

ADRCs' Potential Role in Managed Long-Term Care

Prepared by Amy Herr and Christina Neill

INTRODUCTION

ADRCs seek to simplify the process that often accompanies seeking long-term care services and supports by providing a trusted source of information about options available to persons needing services. Although these services have traditionally been provided on a fee-for-service basis, states continue to implement and expand the use of managed care for older adults and persons with disabilities. This makes 2007 a critical time for collaboration between ADRCs and state managed care initiatives to promote a LTC system that supports consumer choice, maintains quality, and offers cost-effective care.

Aging and Disability Resource Centers (ADRCs) have assumed many and varied roles within state long-term care systems since the beginning of the grant program in 2003. The role of ADRCs will continue to evolve and expand to fill in gaps in the provision of information, referral, counseling, and streamlining access to supports for persons of all ages with long-term care needs. ADRCs' roles will need to adapt as the service delivery and financing systems in their states change. Managed Long-Term Care (MLTC) programs will likely play a role as states restructure systems of care, and ADRCs will need to be part of those discussions.

This issue brief outlines potential roles that ADRC staff can play to complement the activities of managed long-term care. There are likely to be additional unanticipated roles and some ADRCs may play only a subset of these roles.

OVERVIEW

Managed Care Defined

Managed care serves as both an insurance mechanism and a health care delivery system.¹ The insurance mechanism consists of monthly premium payments made to MCOs, which use the money to provide care to all members. Because some members need more services and these services will cost more than others, the MCO must manage the risk that costs of care might exceed payments received for the care. Rates are set based on complex methodologies about cost of care and MCOs generally have financial incentives to do their best to keep members healthy.² The MCO assumes financial risk for the enrolled population and MCO staff and network providers can provide the continuum of services that appropriately serve their

¹ Administration on Aging. Managed Care Principles. Information Memorandum AOA-IM-97-08 -- April 4, 1997 Available at http://www.aoa.gov/prof/agingnet/IM/IM_97_08.asp.

² Ibid.

members. (This is in contrast to providers in the fee-for-service system, who are paid for services rendered.)

As a health care system, a managed care approach allows one entity (i.e., the MCO) to manage a person's full continuum of covered care needs. Unlike in the fee-for-service market, where primary care physicians, specialists, therapists and other providers may not be aware of care being provided by others, a managed care plan can provide a point of contact for a member that works with him or her to ensure that needs are met in a coordinated and effective manner. The point of contact can be a case manager (usually a nurse or social worker) or a primary care physician. For persons with multiple providers, prescriptions, and complex care needs, a managed care plan can assist in reducing duplication of effort and avoiding potentially harmful adverse effects of certain conflicting treatments. A Health Maintenance Organization (HMO) is a type of managed care organization.

History of Managed Care

States have employed managed care as a vehicle for delivering services to Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries for well over a decade. Historically, most managed care contracts provide primary and acute care services, and managed care was seen as a way to trim costs from an expensive Medicaid program. Most states did not initially include older adults and individuals with disabilities in its managed care programs. However, managed care for improved care coordination for persons with complex primary, acute, and long-term care needs has received attention in some states.

Managed care plans have had varied success in the private market since the early 1990s. Some advocates have expressed dissatisfaction with how managed care has been delivered resulting in significant skepticism. Some commercial health plans have left the Medicaid managed care markets due to insufficient reimbursement and complex regulations, resulting in less choice for consumers. However, Medicaid managed care plans continue to flourish, and many states have mandatory enrollment for children and mothers enrolled in Medicaid. A few mandate enrollment of elders and people with physical disabilities.

More recently, states have been turning to managed care models to serve the long-term care population of older adults and persons with disabilities. However, states and policy makers have focused attention on care coordination and enhanced care management, rather than using the term managed care alone. The difference is more than semantics, with the focus on providing improved care to this population, rather than on saving money. Some managed care advocates also argue that it will help shift the balance to home and community-based care from Medicaid's bias toward institutions, since the MCO has a financial incentive to serve members in their homes, when possible.

Sixty-three percent of Medicaid recipients were enrolled in managed care plans as of June 2005, according to the Centers for Medicare & Medicaid Services. Mothers and children constitute the vast majority of these enrollees. Only a small percentage of seniors and persons with disabilities are enrolled in managed care at present, although the number is growing quickly. ADRC consumers may also participate in private health plans serving individuals who have

employer-sponsored coverage, Medicare Advantage plans, and other managed care contracts. This paper focuses primarily on managed long-term care plans that serve the Medicaid population or persons who are dually eligible for Medicare and Medicaid.

Managed Long-Term Care

Managed Long-Term Care (MLTC) refers to care coordinated through a managed care organization for long-term care services such as personal care, home health, meal preparation, medical transportation and other services typically covered in §1915 (c) home and community based services waivers. Some ADRC consumers may be served by a managed long-term care plan as part of a state's home and community-based services program under Medicaid. Programs can have voluntary or mandatory enrollment.³

In MLTC, the state Medicaid agency, under a contract, makes payments to the MCO to provide long-term care services. The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO.⁴ The MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. MCOs can be non-profits, such as public hospitals and community health centers, for-profit companies, or governmental organizations such as counties.

The MCO assumes full or partial risk for delivering the services. Medicaid enhanced care management serves as a partially capitated system. MCOs receive fee-for-service payments for clinical services, but they receive a small per member per month (PMPM) payment for case management. Enhanced care management programs are often found in rural areas, where MCOs may be reluctant to take on full risk due to low number of enrollees.

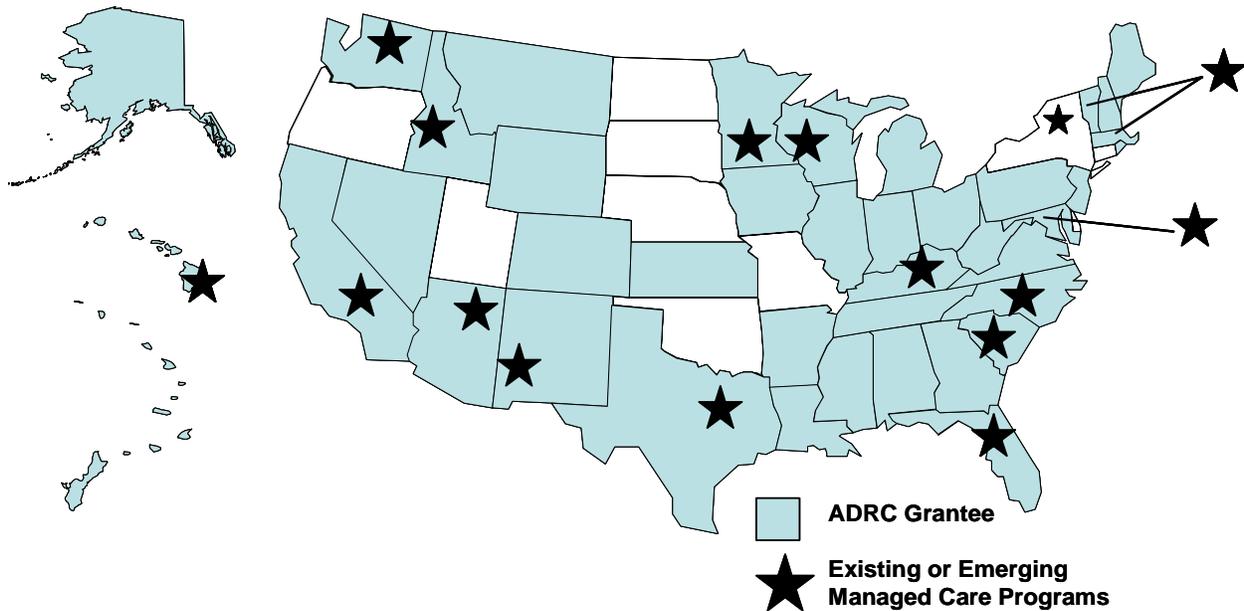
CURRENT INITIATIVES: ADRCs and MANAGED LONG-TERM CARE

Medicaid Managed Long-Term Care (MLTC) exists in several states today. The map in *Exhibit A* below displays states that participate in the ADRC program and states with managed long-term care models in place or in development. Although the sizes and geography of states with MLTC vary, some populous states instituted programs such as New York and Florida, and emerging markets include Texas and California. With tight state budgets and increasing numbers of people with long-term care needs, MLTC programs will likely play a role as other states restructure systems of care, and ADRCs will need to be part of those discussions particularly around how individuals access and decide upon appropriate care.

³ In a voluntary program, individuals elect to enroll in managed care or default into their existing programs (usually, fee-for-service). In a mandatory program, all Medicaid beneficiaries are required to select a managed care plan and they are given a choice of plans.

⁴ Payments are known as capitated payments or Per Member Per Month (PMPM) payments and are paid by Medicaid to the MCO for each member. Payments may vary based on the characteristics of the member (e.g., age, health status).

Exhibit A: States with ADRC Programs and/or Managed Long-Term Care Programs



Examples of ADRC collaboration with MLTC exist in some areas. State examples of emerging and potential collaboration appear in *Appendix A*. In addition, the surge in managed care activity during the past few years prompted AoA to award grants to community organizations in eleven states to develop partnerships with Managed Care Organizations (MCOs).⁵ The Center for Health Care Strategies also initiated a grant program to help states refine managed care programs for individuals with disabilities. They also released an issue brief in December 2006 outlining cost saving strategies for state Medicaid program which could serve as a useful tool as ADRC planners engage in discussion with Medicaid agencies.⁶

ROLE OF THE ADRC

ADRC grant requirements include engaging in “Awareness and Information, Assistance, and Access” to empower consumers to make informed decisions about their long-term support options and streamline access to needed care. Most grantees coordinate or integrate with other community agencies to offer a range of functions, such as public education and information on long-term support options, community referrals, crisis intervention, and streamlining access to Medicaid.

This section includes a few of the most crucial roles for ADRCs to consider. Because managed long-term care is an area that continues to evolve, these roles serve as suggestions, not prescriptions. State examples appear where they assist in illustrating the potential role.

⁵ More information can be found at <http://www.aoa.gov/prof/integratedcare/integratedcare.asp>.

⁶ More information can be found at http://www.chcs.org/usr_doc/Medicaid_Best_Buys_2007.pdf. Accessed June 12, 2007.

The ADRC could:

- Collaborate with state Medicaid agency in designing systems;
- Serve as a trusted source of unbiased information and conducting outreach;
- Perform/coordinate functional eligibility determination;
- Deliver enrollment/disenrollment counseling;
- Advocate on an individual level;
- Contract to perform long-term case management for MCOs;
- Train MCO case managers on availability of community services; and
- Coordinate prevention and health promotion activities.

Collaborate with State Medicaid Agency in Designing MLTC Systems

As highly visible and trusted places for LTC information, ADRCs can have a role in contributing to the development of MLTC in their states. The goals of the ADRC program—to support consumer decision making, streamline access to appropriate LTC services, and facilitate home and community-based services (HCBS)—complement states' goals in designing MLTC systems. State ADRC leadership can provide valuable information to State Medicaid Agencies about needs in the community especially for hard to reach populations who may be at high risk of institutionalization. State-level ADRC leaders can also gather and share the experience of local ADRCs' contact with consumers and offer valuable insights on how proposed program designs will impact various consumer needs and preferences.

Serve as a Trusted Source of Un-biased Information and Conducting Outreach

ADRCs offer balanced information on both public and private health options for care. For example, the State Health Insurance Assistance Programs (SHIPs) have been assisting Medicare beneficiaries with one-on-one counseling via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities since 1990. The majority of ADRCs are co-located with the SHIP offices in their areas. Similarly, ADRC staff have assisted individuals enrolling in the Medicare Part D benefit in deciding whether to choose a stand-alone prescription drug plan (that covers prescription drugs only) or a Medicare Advantage plan, which is a managed care plan offering prescription drug coverage as well as a package of acute and primary care services. They also helped individuals decide among the multitude of Medicare Part D plan options. In addition, some states have comprehensive managed care programs that combine acute and long-term care services and a pharmacy benefit in one package.

With a comprehensive database of information, the ADRC is a leader in centralizing information about long-term care services and supports. The ADRC plays a critical role in

connecting persons with services, including managed long-term care plans. It provides outreach to diverse and hard-to-reach populations and can help target services to people who are most in need. In Wisconsin, the ADRC is the single entry point to their managed long-term care programs. Kentucky's ADRC may become the single entry point offering options counseling and eligibility screening for the state's new 1115 waiver, KY Health Choices (see Appendix A).

Perform/ Coordinate Functional Eligibility Determination

ADRCs can assist consumers in becoming eligible for MLTC. They may be able to assist in performing functional eligibility and/or support the agency that determines functional and financial eligibility by assisting consumers with the application process. Many ADRCs have already developed capacity in this area through activities to streamline access to Medicaid services for consumers.

Deliver Enrollment and Disenrollment Counseling

ADRCs are well-equipped to offer objective information about managed care options for consumers. Introduction of MLTC in a state Medicaid program can mean disruption for beneficiaries. As the transition occurs, beneficiaries must decide whether to enroll (in a voluntary system) or in which plan to enroll (in a mandatory system). Beneficiaries must consider whether their physicians and other providers are included in the MCO's network. In most states, an outside entity is hired as an "enrollment broker" to assist beneficiaries with these decisions.

Older adults and individuals with physical or cognitive disabilities may also seek assistance from ADRCs to make informed decision about enrollment. As such, the ADRC must have access to information on the full spectrum of benefits offered in managed care plans in order to provide effective options counseling. For example, ADRC staff could compile health plan performance information from the state Medicaid agency and have it available for consumers in a side-by-side comparison format or have access to an electronic list of which providers are covered by each plan.

This type of information will also be helpful for ADRC staff assisting individuals transitioning out of a MCO or between plans. Depending on the level of contact the individual has with the ADRC, the ADRC staff may have information on the person's health history that can help him or her make the decision to change plans. South Carolina is considering a role for ADRCs in enrollment counseling (see Appendix A).

In addition, the state could establish a procedure in which MCOs are required to refer disenrolled members to the ADRC on a monthly basis. This would ensure that the beneficiaries receive assistance as they transition to other sources of care.

Advocate on an Individual Level

ADRCs are well positioned to offer unbiased assistance to consumers. ADRCs can play an ombudsman role for consumers, including providing advocacy on behalf of members, and assisting consumers with complaints that are outside the scope of the MCO. When conducting individual advocacy, the ADRC can be trusted to maintain consumer confidentiality.

Contract to Perform Long-Term Case Management for MCOs

In some states, the ADRC has a role in long-term case management. In most of these states, the organization which transitioned into an ADRC previously provided case management services under a Medicaid waiver. With the introduction of MLTC, the ADRC may choose to continue in this role. The expertise of waiver case managers could serve as a complement to the MCO in ensuring quality service to the beneficiary. However, to avoid potential conflict of interest, states should have clear separation between the entity determining eligibility and the entity delivering service. Wisconsin developed a document for their ADRCs on the “Organizational Separation between ADRCs and MCOs to Avoid Conflicts of Interest” (link provided in resource list). If contracting with the MCO to be the primary care managers is not an option, ADRCs may participate in inter-disciplinary care management teams as consultants.

Long-term case management includes supporting person centered planning ensuring that the participant is aware of the ability to be involved in the design of his or her care plan. Long-term case managers will be fully aware of the participant’s informal support network and identify services to assist with any unmet needs. For some enrollees, self-direction programs, in which the enrollee can directly hire and fire service workers, will be an option. The ADRC’s long-term case managers can play an important role in educating enrollees and MCO staff about self-direction programs.

Train MCO Case Managers on Availability of Community Services

MCOs have an obligation to create an adequate provider network with capacity to meet all the benefits outlined in the benefit package. However, ADRCs could assist MCO case managers to obtain services that are not covered by the MCO. Certainly, case managers employed by managed long-term care organizations will be trained to assist their members with receiving services within the scope of their benefit plan. The MCO case manager might not be trained on services excluded from their benefit package, but of great benefit to the members they serve. The ADRC may be of assistance to a managed care plan case manager by assisting to coordinate informal supports such as neighbors, churches, and relatives and formal supports such as state-funded services (e.g., medical transportation) to the extent that these services are not covered by the managed long-term care plan.

As the trusted source of long-term care information in the community, the ADRC could also educate MCO case managers on resource database information on availability of community services and potentially share data systems for tracking and organizing this information. The ADRC, as the central point for information and assistance on long-term care programs in the state or community, has a wealth of information collected on the availability of long-term care

services. In many states, this information is, or will be, available to the public using on-line information portals.

Another potential role for ADRC staff could be developing training for managed long-term care case managers, upon hire and periodically, to update them on the availability of community resources that could be beneficial to their consumers. The training could also include information on the ADRC's role in the long-term care system. ADRCs may also consider providing the managed care plan with one contact person who would assist with all inquiries from the plan, or a staff list of individuals and their responsibilities within the ADRC. Some MCOs may be willing to defray the cost of this type of training.

Coordinate Prevention/Health Promotion Activities

Many opportunities exist for ADRCs to collaborate with MCOs around health promotion and disease prevention. MCOs have a vested interest in keeping their members healthy. Many have started disease prevention programs and have extensive literature on specific diseases.

In addition many MCOs have implemented disease management programs. Disease management is "a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health."⁷

MOVING AHEAD

As states consider implementing MLTC programs, ADRC program managers or directors should be involved in the design of the system to ensure coordination between the MLTC program and the ADRC and to ensure that the MLTC system supports the ADRC's goals of consumer choice, streamlined access to services, and increased access to home and community-based services.

Collaboration opportunities for ADRCs and state managed care initiatives will prove crucial for a system that supports consumer choice, maintains quality, and offers cost effective care. The aging and disability networks have a long tradition of advocating for consumers and assisting them in making informed decisions. This role becomes even more important as options for consumers change with the introduction of managed care systems.

The Medicaid staff focusing on managed care may not be the same ones the ADRC has worked with on developing the ADRC and as a result may not be aware of the potential role ADRCs could play. Therefore, the ADRC must stay attuned to developments related to Medicaid

⁷ Disease Management Association of America at http://www.dmaa.org/dm_definition.asp, accessed January 4, 2007.

managed care for long-term care populations if the ADRC is to be at the table in the early stages.

RESOURCE LIST

Medicare Advantage Special Needs Plans Site Visits (June 2006)

This study, conducted by Mathematica Policy Research, provides a snapshot of the progress that Special Needs Plans (SNPs) had made by June 2006, based on site visits to SNPs in Boston, Miami, and Phoenix.

http://www.medpac.gov/publications/contractor_reports/Jun06_MA_SNP.pdf

The Past, Present and Future of Managed Long-Term Care (April 2005)

In this report, HHS ASPE provides an overview of Medicaid managed long-term care programs, including a history of managed long-term care and the status of the long-term care market in April 2005, a description of state programs and the health care market, and considerations on the future of managed long-term care.

<http://aspe.hhs.gov/daltcp/reports/mltc.htm>

AoA's Integrated Care Management Grant Program

AoA's Integrated Care Management Grant Program is designed to identify and support innovations in aging services that involve the use of partnerships with managed care organizations or Medicare Modernization Act Demonstrations and/or the creation and use of capitated financing arrangements that improve older people's access to social and preventive services. This report includes brief descriptions of the grantee programs.

<http://www.adrc-tae.org/tiki-index.php?page=StrategicPartnershipsandCollaborationPublic>

Establishing Partnerships Between Managed Care and Aging Service Organizations

Part of the National Council on Aging's Healthy Aging program, this document provides information on Kaiser Permanente's Metropolitan Los Angeles Service area partnership with the Alzheimer's Association of Los Angeles to assess and improve the quality of care provided to people with dementia. The replication manual highlights some important issues that should be considered before establishing one of these partnerships, including:

- Selecting a partner managed care organization
- Selecting goals for the project
- Considering options for the model of care
- Matching the strengths of the two partner organizations

- Determining resources for training health care providers
- Examining the role of care management and of the community aging service provider
- Evaluating the project and sustaining the change.

<http://www.healthyagingprograms.com/content.asp?sectionid=68&ElementID=262>

Organizational Separation Between Aging and Disability Resource Centers and Managed Care Organizations To Avoid Conflicts of Interest

This information bulletin, published by Wisconsin's Department of Health and Family Services, provides guidance to counties and planning consortia regarding the degree of separation required between an Aging and Disability Resource Center (ADRC) and a managed care organization (MCO).

<http://dhfs.wisconsin.gov/LTcare/pdf/adrc4separation.pdf>

Medicaid Managed Long-Term Care Issue Brief (November 2005)

In this issue brief, AARP provides an overview of Medicaid managed long-term care programs that were in operation at that time.

http://www.aarp.org/research/assistance/medicaid/ib79_mmltc.html

Medicaid Managed Long-Term Care: An Introduction (December 2006)

http://www.pascenter.org/documents/Medicaid_Managed_%20LTC.doc

This report documents the history of MLTC programs that provide some home and community-based services (HCBS) and those which were designed specifically to provide HCBS.

Appendix A

State Examples

Following are several state examples of efforts in which ADRC staff are (or plan to be) involved in assisting individuals in understanding, accessing, or relating to managed long-term care programs or manage long-term care type initiatives.

Georgia

2003 ADRC grantee

Program Name: AoA Integrated Care Management Grant

ADRC Role: Through an AoA Integrated Care Management grant, the Atlanta Regional Commission AAA, which is also an ADRC pilot, worked with a health plan to assess consumer needs and develop a care plan for Evercare enrollees who also were receiving needed services through the Aging Services Network. Although not a Medicaid managed care initiative, the enrollees were older patients with chronic illnesses. The project focused on home monitoring, communication between partners for status updates and referrals, and promotion of chronic disease self-management. They accomplished this through joint home visits, telephone, e-mail, and team meetings.

Kentucky

2005 ADRC grantee

Program Name: KY Healthy Choices

ADRC Role: Kentucky's state Medicaid agency would like the ADRCs to serve as the gateway for KY Health Choices, which is Kentucky's new 1115 waiver. The ADRC plans to conduct options counseling and eligibility screening (functional and financial screening) for KY Choices but the scope of work has not yet been determined. The state's Medicaid agency has also approved the proposal for the ADRCs to conduct case management for all HCBS waiver consumers through the AAAs. Although eligibility determination will still be conducted by the Agency for Community Services, the AAAs (through the ADRC) will be able to assist Medicaid with expediting functional and financial eligibility for consumers which would assist the streamlining effort.

Kentucky has revised their original work plan as a 2005 ADRC grantee because this opportunity supports the expansion of a statewide ADRC model. KY Health Choices includes targeted benefits, cost sharing, ability for people to enroll in employer sponsored programs, care integration, and health promotion and disease management. While they wait for approval, the State has begun to consider the possibility of the ADRCs conducting outreach for the new managed care waiver.

Maryland

2003 ADRC grantee

Program Name: Managed Care 1115 Waiver

Potential ADRC Role: An 1115 waiver application was submitted to CMS in August 2005 which includes coverage for dually eligible persons, people who are age 65+ and on Medicaid, and people on Medicaid of any age who are using LTC services. The MLTC program will be known as Community Choice. Many goals of the ADRC including the provision of information, streamlining eligibility, and improving access will be important to the implementation of MLTC as well as to ease the transition of individuals from other programs to Community Choice. Maryland currently has two ADRC sites – Howard County and Worcester County on the Eastern Shore. None of the proposed pilot sites for MLTC are in either geographic area. The state expects to add four new ADRC sites and will probably give priority to sites that overlap with the proposed MLTC sites.

Massachusetts

2003 ADRC grantee

Program Name: Senior Care Options (SCO)

ADRC Role: In nearly the entire state, AAAs, known as Aging Services Access Points (ASAPs) in Massachusetts, inform individuals about all long-term care options. The managed care organization completes functional assessments for the SCO program, and Medicaid enrollment centers handle the financial eligibility. SCO is a voluntary program. Each SCO recipient has a care management team consisting of the member, a social worker from a local ASAP, the beneficiary's physician, and a nurse. The team works together to develop a plan of care for the beneficiary, who signs off on the plan. SCOs are required to use social workers from the ASAPs. Massachusetts plans to use 2006 ADRC supplemental funding to build statewide capacity for the establishment of several ADRCs which will grow out of ASAPs. Therefore, the ADRC project will likely reach each ASAP in the state and interface with the SCO managed care program.

Minnesota

2003 ADRC grantee

Program Name: Minnesota Collaborative Planning Model: A Cross-System Approach to Evidence-Based Health Promotion

Potential ADRC Role: In September 2005, the Minnesota Board on Aging (SUA) received a grant from AoA to develop a coordinated, statewide evidence-based initiative to prevent falls in older adults. Goals of the project include developing a collaborative planning model that integrates federal, state, and local priorities, links strategic partners, including health plans, and results in new and effective system change. Partners include the Minnesota Department of Health, Stratis Health (the regional healthcare quality improvement organization), the Minnesota Council of Health Plans, the Minnesota Chapter of the Physical Therapy Association, the Minnesota

Occupational Therapy Association, the Minnesota Home Care Association, the Minnesota Health and Housing Alliance, Volunteers of America, and regional Area Agencies on Aging.

ADRCs are the next natural link in this coordinated effort. The SUA has collaborated with health plans by becoming a resource for evidence-based prevention and health promotion models for the dually eligible persons the health plans serve. They also have been able to convince the health plans that they are a strong source of objective information on long-term care. Plans exist to have the ADRC in MN develop strategies to market health promotion expertise to a broader audience through education of staff about evidence-based interventions and enhancement of database resources on topics such as fall prevention. Additional plans focus on (a) ensuring that new evidence-based programs are systematically included in the ADRC database and (b) educating consumers that contact the ADRC about health promotion resources in their communities and strategies for healthy living.

South Carolina

2003 ADRC grantee

Program Name: Healthy Connections

ADRC Role: The 1115 waiver application submitted to CMS by South Carolina states that enrollment counseling will occur through a contract or state employees. This role could fall to the ADRC. Counseling will include assessment of needs and assistance in evaluating options. Enrollment counselors will perform a health assessment to determine the healthcare needs for each beneficiary. Currently, managed care exists in the ADRC pilot areas of Aiken and Barnwell (CHS and Unison are the MCOs involved).

Vermont

2005 ADRC Grantee

Program Name: VT Choices for Care

ADRC Role: The ADRC program in Vermont serves as one gateway for VT Choices for Care (CFC), Vermont's new 1115 waiver. The goal of the waiver includes promoting community living over institutional care by increasing public information, promoting long-term care insurance, and encouraging prevention strategies. Although Choices for Care fails to meet the definition of managed long-term care because it lacks per capita payment to a third party, it serves as an example of collaboration with the state Medicaid agency. The VT Choices for Care program staff played an active role in constructing the ADRC streamlining access plan by participating in an ADRC streamlining access workgroup. Work group goals include 1) expansion of the LTC Clinical Coordinator role who determines functional eligibility to initiate Medicaid financial applications for CFC and 2) access to the CFC database to check the status of applications for consumers.

Wisconsin

2004 ADRC grantee

Program Name: Family Care and Wisconsin Partnership

ADRC Role: Designers of managed care in Wisconsin felt that ADRCs were so critical in managed care that they require that an ADRC must be in place before managed long-term care enters each area in the state. Wisconsin currently has two MLTC programs operating – Family Care and Wisconsin Partnership. In February of 2006, Wisconsin Governor Jim Doyle announced his intention to expand managed care in the state over the next five years. The Department of Health and Family Services (DHFS) has awarded grants to ten groups to carry out intensive planning activities to achieve this goal. DHFS has launched a website <http://dhfs.wisconsin.gov/managedLTC/> which offers information about expansion activities for these groups and other interested individuals. The ADRC serves as the entry way into the MLTC system in Wisconsin. ADRCs educate consumers about options, screen for eligibility, and assist consumers in applying for MLTC.