. Participants will develop their own service plans with the assistance of an independent consultant. The consultant will review the care plan to be sure it meets health and safety needs and is consistent with

<sup>1</sup> Milwaukee County is currently planning to have both models. Milwaukee County CMO currently serving only frail elders will expand operations to include adults with disabilities. Private CMOs will also provide Family Care in Milwaukee County. Dane County does not have the consumer population to support both models.

waiver allowable services. The participant will be responsible for reviewing and approving time sheets and other documents and send them on to a State identified financial services agency for payment. The financial services agency serves as the banker or bill payer for supports and services authorized by the care plan and approved by the participant. (Appendix I: SDS options flowchart)

Implementation planning for this waiver is currently in process. All 3 target groups are eligible for this waiver. Initial feedback is that local DD and PD consumers are interested in the SDS Waiver. The RFPs for Independent Consultant and Financial Services were released in February of this year. In counties that currently have Family Care the SDS Waiver must be operational no later than July 1, 2008. The SDS Waiver will expand to other counties as Family Care is established in those counties.

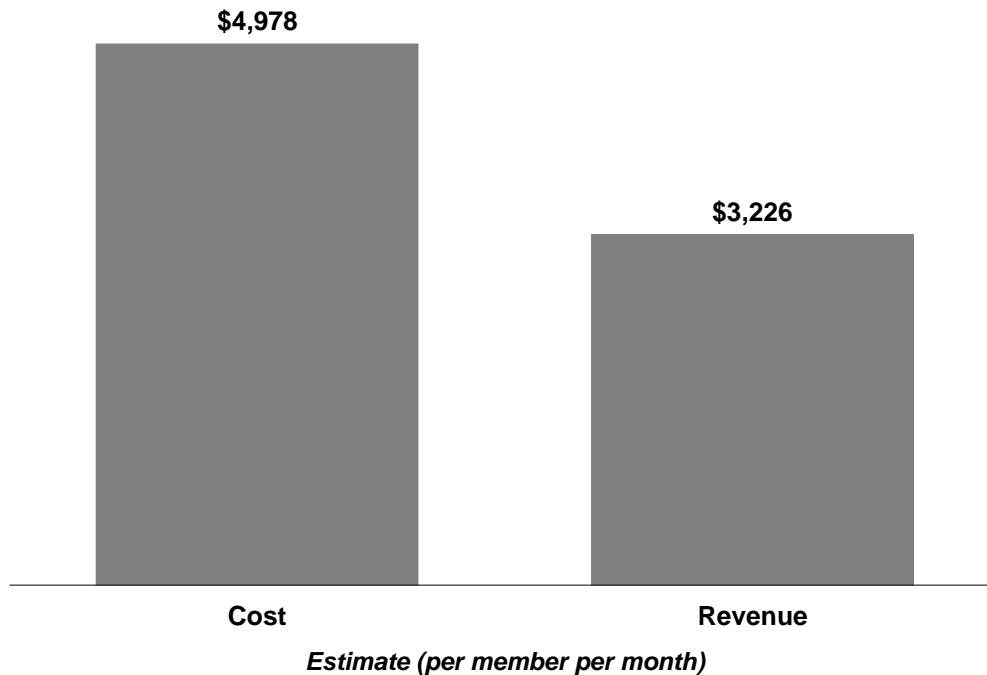
#### **IV. Analysis of Key Issues**

As a managed care program, the complexities of operating Family Care are much greater than those of operating the traditional COP/CIP programs counties have managed. There are significant financial considerations including adequate capitation rates, start up costs including the costs of transitioning existing programs to Family Care, infrastructure development, and the loss of waiver administrative revenues that support many areas of the Department besides the ACS Division. There are issues of service provision, coordination with a wide variety of non-Family Care County programs, and the flexibility to respond quickly to needs and issues. The County must consider governance structure, its local policy role, and the complexities of developing a business infrastructure and systems framework to successfully operate a Managed Care Organization. This is not an exhaustive list but reflects some of the issues initially identified as key concerns in the planning for managed care. Alternatively, if the County chooses not to operate Family Care, planning issues will include staff transitions to the ADRC and staff reductions, determining the Department's preferred role in the oversight of Family Care and negotiating that agreement with the CMO.

##### Adequate capitation rates

Will the Family Care capitation rate for this region be sufficient to adequately operate the program? The capitation rates for existing Family Care counties are significantly less than per member per month (PMPM) waiver costs for Dane County's waiver participants. This may be a function of Dane County serving a more acute population with greater needs and its commitment to individual choice and the most normalized life possible. As a policy matter Dane County has chosen to provide services well beyond the level required by the State. On behalf of the Dane-Rock planning consortium we have contracted with an actuarial firm to complete a study of the service costs and anticipated capitation rates for Dane County only, Rock County only and a Dane-Rock region.

## 2008 Cost and Revenue Estimates For Waiver Eligibles in Dane County



The Family Care pilot programs took a number of years to develop infrastructure and efficiencies. Initial capitation rates were based on the counties' historical expenses. The actuarial rates for expansion counties are based on the cost data of the existing Family Care programs. This seems to indicate an implicit expectation that new programs are efficient on day one and have the same program expenses as all other Family Care counties. Dane County does not fit this model at the present time. This change to managed care will require reductions in service costs to be financially viable. In addition, new programs will be expected to build the required risk reserve over the first 3 years of operations if the MCO does not have adequate risk reserves established at implementation. Risk reserve minimum balances are calculated as a percentage of the annual capitation payment. The maximum required minimum balance is \$2 million.

### Transition costs and loss of waiver administrative revenues

In the first year of Family Care implementation, the County will continue to operate the waiver program as waiver participants' transition to Family Care. Both programs (Family Care and waiver programs) will need to be operational until all current waiver participants' transition to Family Care. The State's expectation is that transition will take 6 months though each county or region must submit a transition plan for approval and may choose a more aggressive timeline for transition. If the County is not the CMO, transition should be less work although it will most likely lead to the loss of County staff.

As a result of the county contribution to Family Care, and the loss of waiver administrative dollars, there is a funding gap in the Department's budget that is

created. Although many administrative costs will be eliminated or moved to the MCO with the introduction of Family Care, many positions/functions that have been supported in part with waiver administrative revenues will continue to remain with the Department. For example, waiver administrative funds cover a portion of the office of the Department Director's salaries and other support functions such as purchasing, information technology (IT), fiscal, etc. The gap in funding is estimated to be \$2.7 million. Other Divisions within the Department may also be impacted by these program changes. The distribution of County overhead costs across all divisions within the Department is likely to change due to the loss of waiver program revenues.

#### ADRC Infrastructure and start up

Although the details of space and location have not been determined it is estimated that start up funds of \$367,000 will be needed to set up new office space for the ADRC, implement an adequate phone system, and IT systems for program tracking, reporting and billing. The ADRC funding formula is based on statewide average staff salary and benefit costs and each county or region's population. Whether the average cost methodology can support tenured county staff position costs is questionable. The State does provide ADRC funding for operations, but start up funds for infrastructure development are not explicitly budgeted. We are aware that counties have submitted requests for and received funds for ADRC start up.

Higher MA caseloads are anticipated with the growth in Family Care putting increased pressure on Economic Support Specialist (ESS) staff to meet the needs of a growing caseload. ESS positions are not included in ADRC funding projections. The State's projections identify increased efficiencies in ESS workloads that will offset the increased caseloads typically associated with Family Care. In Dane County, current average ESS caseloads for this function are 617 ongoing cases per worker. Average intake per worker per month is 15 applications. We do not anticipate efficiencies will result in available time to handle additional caseload numbers associated with Family Care expansion. Any new ESS staff positions would likely receive only the current 48% federal reimbursement and would require 52% of local funding to create them.

#### Adult protective services

Counties will continue to be responsible for adult protective services (APS) and other statutory or policy provisions. Though it is assumed that APS related long-term care services will be covered by the CMO for eligible persons, there are a number of services and activities that the CMO will not be responsible for providing, including:

- Adult protective investigation and placement responsibilities under WI Statutes Chapter 55;
- Emergency detention responsibilities under WI Statutes Chapter 51;
- Elder abuse investigations under WI Statutes Chapter 46;

- Guardianship responsibilities under WI Statutes Chapter 880
- Any direct consumer services that CMO's are not required to provide.

The State has announced that it will provide APS funding for Family Care expansion counties. The APS allocation becomes available when counties begin transition to Family Care. It is intended to help offset staff costs and services that Community Aids currently covers and is equal to 2% of the county's BCA. In Dane County that amount is \$353,921 (based on the 2006 BCA).

If the County is not the CMO there is the potential for the County to see increased costs. For example, increased expenses are likely to occur in institutions and WI Statutes Chapter 51 or 55 workload, if the CMO does not deliver proactive services. There is no way to estimate this potential cost. If the County does not control the service delivery system, it will have a limited ability to impact those services but may be responsible for the outcome as a result of its statutory responsibilities. For those counties where a private provider is the Family Care MCO, memorandums of understanding (MOUs) have been developed to specify the relationship, roles and responsibilities of the county and the MCO in these situations. The private provider model is too new to determine the effectiveness of those MOUs and the impact on APS.

#### Single county or regional MCO

Dane County is second only to Milwaukee in the number of Medicaid recipients and services provided and did receive initial approval from the State to plan for Family Care expansion as a single county. Partnering with another county adds a layer of administrative and program complexity requiring the regionalization of services and the negotiation of an agreement that is satisfactory to all parties with regard to who will share the legal and/or financial risk in the service delivery model. The agreement must address operating arrangements for the region, by-laws and protocols for business between partners, the development of a mission statement and a strategic plan for the new entity and the creation of multi-county committees for continued planning and program oversight. Multi-county regions have been planning to organize under 66.0301 agreements or as Long-term Care Districts. Capitation rates will also be impacted by regionalization, and administrative costs could increase as we expand beyond our current boundaries.

#### CMO management

The viability of the Family Care managed care program is heavily dependent on its business and IT infrastructure. This infrastructure must be built carefully and strategically using proven business and IT models. There are many options available; they vary based on questions that are not yet answered. However, to operate a successful MCO, there are certain MCO components that must be in place. Those operational components can be summarized into three broad areas: management and support, operations, and information technology.

Management and support includes financial management, quality management, along with human resource management. Operations includes claims processing, provider management, member relations, and care management. Information technology includes software applications, IT services & support, IT management, along with infrastructure development and migration.

The MCO is responsible for the operational components, even though the MCO may purchase all or part of the functions. Hence, when the costs are factored into an estimate, though they may vary based on which path is chosen, it assumes that several key types of costs must be considered. Those include staffing (based on FTEs), facilities, equipment (both IT and non-IT), and other operational costs.

The estimates of the costs associated with each of the components could vary based on whether those components are purchased or developed. The IT and business infrastructure costs are summarized below in Table 1. The IT infrastructure costs assume the IT system(s) are developed in-house using a combination of new County IT staff and consultants. Other options may be available using a combination of web-based products or the purchase of existing software with Dane/Rock specific modification. Other options, if viable could reduce the IT costs significantly.

It should also be noted that another option that may be considered is whether the CMO would purchase via contract the claims processing function. If that option is pursued, both the IT and business infrastructure costs would be significantly reduced. However, costs are just one of the component parts of that decision-making matrix.

For more summary detail see Table 2.

<b>Category</b>	<b>Costs</b>
IT Infrastructure	<b>\$ 6,679,260</b>
Business Infrastructure	<b>\$ 1,790,418</b>
<b>Total Costs</b>	<b>\$ 8,469,678</b>

**Table 1**

To be able to effectively manage day one, these processes must be in place prior to roll out July 1, 2010. The development of these processes will be ramped up beginning as early as 16 to 22 months prior to Family Care roll out (see assumptions in Table 2).

<b>Dane/Rock County Consortia</b>			
<b>IT/Business Infrastructure Start-up Costs Summary</b>			
<b>IT Infrastructure Costs</b>	<b>FTE</b>	<b>Budget</b>	<b>Ramp-up Costs</b>
Hardware		\$ 1,197,200	\$ 1,197,200
Software		\$ 2,500,000	\$ 2,500,000
Facilities		\$ 106,560	\$ 106,560
Consultants		\$ 1,638,000	\$ 1,638,000
Staff	7.5	\$ 1,237,500	\$ 1,237,500
<b>Total IT Infrastructure Costs</b>		<b>\$ 6,679,260</b>	<b>\$ 6,679,260</b>
<b>Business Infrastructure</b>	<b>FTE</b>	<b>Budget</b>	<b>Ramp-up Costs</b>
Staff	47.5	\$ 5,343,750	\$ 1,447,266
Operating Costs		\$ 195,552	\$ 195,552
Facilities		\$ 147,600	\$ 147,600
<b>Total Business Infrastructure Costs</b>		<b>\$ 5,686,902</b>	<b>\$ 1,790,418</b>
<b>Total IT &amp; Business Infrastructure Costs</b>		<b><u>\$ 12,366,162</u></b>	<b><u>\$ 8,469,678</u></b>
<b>Assumptions</b>			
1. We will roll out Family Care countywide beginning July 1, 2010.			
2. We will serve 4300 consumers in Dane & Rock in Family Care			
3. 3,225 or 75% of the Family Care eligible population will be enrolled during the first month (or July 2010)			
4. 27 or 1/24th of the eligible FC waiting list population will be enrolled during the first month.			
5. Ramp-up costs are those costs that will mostly be incurred prior to roll out July 1, 2010 so that we can begin serving consumers day 1. These costs assume a ramping up of staff, IT, along with other operating and facilities costs.			
6. Software costs assume using a combination of purchased and modified IT systems			
7. Consultant costs assume hiring business analyst with managed care expertise to both lead and advise on the development of the IT infrastructure 16 to 20 months prior to roll out.			

**Table 2**

DHFS requirements include the development of a 3-year business plan including a timeline for providing the required risk reserve, solvency requirements and working capital to assure protection against losses. The organization must be a legal entity that can carry risk and assure program quality with a governance board to provide program oversight.

An information plan is necessary to support the business operations and information technology needs. The CMO is responsible for budgeting and projections (an initial 3 year budget must be approved as part of the business plan), managing enrollment and capitation, care management and care planning, service authorization, utilization management, member grievances and appeals process, service provision, provider network development, contract management, provider relations and claims processing.

Financial management and reporting include appropriate accounting procedures and policies being in place along with the requirements for a cost allocation plan, utilization review and encounter reporting. Quality management (also identified below) is a significant piece of program management as well requiring dedicated staff for its operation, active participation from consumers and staff, etc. (Appendix II: Readiness Template from DHFS).

### Risk

This paper does not presume to identify every possible risk associated with program operations. Some risks are similar to those the County currently manages such as risk associated with the Department's decision-making authority in provider contracting, managing funds from the State or federal government, grants, etc., operations, financial planning, developing budgets and meeting contractual requirements and compliance standards specified in the State contract. The Family Care contract is a risk-based contract. Following the transition period (first 2 contract periods), Family Care becomes an entitlement, and thus costs cannot be controlled by limiting enrollment.

There is risk associated with the liability for losses from adverse selection. One example of adverse selection would be the population that is entering the program has a higher acuity and greater service needs than is covered by the current Family Care capitation rate for the CMO. Changes in overall client mix will be picked up in future capitation rate development, but reconciliation is not done on an annual basis meaning the CMO covers the risk of adverse selection in any given year after the 2-year grace period at start up. At start up, the State will conduct quarterly reconciliations and rate adjustments with the new entity during the first 2 contract periods. If enrollment does not mirror the anticipated client mix, the capitation rates will be adjusted to reflect actual experience. After that initial period it is assumed that the Family Care program population is stable, and the CMO assumes the risk or reward for changes in the population mix in any given year.

The Family Care contract with the State includes some contractual obligations for protections against losses requiring the CMO to maintain risk reserves, meet solvency requirements and establish working capital. The CMO may consider the purchase of catastrophic (stop loss) insurance within the provisions of the State contract for a calculated premium.

The CMO is also responsible for start up funding including infrastructure costs and staff costs identified above in Tables 1 and 2.

### Quality management

Family Care requires a quality management (QM) organizational structure including staffing level requirements. The QM program must assure quality of services, monitor performance, identify problems and remediate them, prioritize quality improvement activities, and plan and deploy at least one focused

performance improvement project annually. DHFS must approve the Quality Program or Plan adopted by the CMO governing board. The CMO is required to assure participation of consumers, their representatives and other stakeholders in the quality management and appeals and grievance processes.

#### Local policy role

In the Family Care model it is expected that counties will operate the ADRCs. The ADRC is the front door to the long-term care system. ADRC requirements include the establishment of a Resource Center (RC) Governing Board. At the discretion of the County Board and County Executive, the governing board may assume the responsibilities of the County's long-term support planning committee. The RC Governing Board responsibilities include determining the structure, policies and procedures of the resource center, information and data gathering concerning the adequacy of services, service capacity, etc. and an opportunity to report findings or recommendations to local elected officials, the regional LTC Advisory Committee and DHFS.

DHFS will establish regional LTC Advisory Committees. Membership will include representatives from Resource Center Governing Boards in the region. (Appendix III: Summary of RC Boards, Local and Regional Committees).

In the Family Partnership Care Management Coalition (FPCMC; Columbia, Dodge, Green Lake, Jefferson, Marquette, Ozaukee, Sheboygan, Walworth, Washington, Waukesha and Waushara Counties), a region that will be expanding to Family Care during this biennium using a private HMO model, counties have collaborated with the MCOs on the development of a template MOU that will be executed with each MCO and each county. The MOU establishes an FPCMC Operations Council that will include a representative of each county and each MCO. The MOU specifies the responsibilities of MCOs and counties and provides for the collaboration of some services and provides for county input into MCO operations in areas such as the Quality Assurance Program and member satisfaction.

#### Non-Family Care related services

Regardless of the County's decision concerning its participation in Family Care, the County will operate the ADRC and the Department will continue to be responsible for a number of services to adults such as nutrition services to elders, transportation services, mental health services, alcohol and other drug abuse services, services for persons with sensory disabilities, services for persons who are not Family Care eligible, etc. Coordination of services is intended to improve efficiency and effectiveness, making the best use of all available resources. If the County is the Family Care CMO it will be in a position to continue coordination of all of these programs and services.

## V. Options

**Option 1:** The County chooses not to be the Family Care CMO; the ADRC will be located in the Adult Community Services Division. County staff will transition to other positions in the Department such as the ADRC and some positions will be eliminated. Many POS contracts within the ACS Division will no longer be required. The Long Term Support Unit and the Adult Developmental Disabilities Unit may be dismantled or consolidated. The details of downsizing existing service systems and coordination of services with the Family Care CMO and the County's role in program oversight or service delivery will be developed during the planning process.

**Option 2:** The County will be the CMO for Dane County, holding the contract with the State, assuming program risk and responsibilities and will require significant resources to assume operations. The details of this plan will be further developed during the planning process. The model the Department plans to pursue would include contracting with POS agencies to share risk and provide services. The contracting could take two forms. Dane County could contract directly with each agency in its provider network similar to its current practice, or Dane County could contract with a small number of entities (perhaps 1 – 3), and those entities would be responsible for contracting with and managing the provider network. The Department is leaning to the latter approach.

Any plan the Department develops would require the following factors or circumstances to be in place in order to be successful:

- Start up funds to develop infrastructure (IT system development, business infrastructure development, adequate staffing). It is estimated that this initial investment for start up will be as much as \$8.9m. These costs and all available options will be further researched during the planning process. The Department's proposal will include a request for one-time funding from the State to cover some of these costs, but it is unknown if any State funding will be available.
- Satisfactory negotiations with the State on
  - Capitation rate for this region
  - Actuarial soundness of the capitation rate
  - Acceptable level of local contribution

Data from the actuarial study will inform this process. The information will be used during the planning process to assist in the development of an alternate proposal if results indicate that Dane County would have to substantially change its programs to make Family Care financially viable in this region as it is currently funded.

- Recognition by the County that this expansion will require a financial investment by the County at start up and adequate resources to manage the program successfully.
- This program should be operated as an enterprise fund. The enterprise fund will have a separate reserve.
- Family Care expansion will require partners that we believe we can trust.
- Proposed governance structure would have the CMO attached to the Department of Human Services and the ADRC positioned elsewhere in the county to provide the appropriate firewall.

**Option 3:** Dane and Rock Counties will collaborate to create a regional MCO. The counties will develop a plan for operating the MCO, holding the contract with the State, assuming program risk and responsibilities and will require significant resources to assume operations. The details of this plan will be further developed during the planning process. Many of the factors mentioned under Option 2 also apply to Option 3.

## **VI. Discussion**

The Family Care program that exists today is different from the Family Care program that was originally implemented and it will continue to change. There are statewide Family Care work groups that include county, State and Family Care Partnership representatives that routinely discuss policy and fiscal issues. Those discussions result in changes to the Family Care contract and capitation rates on an annual basis. The question at this time is whether Dane County wants to be involved in Family Care and its evolution or if the County would prefer to move out of the business of providing and managing long-term care services to its eligible citizens. The planning grant the Department received to develop a plan for Family Care in this region expires June 30, 2008. A decision is needed as to which Family Care model the Department should proceed to plan for in these remaining months. At the end of the planning process the County will let the State know whether or not it wishes to proceed to the RFP stage. The planning process offers an opportunity for the County to flesh out a plan for Family Care but does not commit the County to operationalize that plan.

Dane County is well known for its quality programming and its significant investment in long-term care programs. Initial review of the County's expense data in comparison to estimated Family Care capitation rates for this region indicates a significant disparity between the per member per month (PMPM) costs and the anticipated PMPM capitation or funding. This is a significant point as it addresses the potential financial viability of the program in Dane County. It also speaks to the service delivery model and the service mix available to participants within Family Care in comparison to that which is currently offered in

Dane County. It suggests that consumers will face reductions in service levels regardless of whether Dane County or a private corporation is the CMO. If the County chooses to operate Family Care, it will need to initiate a serious dialogue with the State during the planning process to discuss program operations and capitation methodology to determine what type of flexibility, if any, is available within the Family Care model.

The initial years of Family Care implementation will carry a significant price tag, especially the first year, as infrastructure must be developed and established before the program begins. Any proposal the County develops will include a request to the State for one-time monies, but it is also clear that the County will be investing in the creation of a sizeable managed care administrative entity to successfully operate the program. The CMO must have the tools and staff necessary to operate in real time, responding to changes in the environment as they arise. The original Family Care pilots have had years in which they lost money because business infrastructure was not adequate to track program operations. Adequate business and IT systems are essential. In addition to infrastructure investment, the CMO must establish adequate risk reserves, meet solvency requirements and have sufficient working capital. The County's local investment paid to the State will be at its highest in the first year unless another arrangement is negotiated. The local investment to the State will drop over time freeing up an annual \$14 million County investment (when you compare 2006 local investment to local investment required in year 5 and beyond - approximately \$1.6 million in non-county local match is included in the local match total), but at start up Family Care will require significant investment. Operating the program will also put the County at risk for future investment if there are program losses.

There are financial risks to the County if it chooses not to operate Family Care. The County may be responsible for the outcome of services provided by a CMO as a result of its statutory responsibilities. The County could see an increase in its WI Statutes Chapters 51 and 55 workload and costs if a CMO does not provide adequate proactive services. If the CMO waits to serve "at-risk" individuals until all eligibility documentation is completed, the County may need to serve those individuals during the interim period before they move into the Family Care program. The Department's capacity will be reduced with the loss of the waiver programs. The ACS Division's \$126 million budget will be reduced by \$79 million. If the private CMO model of Family Care is not successful in this region, Dane County having eliminated its long-term care units would not have the infrastructure in place to respond to this situation and would have to re-build a system of care.

Family Care provides an opportunity for consumers, their family members and other stakeholders to be involved in program quality and appeals and grievances. Consumers have certain rights within the program including the right to file an appeal or grievance concerning decisions about their services, the adequacy of

services, etc. Those protections are currently in place with the waiver programs as well. Providing long-term care services is a significant part of the Department’s mission to meet the needs of its most vulnerable citizens. In addition, when the County operates the program there is another level of accountability in the form of the local policy makers, the County Executive and County Board members. A number of town hall and informational meetings have been held to discuss planning for changes in long-term care in Dane County. Consumers, their family members, providers and other stakeholders attended those meetings. Comments and questions presented by consumers or their family members spoke to the importance of County oversight and involvement in providing long-term care services to vulnerable populations. This increased accountability is certainly viewed as value-added to these programs.

**Summary of County Impact per Model**

	<b>County is CMO (Single or Multi County Model)</b>	<b>Private Corporation Operates CMO</b>
<b>County Financial Risk For CMO Cost</b>	High Risk	No Risk
<b>County Start-up Cost</b>	High Cost	ADRC Start-up Only
<b>County Financed Risk for Court Orders and MMHI</b>	Lower Risk	Higher Risk
<b>Policy Role</b>	Strong Policy Role	Advisory Input Only
<b>Quality Assurance Role</b>	Strong QA Role	Little or No QA Role
<b>Responsiveness to Dane County Residents</b>	Higher	Lower
<b>Risk to Service Delivery Infrastructure</b>	County Maintains Lead Role in Service System Management.	Service Delivery Dependent Upon Private Corporation. County Human Service Management Dismantled.
<b>County Government</b>	Budget Responsibilities Increase	Budget Responsibilities Decrease
<b>Consumer Service Levels</b>	Lower to Significantly Lower	Lower to Significantly Lower

**VII. Conclusions**

The State is proceeding with its plans to eliminate the existing Home and Community Based Waiver programs serving elders, and adults with disabilities. The current waiver programs are being replaced with managed care program options including Family Care Plus (includes acute and primary care, which requires HMO licensure, in addition to long-term care services), Family Care Partnership and Family Care and the SDS Waiver. The benefit of Family Care expansion is the elimination of waiting lists for long-term care services. The implementation details of the SDS Waiver are currently under development. In the current phase of Family Care expansion some counties are expanding on the

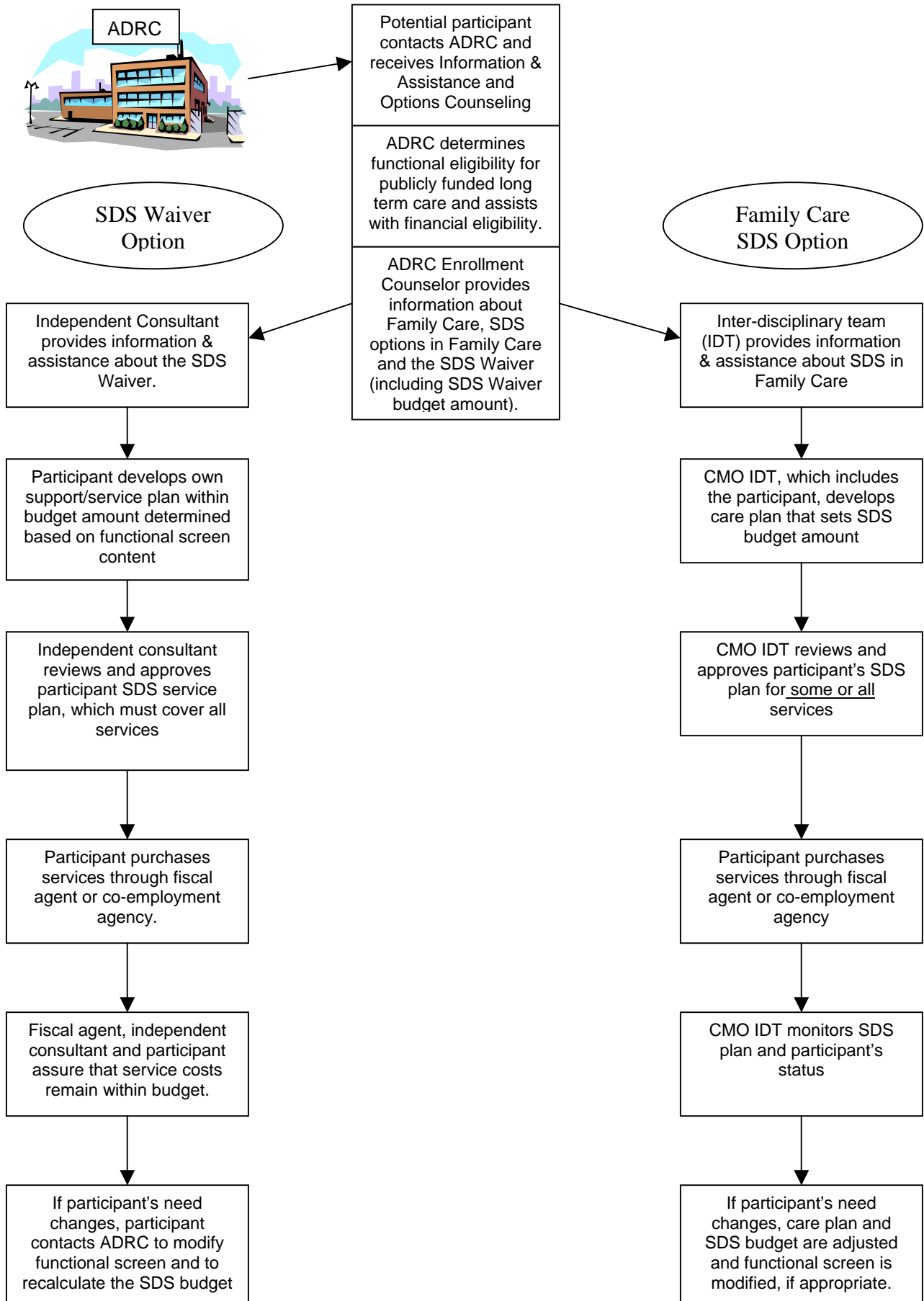
private provider model initiated in Racine and Kenosha Counties. A larger number of counties are moving to county operated programs, regionalizing with an existing Family Care County or creating a new Family Care MCO. The Northwest region (Douglas, Bayfield, Ashland, Iron, Burnett, Washburn, Sawyer, Price, Polk, Barron and Rusk Counties) is creating a new Family Care MCO entity, as there is no existing Family Care program in that region.

The expansion of Family Care means the subsequent elimination of waiting lists for long-term care services to eligible adults. Dane County has invested significant time and resources in developing and providing quality programs for frail elders, adults with physical disabilities and adults with developmental disabilities. That experience can greatly impact the next generation, the managed care generation, of long-term care programs that are being planned across the State. The County must be pragmatic in its approach as managed care expands program operations and requires a sizeable business and IT component to operate successfully. The planning grant presents an opportunity for the Department to further research with its community partners, the viability of an innovative county operated model of managed care that makes extensive use of contracts to purchase services and share risk with its partners.

## **Appendices**

Appendix I	Self-Directed Supports Flowchart
Appendix II	WDHFS “Readiness Template”
Appendix III	Summary of RC Boards, Local and Regional Committees

# Self-Directed Supports Choices in Wisconsin Long Term Care Redesign



**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Strategic Planning	<p>The 3-year MCO business plan approved prior to contract effective date, including:</p> <ul style="list-style-type: none"> <li>- Timeline for providing required risk reserve, solvency requirements, and working capital (if not licensed as an HMO).</li> </ul> <p>Organizational design and governance:</p> <p>Existence of legal (contracting) entity that will carry the financial risk and be responsible for quality, including:</p> <ul style="list-style-type: none"> <li>- Governance board with membership able to provide appropriate oversight.</li> <li>- Organization chart w qualified and full-time CEO, CFO, and Quality Manager.</li> </ul> <p>Documentation of how MCO will coordinate with adult protective service and counties' 51/55 systems.</p> <p>Evidence of consumer and other stakeholder involvement in strategic planning.</p>	<p>Establishment of a Risk Reserve and Business Solvency Plan, with timeline and financing strategy.</p> <p>Consumer and Stakeholder Participation:</p> <ul style="list-style-type: none"> <li>- Identify stakeholders and provide opportunities for consumers and stakeholders to participate in planning process.</li> <li>- Provide training/support to enhance meaningful consumer and stakeholder participation.</li> <li>- Create mechanisms for consumers and reps to participate in quality management and appeals and grievance processes.</li> </ul> <p>Develop policies and procedures for best practices (designing quality into the organization).</p> <p>Legal and Operational Platform for Regionalized Governance satisfactory to all planning partners, including:</p> <ul style="list-style-type: none"> <li>- Mission and values statements.</li> <li>- Operating and risk sharing agreements.</li> <li>- By-laws and business protocols.</li> <li>- Steering and oversight committees, including consumer and stakeholder members.</li> </ul> <p>Organizational needs assessment (strengths, weaknesses, opportunities, barriers) for administrative, care management, IT and financial management tools and competencies to carry out managed long-term care, including:</p> <ul style="list-style-type: none"> <li>- Strategies to learn management techniques.</li> <li>- Identification of essential IT and competencies.</li> <li>- A claims payment / business system adequate for             <ul style="list-style-type: none"> <li>- Encounter reporting</li> <li>- Service authorization and benefit coordination</li> <li>- Utilization management</li> <li>- Fiscal monitoring analysis</li> <li>- Managing enrollment</li> <li>- Provider network monitoring and contracting</li> </ul> </li> </ul>

**NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.**

**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

<b>Business Area</b>	<b>State Performance Indicator (Certification Requirement)</b>	<b>Detailed MCO Systems (including IT)</b>
<b>Information/ Knowledge Management</b>	An information management plan that supports each business process's specific information management and information technology (IT) needs.	Identification of essential IT and reporting tools and competencies to carry out managed long-term care  Plan for control of data: <ul style="list-style-type: none"> <li>- Data governance</li> <li>- Documentation</li> <li>- Data integration rules, data security</li> <li>- Data retention</li> <li>- Policies and procedures for disaster recovery.</li> <li>- Current and future HIPAA/HIT requirements</li> </ul>
Budgeting and Projections	Initial 3-year budget approved as part of business plan.	Data collection and analysis to support the budgeting process.
Managing Enrollment	Approved Access Plan. ADRC and ES readiness requirements are documented separately.	Participate in Access Plan development with ADRC and ES.  CMO enrollment processes in place to accept new enrollments, assign care teams, make sure needed services are in place on day of enrollment, develop initial care plan w/in 10 days. (FC)

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**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Managing Enrollment and Capitation	Policies and procedures to manage enrollment and capitation developed prior to implementation.	<p>Reconcile enrollment reports and capitation payments with member enrollment, disenrollment and LOC effective dates.</p> <p>Process for resolving discrepancies.</p> <p>Recertification processes in place to maintain enrollee eligibility – functional screens, interface with ES.</p> <p>Management of cost share receivables, process for interventions if cost share payments not timely, process to refer for loss of eligibility if interventions are not successful.</p>
Care Management and Care Planning ----- Service Authorization ----- Utilization Management	<p>Adequate and trained care management teams in place.</p> <p>Approved Service Authorization Policy (RAD) in place (dif. for FC / WPP).</p> <p>Policies and procedures for SDS in place.</p> <p>Appropriate interdisciplinary plans for benefit package provided are in place.</p>	<p>Strategy and timeline to achieve employed and/or subcontracted IDTs.</p> <ul style="list-style-type: none"> <li>- Training in the needs of the target groups, service authorization policies and utilization management, care management techniques including outcome assessment, risk management and negotiation skills.</li> <li>- Training plan developed and in place.</li> </ul> <p>Process for prior authorization of services, clerical support and integration with fiscal systems.</p>
Member Grievances and Appeals Process	Policies and procedures and MCO structure in place.	

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## DDES Management Planning Tool For LTC Expansion “Readiness Template”

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
<p>Service Provision</p> <p>-----</p> <p>Provider Network</p> <p>-----</p> <p>Contract Management</p> <p>-----</p> <p>Provider Relations</p>	<p>State review and certification of adequacy of service capacity prior to implementation.</p> <p>Process for determining future provider network needs is in place.</p> <p>Have negotiated and executed cost-effective provider contracts.</p>	<p>Identification of service needs among potential enrollees, assessment of the capacity of the local provider pool to meet these needs (gap analysis); planning with potential providers to achieve a satisfactory workforce and provider pool in regard to capacity, quality and options for consumers; and establishment of minimum provider competencies.</p> <p>This planning must address the needs of consumers who are interested in self-directed supports.</p> <p>Develop contracts and put in place (contract language must be approved by DHFS).</p> <p>Train providers in philosophy of managed LTC, claims processes, etc.</p> <p>Process to ensure an adequate number of personnel with the appropriate skills to meet the scope of services, including policies to ensure services do not decline during personnel shortages due to operational contingencies or changes in staffing structure or mix.</p> <p>Provider capacity monitoring and management.</p>
<p>Claims Processing</p>	<p>Demonstrated ability to submit acceptable encounter data.</p> <p>Policies and procedures to handle provider appeals.</p>	<p>Acquire or develop claims processing capacity. Considerations include:</p> <ul style="list-style-type: none"> <li>- Customer Service functions,</li> <li>- Customized Check/EOB printing</li> <li>- Communications with members</li> <li>- Reporting requirements,</li> <li>- QA/audit,</li> <li>- High cost \$ claim procedures,</li> <li>- Cost containment procedures,</li> <li>- Coordination of benefits</li> <li>- Processes for adjustments, corrections, and claims that cannot be adjudicated</li> <li>- Reconciliation with service authorizations</li> <li>- Encounter submissions, tie-outs</li> </ul>

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**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
<p>Financial Management and Reporting</p>	<p>Full-time, qualified fiscal manager (working on definition of “qualified”).                      Ability to manage and effectively utilize sophisticated information systems.                      Accounting policies and procedures in place, including for use of GAAP accrual accounting practices.                      Cost allocation plan.                      IBNR model developed (and approved by state? Certified by actuary?).                      Ability to produce financial statements that tie out to claims.</p>	<p>Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable.                      Cost allocation: Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies).                      IBNR methodology; process to monitor accuracy and reliability of the methodology.                      Procedures for monitoring consumer cost sharing collections.                      Methodology for analyzing (fiscal) risk.                      Monitor and analyze budget versus actual variances.                      Process to identify “outliers” (members whose claims exceed expected costs).                      Process used to ensure the accurate recording and timely collection of accounts receivable; including processes for member obligations receivable and capitation receivable.                      Maintenance of solvency protections.                      Process used to determine accurate proportion of shared administrative services and costs (e.g., support staff, fiscal staff, management staff, IT, building costs, and supplies).                      Develop and test IBNR methodology; process to monitor accuracy and reliability of the methodology.</p>

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**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
Utilization Review	<p>Demonstrated ability to produce reports that clearly communicate utilization information and trends to all levels of the MCO.</p> <p>Process by which utilization information will be shared with IDTs and other parts of the MCO, and how IDTs and others will be given help in analyzing that information.</p>	<p>Process for reconciliation and reporting on services authorized versus services used; service utilization reports.</p> <p>Process to communicate changes in practice patterns and health care delivery identified through utilization management reviews.</p> <p>Process to review and evaluate high volume / high risk indicators, practice guidelines and protocols, unusual occurrences, clinical outcomes, and services provided. How are these reviews used to minimize risk?</p>

**NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.**

**DDES Management Planning Tool For LTC Expansion**  
**“Readiness Template”**

Business Area	State Performance Indicator (Certification Requirement)	Detailed MCO Systems (including IT)
<p>Quality Management</p>	<p>QM organizational structure, including:</p> <ul style="list-style-type: none"> <li>- A senior manager with resource-deployment authority is designated as responsible for QM program.</li> <li>- A full time qualified professional is in place to coordinate the quality program.</li> <li>- QM activities have individuals or units with clearly assigned responsibility for them.</li> <li>- Mechanisms for active participation from consumers, staff, and others.</li> <li>- Must have clear operational links to and support from other functional areas.</li> </ul> <p>DHFS- approved Quality Program/Plan, adopted by gov. board, including:</p> <ul style="list-style-type: none"> <li>- Includes annual goals based on findings from previous QM activities;</li> <li>- Describes quality-monitoring processes and activities;</li> <li>- Describes at least one performance improvement project.</li> </ul>	<p>Design QM program that will:</p> <ul style="list-style-type: none"> <li>- Assure quality of both provided and purchased services;</li> <li>- Monitor performance and Detect problems;</li> <li>- Determine causes of problems;</li> <li>- Prioritize quality-improvement activities;</li> <li>- Determine effective remediation;</li> <li>- Follow up to verify problems are fixed; and</li> <li>- Carry out improvement efforts even in absence of identified problems.</li> </ul> <p>MCO ensures that assessments and care plans are timely and of high-quality—without checking or prior approval from DHFS.</p> <p>MCO determines, documents, and reports its own performance (e.g., immunization rates)</p> <p>MCO plans and carries out tightly focused improvement projects.</p>

**NOTE: This document is not a definitive checklist of MCO certification requirements. It describes the developmental tasks that must be accomplished before any organization begins to operate as a MCO.**

## **Summary of Resource Center Boards, Local and Regional Committees included in the Wisconsin 2007-2009 Biennial Budget**

Resource Center Governing Boards - with approval of county board these governing boards can assume the responsibilities of counties long term support planning committees.

1. Determine structure, policies and procedures of the resource center (RC)
2. Complete annual data collection for consumers and providers of LTC services concerning the adequacy of services offered.
3. Identify gaps in service for client groups served by the RC
4. Advertise opportunities to participate in boards information gathering activities.
5. Report findings to regional LTC Advisory Committees.
6. Recommend strategies to build local capacity to local elected officials, regional LTC Advisory Committee and DHFS.
7. Review interagency agreements between RC and CMO in the area and make recommendations.
8. Review grievances and appeals
9. Identify potential new sources of community resources and funding for needed services to RC client groups
10. If directed to do so by the county board, assume duties of the county LTS planning committee.
11. Appoint members to the regional LTC Advisory Committee

Regional LTC Advisory Committee – DHFS establishes regions for regional LTC Advisory Committees. Membership includes representatives from RC Governing boards in the region.

1. Evaluate performance of CMO/PACE/WPP programs and make recommendations to DHFS.
2. Evaluate performance of RC and make recommendations to DHFS.
3. Monitor grievances and appeals to CMO/WPP/PACE
4. Review utilization and LTC services in the region.
5. Monitor enrollments and disenrollments.
6. Identify gaps in services and develop strategies to address gaps.
7. Perform long range planning on LTC policy.
8. Annually report to DHFS re: significant achievements and problems with LTC services in the region.