

Questions from Family Care Briefing

Structure and Governance

Can you talk more about how the decision was made to go with a Long Term Care District and what other alternatives were and why we ultimately chose this model?

The Northeast Counties analyzed three options: (1) counties having no part of the governance and allowing a private non-profit managed care organization to provide the services;(2) public model creating a multi-county quasi-governmental Long Term Care district specifically created in State statute for this purpose; or (3) counties could join together for a 66.03 agreement where they would be at risk for the Family Care operations. The counties agreed to the quasi-governmental unit structure to allow for public accountability but eliminate county risk.

Who appoints the consumer representatives to the District after the initial resolution?

The Long Term Care District statute requires that the Board of Directors contain at least 25% consumer representatives. The consumers need to be appointed when the Board first meets. Since the statute allows only counties to appoint members to the Board, the names of the consumer representatives will be contained in the initial county board resolution creating the District.

The process for reappointments will be written into the Board of Directors' by-laws. It is expected, however, that the Board will assign a Committee to recruit and recommend future consumer reappointments. To avoid each county board having to pass a resolution whenever a consumer reappointment is needed, the by-laws will likely allow for reappointments by only the county of the person's residence.

The County representative on the Board does not necessarily have to be a County Board member. All Board members must not have a conflict of interest.

With so many differences in urban and rural areas, how can we have one District with one set of rules or guidelines?

Just as in the existing county waiver system, all Family Care Programs operate under a single set of rules set by the State and Federal government. Within that single set of rules, however, each Family Care agency will have different approaches to achieving their goals. These different approaches may be due to differences in geographical areas of the state but must still comply with the

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State-wide rules. Within a District, there will probably be some different operating procedures based on local differences including the availability and range of providers, distances traveled by care management staff, differing percentages of target groups served, etc.

With all the restrictions (Federal, State) on a managed care organization, why would any MCO want to get into doing this—especially if they are supposed to be non-profit?

The mission of NEW FC is to ensure that all of our fellow residents who are eligible to receive long term care benefits do receive those benefits. The State contracts with organizations, like NEW FC, to ensure that all eligible Wisconsin residents receive benefits on a consistent basis throughout the state.

Financial

Where does the funding come from for expanding Family Care?

Existing funds will be reallocated from other State funded long-term care programs including Medical Assistance (MA) Waiver programs like Community Options Program (COP), Community Integration Program (CIP) and the Brain Injury Waiver Program (BIW), and some MA ‘card’ services like institutional and personal care. Family Care combines most of the Federal, State and County funds associated with these programs.

Beginning in 2000, the State piloted Family Care in five count-operated programs. An independent evaluation of these pilots showed that Family Care achieved an average savings of \$452 per month, per member. Savings occurred in institutional costs in the state Medicaid budget as well as in care plans and provider costs for Family Care enrollees.

How is the “capitated” rate determined? Who does it?

The “capitated” rate is the amount that the State pays the Family Care agency for each member. An actuarial firm (currently Price Waterhouse) determines the “capitated” rate. The “capitated” rate is intended to be actuarially sound which means it is set at a rate that is adequate to meet the needs of a group of members. Some MCOs have experienced financial losses in the initial expansion period and part of these losses may be due to the assumptions regarding how rapidly MCOs can achieve cost savings.

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What would be the base limit per consumer?

The “capitated” rate that the Family Care agency receives for each Family Care member is an average of the costs for all members. Rates are calculated for each of the three target groups. The rate varies among Wisconsin’s Family Care agencies and cannot be determined prior to start up but NEW staff is using an estimate of an average of \$3,000 per member, per month (PMPM). However, the cost of each member’s plan is based on his or her desired outcomes and needs, regardless of the “capitated” rate. Some member care plans will cost significantly higher than the “capitated” rate and others will be lower.

Does the MCO limit consumer service to limit business losses?

The MCO is required to provide services that will meet the consumer’s needs. The MCO is responsible for using cost-effective approaches to meeting consumers’ needs. Some of these approaches include maintaining the consumer’s health to avoid most costly services, reducing duplication of service, using the purchasing volume of a larger organization to limit prices of goods or services, and benefiting from a large provider pool to target service more specifically to a member’s needs.

How are provider rates set?

Some of the services in Family Care are traditional Medicaid “card” services such as physical therapy, home health care, durable medical equipment, etc. The State sets the rates for those services. For residential services, the State is developing a rate setting methodology that Family Care agencies will use to negotiate rates. For other services, the MCO will negotiate rates based on the needs of the members using the service and the cost-effectiveness of the services provided.

Are MCO provider rates approved by the State?

The State does not approve MCO provider rates but does approve the model contract each MCO uses to purchase services from providers.

What would happen if a MCO “failed” or went out of business?

The State is trying to build in “healthy redundancy” so that if an MCO went out of business, another MCO would be able to serve their geographical area. The State says that they are responsible for ensuring adequate services are provided and there is an appropriate plan in place for consumers to move to a different MCO service without an interruption in services. The State is also working to strengthen the business model and financial health of all MCOs.

**We have heard that some providers were not paid by MCOs for months?
Does this mean that Family Care is running out of money?**

There were some providers whose claims were delayed by one of the MCOs. That MCO experienced administrative problems in the switch over to a new Claims Administration service. They eventually sent funding to cover provider agencies and are now paying claims on time. That MCO had adequate funding to pay provider costs.

Employees

How many employees will be within the District? How will they be selected?

At full implementation (about three years from the first consumer enrollments) the District is estimating there will be about 200 employees.

The Board of Directors will approve a Human Resource system and policies for the District. The Board of Directors will hire the Chief Executive Officer. The Chief Executive Officer, District's Human Resources, and other management staff will hire all other employees.

County employees that go to the District will have the same benefits until the end of their Collective Bargaining Agreement and then what happens?

The District will be developing a Human Resource system and Department, personnel policies, and a wage and benefit plan for all employees. That plan will certainly consider the wage and benefits needed to attract experienced county care managers, nurses, etc. At the end of the Collective Bargaining Agreement for a particular former county employee, the District wage and benefit plan will apply to the employee. Some of the Family Care Districts are unionized and some are not and that will be a decision of the employees.

Can employees that go to the District come back to the county and bump within the union? Would this be something that should be included in a county's Collective Bargaining Agreement?

Employees who join the District will no longer be county employees. It would be up to each county to determine if they would have any right to return to county employment and under what conditions.

County Role and Impact

Has there been any discussion/anticipation of staffing issues and levels for Economic Support as they first determine eligibility? Can the counties that have already implemented Family Care share anything?

The District, with Economic Support Units and ADRCS, will develop an entire Enrollment and Eligibility Process. As part of that process, the District will examine the requirements and processes for all parts of the Enrollment and Eligibility process as well as guidelines and information from State staff responsible for the transitions process. The NEW District will use information and data from counties that have already implemented Family Care.

The Committee to begin working on these processes will probably be started in the fall of 2010.

How are counties assured that the State won't limit eligibility for Family Care in the future and the county end up being responsible for additional consumers? For example: could they modify the eligibility-screening tool or the functional screen to limit eligibility?

The State has told the NEW District that in terms of modifying the functional screen, the screen is the expression of eligibility policy contained in State statute and administrative code – DHS cannot just determine to change eligibility policy and implement that. With any change in statute, there are obviously lots of opportunities for input.

Is it true that most of the people on waiting lists are in the urban areas?

The Northeast has both urban and rural areas within each county but specific data is not available to determine whether people on the Wait List live within urban or rural areas of a county. A good example of this is Brown County—they comprise approximately 55% of the projected enrollment. They have a number of people on the waiting list; however, only a portion of Brown County is urban; many on the waiting list live in the rural areas of Brown County.

The number of people on the Wait List for the entire seven-county area is about two-thirds of the number of people on the Waiver. Of the seven counties, only one county has a very small wait list.

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By moving central and administrative operations to a higher level, will counties lose control?

By joining in with a multi-county, quasi-governmental organization to provide care, individual counties will no longer be hiring most of the employees or contracting with the service providers or individually “running” the program. Some counties may provide care management under contract with the District during the transitional time. The District may also contract with counties for other services such as behavioral health, and representative payee services.

Individual counties will appoint a representative to serve on the Board and may want to arrange for periodic reports from the District to the County Board. County agency directors will be involved in some type of advisory role with the District. Each county agency will develop a Memorandum of Understanding regarding the coordination of services with the District since counties will continue to provide related services such as Adult Protective Services and Emergency Services. County Economic Support units and ADRCs will also have coordinating relationships with the District.

Operations

How will quality be maintained – especially if extra staffing is needed and no extra money is available?

The Northeast Wisconsin Family Care Board will be responsible for ensuring quality. Quality begins with employees and the culture of the organization. NEW FC culture will embody staff professionalism. NEW staff will be selected that have the desired attributes for embracing quality.

There will be additional funding as additional enrollment occurs which will support additional staffing. The District will receive a monthly capitation (revenue) for each member enrolled with the district. Additional funding will be available, as people currently on Wait Lists will receive a “capitated” rate for services. With the expansion of services to Wait List people, the overall revenues available to the District will be significantly more than those available previously to the counties.

What happens with our current providers with whom we are satisfied?

Northeast Wisconsin Family Care plans on contracting with providers that the county waiver programs currently use and counties recommend if the providers choose to become part of NEW Family Care’s “provider network” and agree to the

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contractual arrangements including rates. In Family Care, the number of providers available to members actually increases because the program is required to have providers for the additional people served and to offer a choice of providers for most services. Family Care members might have additional providers available to them.

However, NEW Family Care may have a more cost-effective arrangement with one provider than another. In this case, NEW Family Care can offer the most cost-effective way to provide the necessary supports. For example, there might be an arrangement with one home care provider for a daily or overnight rate for services, but contract for hourly services with another home care provider. The daily rate is almost always more economical; and Family Care can limit choice to the most cost-effective way to provide needed support.

Will clients be required to travel to out-of-county services?

There will probably be some services that some consumers may continue to receive out-of-county just as there are in the Waiver program. However, since the increased volume of business in Family Care MCOs will result in the availability of additional providers, it is likely that the choice of providers within a closer distance to consumers will actually increase.

Concerns have been raised in some parts of the State that some consumers need to move out of their residential program because the MCO and the provider could not agree on the rate for service.

At this time, 100 people statewide (out of 33,000 Family Care enrollees) have moved out of their residential program because providers would not accept the rate the MCO was paying. Although there were fears this might be done to move people into larger facilities, only 15 of the 100 people moved into a placement with more residents. Because needing to move out of a residential program is difficult for consumers, the State has now put a process in place to review such proposed moves to ensure that the consumer's needs are met.

How will out-of-state participants be handled; for example: Wisconsin residents eligible for nursing home services in Michigan and vice-versa?

If a legal resident of one of the seven Northeast Counties lives in a residential program in another state, the District would likely have a contract with that out-of-state service and with other services needed there.

The rules that determine a person's legal residency and eligibility for long term care services are the same in Family Care as under the county waiver system.

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People who move across counties or across the state line into Wisconsin and establish residency in a Family Care county will be eligible for Family Care. There are people who are unable to establish an “intent to remain” in a particular location because they are not competent to make that decision and the decision is made by a guardian. With some exceptions, the residency of these people will remain with their original county.

Since states surrounding Wisconsin do not have Family Care, anyone moving out of Wisconsin and establishing residency in another state, will have only the Medicaid long term care service options available in that state.