State Profile

Summary of Care Coordination Contract Provisions for the Wisconsin Family Care and Family Care Partnership Programs[1]

This summary was prepared for a study of care coordination in managed long-term services and supports programs, conducted by Truven Health Analytics for the AARP Public Policy Institute.[2] Contracts from the following states were included in the study: AZ, CA, DE, FL, HI, IL, KS, MA, MN, NJ, NM, NY, OH, RI, TN, TX, VA, and WI. The full report and contract summaries from the 18 states are available at www.aarp.org/carecoordination. The full report includes a compilation of findings across the states.

Wisconsin Contract Provisions

Element	Contract Requirement	Summary and Notes
Care Coordination Eligibility and Choice		
1) Which members are eligible for care coordination?	All	All members have long-term services and supports needs, and all receive and participate in care coordination.
2) Can eligible members opt out of care coordination?	No	Members who do not wish to participate in care coordination can return to the Aging and Disability Resource Center to receive counseling regarding their program options. Contractor may disenroll a member for loss of contact. This generally occurs if a member moves or refuses to participate in care coordination.
3) Can members choose or change care coordinators?	Yes	Subject to availability, members may change care coordinators up to two times per year.
Care Coordinator Qualifications		
4) Are care coordinators required to have college or nursing degrees?	Yes	Care coordinators may have: • a bachelor's degree in social work; • a bachelor's degree in any other area with 3 years' relevant experience; or be a registered nurse.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Qualifications (continued)		
5) Are care coordinators required to have experience in long-term services and supports or disability?	Yes	Care coordinators must have knowledge of community alternatives for the target populations served by the contractor and the full range of long-term care resources.
6) Are care coordinators required to receive training?	Yes	Contractor must establish competency standards for its staff and provide training to ensure that its staff meets the standards.
Cultural Competency of Care Coordination		
7) Are care coordinators required to speak languages other than English when the other language is used by members?	No	Contractor must encourage and embrace cultural differences among its members and have policies and procedures in place to ensure that members are allowed to practice their cultural beliefs while receiving care. Care coordinators are not required to speak a non-English language.
8) Are translation/interpretation services required when a care coordinator does not speak a member's language?	Yes	Oral interpretation services must be available without cost to all members who need it. Written materials must be available in a language when that language is spoken by 5 percent of members, and should be made available to anyone who requires it.
Care Coordinator Assignments, Contact Requirements, and Role		
9) Are care coordinators with certain specialties (e.g., nursing, social work, behavioral health) assigned based on the needs of members?	Other	Each member is assigned a team that includes, at a minimum, a social worker and a nurse. The member, along with the assigned team, may utilize other contractor staff, such as an employment specialist, to address specific questions or needs.
10) Is in-person contact required and at what frequency?	Yes	Face-to-face visits must initially occur quarterly, but may be reduced or increased according to the needs of the member, but may not be less frequent than annually.
11) Is telephonic or other remote contact required?	Yes	Contractor must define and, on an ongoing basis, evaluate an adequate level of contact for each member that reflects the member's needs.
12) Must initial contact with a new member be made within a specified time period?	Yes	Initial contact must be made either by phone or in person within 3 calendar days of enrollment.
13) Is an assessment required at initial enrollment?	Yes	An initial face-to-face assessment must occur within 10 calendar days of enrollment and a comprehensive assessment within 30 days of enrollment.
14) Is reassessment required and at what frequency?	Yes	Reassessments are ongoing, but must take place: • Every 6 months; • Whenever the member's needs change; or • Upon request by the member, the member's authorized representative, or the member's primary medical provider.
15) Does the care coordinator authorize long-term services and supports?	Other	Care coordinator and member are part of an Interdisciplinary Team (IDT) that authorizes services.

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Element	Contract Requirement	Summary and Notes
Care Coordinator Assignments, Contact Requirements, and Role (continued)		
16) If the member chooses a participant-directed option, does the care coordinator continue to provide coordination?	Other	Overall care coordination continues to be performed by the care coordinator. A self-directing member has the option of selecting a separate supports broker and paying for the broker from the self-directed supports budget provided by the contractor.
17) Does the care coordinator play a role when members use a transition program such as Money Follows the Person to move out of institutional settings?	Yes	Contractor is responsible for assisting members who leave nursing facilities in the Money Follows the Person program.
18) Does the member have a single point of contact who coordinates across specialized coordinators when needed (e.g., coordinates across long-term services and supports, behavioral, medical specialists)?	Not addressed in contract	
Care Coordination Role with Family Caregivers		
19) Are family caregivers asked directly about (a) their own health and well-being; (b) level of stress and feelings of being overwhelmed; (c) need for training in assisting the member; and (d) any additional services or supports needed to better carry out their roles?	Other	Caregivers must be included in the planning and ongoing assessment process with the agreement of the member, and must be made aware that training, education, and respite are available to caregivers. Together the member and IDT staff evaluate how well the plan is working and if adjustments need to be made.
20) Does the plan of care address needs of the family caregiver raised during the assessment process?	Yes	Training, education, and respite are available to caregivers and included in the plan of care as needed.
21) Are family caregivers given care coordinator contact information?	Yes	Contractor must provide contact information and information about resources to family members. Care coordinators will include anyone the member chooses to participate in the assessment and care planning process.
Care Coordination Information Tools		
22) Does the care coordinator have access to centralized member records?	Yes	Contractor must have a health information system that collects, analyzes, integrates, and reports data. The State provides access to contractors to its LT Care Data Warehouse, which houses member utilization and care data.
23) Does the care coordinator have access to an electronic care coordination program?	Not addressed in contract	
Care Coordination Structures, Policy, and Oversight		
24) Are care coordination caseload ratios required?	No	Staffing must be sufficient to meet the needs of members.

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Element	Contract Requirement	Summary and Notes
Care Coordination Structures, Policy, and Oversight (continued)		
25) Does state program monitoring include a specific focus on care coordination?	Yes	Contractors must report quality indicators specific to care coordination, such as turnover of care coordinators. The contract allows the State to monitor in any area, but does not include any monitoring activities that are specific to care coordination.
26) Outcomes measurement: Does the model include an evaluative component, through which the outcomes of the care coordination are periodically measured?	Yes	Contractors must have a quality management program that includes monitoring the quality of assessments and member-centered care plans. Members and care coordinators evaluate how well the plan is working at each review.
27) Care coordination entity	Partners permitted	The contract neither requires nor prohibits the contractor from using subcontractors to perform care coordination. Contractor must ensure that subcontractors do not have any conflicts of interest.

Contract Reviewed: Contract between Department of Health Services, Division of Long Term Care and [name of contractor] *(January 1, 2014–December 31, 2014).*

1 Wisconsin refers to care coordinators as care managers.

2 Saucier, P. and B. Burwell. 2015. *Care Coordination in Managed Long-Term Services and Supports*. AARP Public Policy Institute.

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