Common Questions and Answers
re: Long Term Care Reform and Aging & Disability Resource Centers

Q1: We hear so much about Family Care and Family Care Expansion. I hear good things about our services and our staff. What's wrong with the present system, and why must it change?

A1: Our clients and their families do like the Long Term Care services that we purchase and provide. The problem is that not everyone that needs services can receive them. Many are placed on waiting lists because under the existing design, the State does not fully fund long term care services. Waukesha County has more than 680 eligible people waiting for services. As more people will need services (i.e., aging baby boomers) the State needed to look to other models (Family Care/Partnership) of service delivery, without which waiting lists will continue to grow.

Q2: I understand that Long Term Care Reform (aka Family Care Expansion) is a state initiative? If so, must we participate, or could we continue to provide case management services as we have?

A2: Family Care is a statewide initiative. As Family Care rolls out, waiver funding (CIP/COP) will no longer be available. If a particular county chooses to not participate in regional planning and implementation, it would likely be held out of implementation until a later round, and then assigned. Regardless, the current case work provided by Senior Services, and that provided by Adult Protective Services would remain a county responsibility.

Q3: If Waukesha County chooses not to authorize ADRC application and planning at this time, how would that impact us as a county?

A3: Waukesha County would need to withdraw from the FPCMC multicounty public/private partnership, and await eventual assignment to one of the regional service areas. The State would then likely contract with a private entity to provide ADRC services. We would then not have the ability to prioritize referrals, have ongoing influences over practice and protocols, and would still retain certain Chapter 51 and Chapter 55 responsibilities – leaving open distinct possibility of problematic service coordination problems with the CMO and increased costs to the County.

Q4: If I understand this correctly, there would be a separate contract from the State for an ADRC, and a separate contract for at least one regional care management organization in each county. Are both these contracts with the county?

A4: If a county chooses to provide ADRC services, the State will contract with that county. The contract for the CMO will be between the State and the CMO, which will then bear the financial risk, which is currently borne by counties.

Q5: How is "care management" provided by a Care Management Organization different from various related care management services provided by existing County HHS staff?

A5: Care management provided by a CMO is team delivered. A nurse and social worker make up the team. Besides coordinating typical long term care services, the team will also coordinate acute and primary (Medical) care needs of enrollees.

Q6: The state is planning to take responsibility for all current county waiver cases, while also ending wait lists over a two year period. Why do they think they can financially make this work?

A6: This projection is based upon the actual successful experience of four Family Care pilot counties (Portage, Fond du Lac, LaCrosse, and Richland) in which the average monthly cost, per person, was reduced $452 compared to traditional long term care programs, (reduction of $55/person/month in Milwaukee County). The savings were used to draw down additional funding to permit the end of wait lists in those counties. It is expected that cost savings will be even greater for clients who choose to participate in a partnership program, where primary and acute medical care is managed, in addition to Family Care core services.

Q7: Just how big are our current county wait lists and how long do people typically remain on them?

A7: Presently there are 684 individuals on wait lists in the Long Term Care Division of Health and Human Services. Of those, 392 are elderly, 151 have a developmental disability, and 141 have a physical disability. The longest wait for services is in developmental disabilities, where the last person to be taken off the wait list for non-emergency reasons had been on the list since 1992.

At times during any given year, Senior Services establishes wait lists for programs funded with Older American Act dollars and that would likely remain necessary in the future if annual allocations are exhausted.

Q8: What if the state finds that their information and fiscal projections are wrong – will clients be at risk of losing their funding?

A8: Due to federal rules, once a client is enrolled into one of the Family Care Expansion programs, they can not have their benefits taken away, unless their eligibility (i.e., financial) changes. State personnel have also indicated that federal requirements of the program would not permit revision to wait listing in a county or region in which Long Term Care Reform has been implemented.

Q9: What is the fiscal impact to Waukesha County as a result of Long Term Care Reform, both in regard to the proposed County Aging and Disability Resource Center as well as the transition from county provided case management services to private Care Management Organization provided services?

A9: Given the fact that for fifteen years the state has not provided increases in Community Aids, which was intended to fund many core human services programs, nor has it provided inflationary adjustments in a number of waiver related programs, the current funding picture is one of constantly increased local levy pressure to sustain services and programs. Transitioning from this picture, to one in which a Care Management Organization will hold the contract with the state for long term care services, and receive annual adjustments to the capitated rate, will relieve Waukesha County of the pressures to find the increased costs of long term care, which has been increasing about $650,000/year. In brief, the benefit to the County on the Long Term Care services side is significant, at it proposes to freeze the local contribution at the 2005 level (or, if JFC language is adopted, at a level less than that after five years of implementation.)

In regard to the ADRC, the state's proposal for expansion includes a commitment to fully fund the costs of new/expanded ADRC functions, so the fiscal impact is neutral while the benefits related to service quality and accessibility are significant.

Q10: How are the services of an ADRC different from the front door services presently performed by other departments of Senior Services and Human Services?

A10: Presently, Human Services and Senior Services provide some services of an ADRC (i.e., Information and Assistance, Assessment, Referral, Eligibility Determinations) but on a smaller scale. The ADRC will act as a clearing house for long term care, making those services available to more citizens, with an enhanced emphasis on options counseling, benefits counseling (elderly and disability specialists), short term crisis intervention and case management, outreach and marketing, and prevention and early intervention activities.

The implementation of an ADRC will modify the present system from coordination of services between two departments to a seamless system of providing an array of services in a simple, customer friendly, one-stop design. It will be the single point of entry where adults with disabilities, and older adults and their families can get information and assistance available in the community.

Q11: Where would the ADRC be located, and will it increase the number of clients?

A11: We are currently working with facilities to determine the best location for the ADRC. We will consider what will be most convenient for the consumer and least disruptive for the staff. There currently is not room at HHS or DOSS for all the staff. Some staff will likely come to the ADRC on an assigned schedule and may then return to their office in a different location when their physical presence is not needed in the ADRC. As outreach and marketing are components of the ADRC, it is anticipated (and has been seen in current ADRC's) that there will be a large increase in calls and also more clients. The majority of the functional screens and services may be done in the community. A resource library will be located at the ADRC as well as all services for walk-ins.

Q12: How many existing staff will be affected by this, and will there be layoffs as a result?

A12: Due to the expanded responsibilities, and work of an ADRC, and based upon state workload formulas developed from existing ADRCs, we expect that all present employee affected by this change will have opportunity for employment in the ADRC. We are working with Human Resources to determine a recommended organizational chart, job descriptions and position classifications. As currently envisioned, all of Senior Services would move into the ADRC. Existing HHS staff from the Long Term Care Division would also transition into the ADRC as the wait lists are eliminated. Some staff may decide that they are not interested in ADRC work, and could then pursue case management employment with the CMO or other options.

Q13: How will quality and customer satisfaction be monitored? What will the appeal processes be?

A13: The ADRC must assure that all people know their rights and responsibilities. They will receive these rights verbally and in writing. They will know how to get assistance if they are not getting their needs met. A variety of advocacy resources will be available for addressing formal and informal complaints in order to manage appeals and grievances related to eligibility and enrollment. We will look at the current ADRC as we develop these. A governance board will be established to include the Commission on Aging and the Long Term Care Committee. They will have oversight of the procedures and processes involved in the appeals and grievances.

Q14: How will the Department of Senior Services or Department of Health and Human Services budgets change if the ADRC is a county provided service but Care Management is provided by a private CMO?

A14: Assuming passage of the Long Term Care reform section of the Governor's budget, and assuming state decision to accept the FPCMC application and timelines, our 2008 budget will begin the first 3 months with two separate budgets. Then, as LTC's caseload is

reduced, LTC staff will transition to the ADRC and the ADRC budget will tentatively begin April 1, 2008. There will be cost center shifting and changes in funds beginning April 1. The 2009 budget would see the elimination of millions of state and federal waiver dollars that will go to the CMO. The Older Americans Act funding (DOSS) and related programs, as well as Adult Protective Services will continue unchanged (APS is funded with levy and state and federal funding). The ADRC would be a separate department which would include existing Senior Services staff and programs, along with the new ADRC staff and programs.

Q15: How will existing governance structure change?

A15: We will have a new governance board that includes consumers, county board supervisors, the Commission on Aging and the Long Term Care Committee. It will be critical to have a cross section of representation. They will play an important role in assuring that the ADRC is meeting the needs of consumers and that the CMO is offering quality programs and satisfying the people that they serve.