Members of the Wisconsin State Legislature – Joint Audit Committee
February 13, 2004
Peggy Herbeck, Supervisor
Aging and Disability Resource Center of La Crosse County

Thank you for the opportunity to testify regarding the successful implementation of Family Care, specifically the establishment of Aging and Disability Resource Centers in Fond du Lac, La Crosse, Milwaukee, Portage, Richland, Kenosha, Marathon, Jackson, and Trempealeau counties.

My name is Peggy Herbeck. I am the supervisor of the Aging and Disability Resource Center of La Crosse County. I am testifying on behalf of all of the Resource Centers. The concept has been so successful and well accepted in our counties we hope that you will consider and vote for the expansion of Resource Centers and Care Management Organizations throughout the state.

Testimony

The Aging and Disability Resource Center concept was developed because people need and want to have a place they can call or come to get clear, understandable, up-to-date information regarding services in their community.

Before Family Care families and consumers did not have a place that they could call that was neutral and that would give unbiased information. There are many private providers but they are only going to have persons well versed on their particular service not the whole picture of what is available.

People want to stay in their own homes as long as possible. To be able to stay in their own homes they need "solid" information on how to put together a comprehensive array of services. One of the big differences from the old system to the new system is that there are dedicated staff who will assist people to plan for future needs, whether or not they are "eligible" for public assistance. In fact, this is what sold our staff on the idea of a Resource Center and why I volunteered to become part of the Resource Center development.

I had been working with individuals in the community for over 20 years –it never made sense that persons were steered away and weren't "eligible" to get the professional planning help they needed because they were middle income and had been able to conserve and save their money.

The Resource Center concept is quite different. Persons receive the professional planning without regard to their financial situation. Persons are very receptive to speaking with the Resource Center, there is no stigma, and they like the idea that their taxes are supporting such a positive service.

I can't tell you how many times over my career, I would meet with individuals when a family situation had completely collapsed and they would say to me "if I would have only known there was some help...maybe things would have turned our differently."

A second major difference between the new and old system is that for the Resource Center staff their job is to be available to respond immediately to questions and concerns - not in 2-3 weeks but within hours or days to a request to assist with planning.

I would briefly like to speak to the importance of the Long Term Care Functional Screen. The Long Term Care Functional Screen is more comprehensive than the full assessments completed under the old system. It allows the consumer and family to look at what is going on in their current life. It addresses a variety of areas they may need help with such as bathing, dressing, cooking, getting groceries, up to and including do they need help writing out checks. It has been tested and revamped for over 5 years. It really does allow you to touch on all areas of planning necessary to successfully and safely help an individual plan out services.

In no way are Resource Centers "providing all the services". We are a clearinghouse of information of what is available in our local community. The Resource Center provides Prevention and Outreach

services in the community. We don't just target the traditional groups of persons but try different and innovative ideas.

The Resource Center taught a one afternoon course to approximately 90 senior nursing students at our local Technical Institute on who to refer to the Resource Center and what the Resource Center can offer to individuals. Can you imagine how this information will be utilized by our young dedicated medical staff? The nursing supervisor told me that after the first time I taught the class- 3 of the nurses passed on information regarding WHERE to find out about resources to patients they were caring for. If people get the right services early enough, potentially medical costs will go down.

What is different from 1998 when we first opened our doors?

- The name…calling the concept a Resource Center gets rid of the artificial stigma of calling any type of a county agency. In the past many people thought "Oh I have too much money for any help." The facts show that less than 20% of the referrals we receive go on to become Family Care members. Under the old system people had no one to call-they would wait until there was a crisis and then call one possibly two agencies and make a quick long term care decision.
- We haven't been able to change the "mindset" of the current generation yet. …we still often get calls of person in crisis BUT because the agencies they are calling must refer to the Resource Center due to the Preadmission Counseling Legislation persons are quickly getting hooked up with a Resource Center professional who can help them weed through all the services and make informed decisions. We always remind people of the old adage "knowledge is power.
- When we go out in the La Crosse community and explain the services that our Resource Center offers to help individuals plan, many times people raise their hands and say, "How can I contact the Resource Center in my county? When we tell them one is not available they are very disappointed.
- Resource Centers are user friendly. We have staff dedicated to answering questions and helping people through the system. Everything was so fragmented before. People would be referred to a variety of different places. No one was able to take the time to help the person through the whole system. This is so much more user friendly. There wasn't a single entry point to long term care services. Usually the first contact the consumer or family had was with a representative of a private agency trying to encourage the person to accept their service or living arrangement.
- The first of the Baby Boomers are hitting age 60 in the next 2 years. We have to be prepared to talk to people about good future planning, whether it be regarding in home help or living arrangements.
- What is great is we serve all disability groups. The individual on the other end of the phone shouldn't have to know to call 3 different agencies to get their questions answered. The professional intervention and planning is made accessible to all adults.
- People need to know that they do not have to struggle by themselves. We run TV and radio ads. People still make their own decisions but now they are based on the whole picture not just the first agency they talk to.
- The Resource Center is very important for the working caregiver. Businesses are becoming more cognizant of the need for their workers to care for family members but may still resent the time away.
- People cannot make good choices if they don't understand the options. People want to be in charge of their own future. Knowing what services are out there to handle the " What if's of life can help people

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- Specialist can assist persons age 18 60 to understand the Social Security Disability application process and assist them to apply if needed.

Stories

One of the nicest compliments that our Resource Center has received is when a nursing home admissions director said, "I'm so glad you are there, now when people ask me about other services than what we offer in our system I don't have to feel conflicted regarding giving out information.

A woman, about 84 yrs old and her daughter, (who lives in Madison) came in to The Resource Center to talk about services. The woman has a husband who is 95 yrs old and because the daughter lives in Madison, she is the primary caretaker. Both the mother and daughter stated that they needed to find out information for the future, as they did not want a crisis to happen to the family, and not know where to turn, or who to contact. They were given information on, the CMO and the services that could be provided in a community setting, housing options for the future, and basic financial information. The family decided that they would go and tour some of the assisted living facilities in case they needed one in the future. No further follow up referral was done at this time, but the consumers left very satisfied that all their questions were answered. They indicated that they will call in the future if the need arises.

Name: **Chester Kuzminski**
Resource Center Manager
Milwaukee County
Department on Aging
414 289-6626

Purpose: **Written Testimony Regarding Aging and Disability Resource Centers to Joint Audit Committee of the Wisconsin Legislature**

Date: February 13, 2004

I am the Resource Center Manager for the Milwaukee County Department on Aging. I have been involved with the pilot project for resource centers since 1999. You will have heard today and read later testimony on various aspects of what resource centers are and what impact they have had. My intent is to share some numbers and facts from Milwaukee County's experience.

Each year of this project our department has received over **50,000** annual contacts. In addition, for 2003 we have received **34,000** website hits to bring our total contacts to nearly **80,000** for the year. The resource center funding has allowed us to provide important information to a large number of people in a very cost effective manner. Most of these contacts involve providing simple information and advice to consumers by phone or mail which increases the likelihood that they will make wise choices for their long-term care needs and avoid the need for public services.

Each month we follow-up on **500-600** of these contacts either with an additional phone call or a face-to-face contact. From these monthly contacts we are **enrolling approximately 150 individuals per month into Family Care.** The others receive "options counseling" to plan privately for their needs.

We have established **4 fitness centers** serving over 1,100 people annually, 37% of whom are minorities who are difficult populations to reach with this type of service. Our

Prevention Team, consisting a nurse and two social workers visited our county senior centers providing wellness checks and counseling to almost 3,000 people last year. *These wellness and prevention efforts make* ***individuals less likely to need to access more expensive public services later on.***

In the last 4 years **14** nursing homes have closed in Milwaukee County. The Resource Center was involved with each of these closings to assist individuals in their relocations. We provided options counseling during these closures to some **640** residents. Many individuals were enrolled into Family Care at a reduction in public costs.

I receive calls monthly from public agencies around the country who are attempting to duplicate what we have done. They agree that providing a central place locally for people to contact and obtain information and assistance regarding their long-term care needs is a cost effective way to provide a valuable service to **all** taxpayers regardless of income. That makes it good public policy.

2003 Resource Center Reported Contacts in Milwaukee County

Contact type	Count
Information	29,321
Assistance	2,440
Web Site	34,310
PAC Referrals	3,266
24 Hour Calls	411
Long Term Care Referrals	6,418
Resource Center Prevention Team	2,982
Total:	**79,148**

February 13, 2004

Family Care Testimony – Aging & Disability Resource Centers
Deb Menacher, Marathon County

Honorable Members of the Joint Legislative Audit Committee

I am pleased to have the opportunity to speak with you regarding the prevention and intervention component of Aging and Disability Resource Center services.

Resource Centers from its initial design to present are the focal point for providing prevention and early intervention to the potential long term care consumer. The goal of prevention and early intervention services is to delay or prevent the need to access comprehensive long term care services. Resource Centers accomplish this through active outreach, conducting risk assessments, creating linkages; and provision of innovative intervention techniques, and solid public education.

Outreach is the cornerstone of effective prevention and intervention services provided by Resource Centers. Reaching people before they are in need of or made choice about the purchase of long term care services is essential to slowing the number of people needing publicly funded long term care. Resource Center outreach focuses on two target populations: 1) those that are in need of long term care services and have the private resources to pay for their care; and 2) those that are at risk or are experiencing a functional decline in their capabilities as a result of aging, disabilities or chronic health conditions.

Resource Centers strive to reach all consumers of long term care services while they still have private resources to pay for their care. Most of the public currently makes long term care choices based on what their family, friends, or neighbors have done in the past. They do not base their purchasing decisions on what best addresses the consumer's need.

This often results in people purchasing more care than they need and depleting their private resources unnecessarily.

The Resource Center provides an objective forum in which to assess the consumer's needs and explore with the consumer and/or their family the array of possibilities that could meet those needs. This is the opportunity to assist in building the consumer's understanding of what services are available at what cost. When a consumer is well educated as to the services available that are appropriate to his/her need and chooses accordingly, private resources can be conserved. Slowing the depletion of these private resources results in the long term care consumer delaying his/her reliance on publicly funded long term care. The process of assessment and consumer education in the Resource Center setting is called long term care options counseling. The more effective Resource Centers are in outreach and long term care options counseling to private pay consumer the longer the delay in needing publicly assisted funding.

The second group that Resource Centers outreach to is those adults who are experiencing the impacts of aging, disabilities and chronic health in their lives. Here often times the family member or primary caregiver is as much the target of our outreach, as is the individual with long term care needs.

In reaching out to the family member and/or primary caregiver through our prevention and intervention services, the Resource Centers' efforts result in the caregiver being able to continue their informal support of the long term care recipient. Resource Centers again offer a forum for the individual and/or the family/caregiver to discuss, assess and plan for the care of individual. Resource Centers can support caregiver's efforts by offering information and assistance that supplements and compliments the caregiver's role. The planning of care for the individual and how the caregiver is also going to take of his/herself such that he/she is able to continue in this capacity facilitates conversations and referrals to service that prevent caregiver burn out. Furthermore, it fosters the planning and decision making for the time when their loved one's care needs may grow beyond their ability to continue to provide all the care. The Resource Center's ability to

provide the assessment, long term care options counseling, information, assistance and support strengthens the caregiver's capacity to continue again slowing the progression to more costly forms of care.

The other target population in this group is the individual who is at risk of or experiencing a functional decline as a result of aging, disabilities or chronic health conditions. The Resource Center through its prevention and intervention services is able to assist people in retaining or improving functioning where possible. This can be accomplished through referral to community resources as well as direct provision of services.

Over the course of the past four years, several of the pilot counties have had the opportunity to demonstrate how a variety of interventions services could impact on retaining or improving the functional status of people. Jackson worked on falls prevention, Milwaukee County on changing health related behaviors, Trempealeau County on nutritional risk identification and intervention and Marathon County on in home preventative health services. Based on the results from each of these counties there are many effective intervention strategies that can be utilized to retain or improve the functional status of people.

I would like to take the remainder of my time to talk about one that holds tremendous promise in its ability to reduce admissions to and length of stay in nursing homes. It is Marathon County's In Home Prevention Project. This project is a replication of a UCLA study. It was constructed as a three year research study in which there was a control group and an intervention group. Drs Paul Moberg (University of Wisconsin Madison Medical School) and Mark Sager (Alzheimer's Institute) are the principal investigators. In 2000, 425 community residing people 75 and older in Marathon County voluntarily enrolled in this research project. Each person received an assessment conducted by a research assistant upon entering into the project. Those persons randomly selected to be a part of the intervention group then received an additional in home assessment by a nurse practitioner who did a full review of systems, contacted the primary care physician

for medical records, worked with the individual to establish his/her health goals and a plan to accomplish their goals. The intervention participants then received a follow up phone call once every three months from the nurse practitioner and an annual visit each of the subsequent two years. The control group received no further intervention but did complete an annual assessment each year.

We have just completed the secondary validation of the first two years of data and can conclusively state that the use of nurse practitioner in this way has a tremendous impact on nursing home admissions and length of stay in the nursing home. Permanent nursing home admissions were reduced by 50% and the length of stay (days) in the nursing home were reduced by well over 50%. As of the two year data we know that for every dollar that was spent on nurse practitioner services six dollars was saved in nursing home costs.

We have just completed the final year of the study and are analyzing this final year data. However, preliminary indications are that the trend of the first two years will continue in the third year. If indeed this holds true, there will be evidence-based proof that Resource Centers can offer services which delay and prevent the need for more costly forms of long term care. The effects of prevention and intervention services are often difficult to quantify, especially in relatively short periods of time. This project clearly has demonstrated the impact of prevention and intervention services even in an older (75+) population and the monetary savings to be gleaned from investing in these services.

Resource Centers are committed to; and effective in preventing and delaying the need for more comprehensive (and expensive) long term care services. Our ability to continue to offer prevention and intervention services like those described above is the cornerstone to our effectiveness.

For more information or questions:

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Statement of Gerald J. Kallas M.D., CEO and Medical Director,
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Testimony before the Joint Committee on Audit of the State of Wisconsin Legislative Audit Bureau

Hearing on the Status of the Family Care Program

February 13, 2004

I want to thank Sen. Roessler and Representative Jeskewitz and the members of the Joint Audit Committee for the opportunity to appear today to testify about the Family Care Program. My name is Dr. Gerald J. Kallas and I am the CEO and Medical Director of Senior Residential Care of America, an assisted living company located in West Allis, Wisconsin. Prior to my role with Senior Residential Care, I was a Medical Oncologist and Hospice Physician. My practice dealt mainly with seniors, and any medical testimony I provide today is based on 35 years experience of working with seniors. We have Community Based Residential Facilities, better known as CBRFs or assisted living facilities in Milwaukee, Waukesha, and Dodge counties. Senior Residential Care has a Family Care contract with the Milwaukee County Department on Aging for five CBRFs located in Milwaukee County.

Earlier today you heard the final report of the Lewin Group which was formally completed and submitted in July 2003. The report attempts to address information about the effectiveness of Family Care regarding implementation, consumer access, along with information as to how efficient the Family Care Organization utilizes the resources available. I believe the Family Care program continues to evolve and many changes have occurred since the inception of the program in 1999 and many more changes still need to occur. The Lewin Report has not informed you of everything that is happening within Family Care. While the Lewin Report discusses the consumer side, it does not address Family Care's relationship with its providers, the people who provide the goods and services to Family Care enrollees, more specifically, Family Care's reimbursement policies for its providers.

I will begin by telling you about my experience as an assisted living provider to the Milwaukee County Family Care program. I will then discuss what I feel are shocking results of a survey I conducted these past two weeks of assisted living providers who participate in the five pilot programs of Milwaukee, Fond du Lac, Portage, La Crosse and Richland counties. The survey will show that the reimbursement procedures to assisted living providers are inconsistent, subjective, and wholly inadequate. You will also hear about the high dissatisfaction rate these providers have expressed about the Family Care program. I will include a discussion on the Capitation Rate paid to the Care Management Organizations (CMOs) and the accounting procedures utilized to keep the capitation rates artificially low. I believe that if Family Care is allowed to continue to operate in this manner without implementing major changes in the formulas that determine CMO capitation rates, which in turn affect provider reimbursement, both of these issues, that is provider reimbursement and CMO capitation rates, will develop into a major state government scandal.

Senior Residential Care of America

Senior Residential Care applied to the Family Care program in August 2001. After completing the necessary paperwork and supplying the audited financials, we received written notification on December 14, 2001 from our contract specialist approving our five CBRFs at a monthly contract rate from $3042.00 to $3423.00. The rate varied by location and services. Our primary resident population consists mostly of individuals with various stages of Alzheimer's disease and many of our residents are non ambulatory, requiring wheelchair assistance. Our residents require a fairly high level of personal care along with some nursing care. Two weeks after receiving our acceptance as a Family Care provider, when we were about to sign the contracts, the Milwaukee County Department on Aging reneged on our previously approved contract rates, and presented us new contracts at a flat rate of $2,700.00 per month per resident at all five of our facilities. We were told this rate was not negotiable, and was essentially a 'take it or leave it' proposal. We had estimated our cost of caring for a resident in our facilities ranged between $2,900.00 and $3100.00 per month, again depending on location and amount of services needed. It was a difficult decision to sign up for the program, but we did not want to lose any of our existing residents, many who would be running out of private funds and would need to apply for funds from Family Care for their housing. At the same time we were verbally reassured by the Milwaukee County Department on Aging that they would review our reimbursement rate and make an adjustment based on our audited financials which would demonstrate our actual cost of operation. We went through the year 2002 with no increase in our reimbursement, although we continued to write and request a review of their reimbursement policies. At the end of 2002, we again formally asked for an increase in the reimbursement rate, and received a negative response. We were told that we would have to wait until our audited financials for year 2002 were completed, and if the audit justified a rate increase, we would receive an increase that would be retroactive back to January 1, 2003. When the audit was completed and presented to our Family Care contract specialist, the figures showed that our monthly cost of caring for a resident in our facilities ranged between $2,903.00 and $3,092.00, confirming our previous estimates of what was our real monthly cost to care for a resident. When we presented the audited figures to Family Care in October 2003, we were told we may get an increase to $2,950.00 for year 2004, but it was unlikely that it would be retroactive for year 2003. Then on January 6, 2004, I heard from our contract specialist that we were not getting any increase, that the Family Care did not have enough funds to give providers any increases for the year 2004. So presently, Senior Residential Care is losing approximately $250.00 to $300.00 per month for each Family Care resident in our facilities. These figures do not include any administrative revenue or profit we should also be entitled to. We currently are currently caring for 65 residents in the Family Care program. When I calculated our total reimbursement for year 2003, we were underpaid approximately $300,000.00.

Last week, I talked with Stephanie Sue Stein, who heads up the Milwaukee County Department on Aging, about our reimbursement. Her comment to me was "If you are losing money, why do you stay in the program?" Not doing business with Family Care would be simple if we chose to accept their "take it or leave it" attitude, and if we did not care about our 65 Family Care residents and the100 employees who care for these residents. Our company's mission statement is to provide quality care and housing for the

elderly. Our private pay residents, who run out of funds after one or two years, end up applying to Family Care. If we didn't accept Family Care, these residents would be moved out of what is now their permanent home to another facility. We recently have been experiencing more referrals of private pay residents who have only enough funds to pay for assisted living for 3 to 6 months. Then they expect Family Care will cover their future housing needs. There are residents on Family Care who want to remain in their neighborhood, near their families, neighbors and church, and our facility may be the closest or most convenient place for them to live. There are social workers and case managers who prefer to refer our homes because they are familiar with our reputation for good care and the improved quality of life we provide our residents. Keep in mind that the Family Care program stresses in its outcome goals "that a resident has the right to choose where he or she may want to live and whom they want to live with without any specific guidance from the CMO organization." This statement is taken right out of their manual. It is also a known fact that the mortality rate rises when residents are displaced from their home or moved from one facility to another.

Family Care Provider Survey (Appendix A)

On January 26, 2004 I sent out a survey to 106 assisted living or CBRF providers who care for residents classified as frail elderly and/or Alzheimer's located in the five county pilot programs. As of yesterday I have received 38 responses from senior assisted living providers.

Results of Survey. See Appendix with questionnaire, and excel spreadsheet with results and comments

106 questionnaires were sent out on January 26, 2004
41 (37%) responses were received by February 12, 2004
35 (33%) responses were from Senior Assisted living Facilities
28 (80%) providers stated they were being paid below their cost of care
as determined by their audit.
3 (8.5%) providers were being paid equal to their cost.
2 (5.7%) providers were being paid above their cost.
12 (34%) providers stated they received an increase since 2000
1 provider in Milwaukee County received an increase in year 2000
11 providers outside of Milwaukee County received increases since 2000
33 (94%) providers stated reimbursement should reflect the level of care the resident requires.
28 (80%) providers were not satisfied with the way Family Care was operating.

Staffing Issues

Approximately sixty percent of our resident revenue goes towards payroll and staffing costs. The employee turnover rate for the assisted living industry is high. A number of respondents in the survey stated that because of their low reimbursement, they were limited as to what they could pay their help. There was a plea for higher reimbursements so they could reduce staff turnover by hiring and paying for more skilled care giving

staff. In addition, many providers cannot afford to provide health insurance for their employees, and many employees have to rely on Badger Care for their health insurance.

Capitation Rate

The current method of capitation payment by the state to the county CMOs is grossly unfair to all providers and suppliers in the Family Care program, and I will explain why. One week ago, I had the opportunity to talk with David Ogden, a consulting actuary, whose company (MillimanUSA) works with the Department of Health and Family Services, in determining future capitation rates. In an article he published in 2003, (see appendix) he described how the State was getting away from using 'historical costs of services' by switching to a functional screen which would more accurately reflect the prices paid for the level and intensity of care. They started integrating the functional screen into their calculations in year 2002. For year 2004, 80% of the calculations are based on the functional screen and for year 2005, 100% of the calculations will be based on the functional screen. My initial reaction was "Great, they are finally coming around to realizing that levels of intensity of care will now be included in the reimbursement formula!" Wrong. What they are doing is looking back at the previous year as a measure what each CMO actually paid for services. They are not taking into account that the CMOs have frozen payment levels to their providers as far back as 1999, so each year what the CMO pays for intensity of services doesn't really change. In reality, their formulas for calculating costs of intensity of care are not realistic, since they are based on reimbursement rates for provider services that have been frozen for the past 4 to 5 years. And for accounting purposes, this is a how the State agency that determines the capitation rates, keeps the capitation rates paid to the county CMOs artificially low.

I relate this to what I call the 'Walmart Syndrome.' If you are familiar with how Walmart negotiates prices from its suppliers, you will understand what I am talking about. When a supplier has a product he wants in the Walmart distribution system, and Walmart is interested in selling the product, Walmart will negotiate intensively with the supplier, sometimes weeks on end until they feel the supplier cannot reduce his wholesale price of the product to them any further. At this point in time, the supplier thinks he has a deal. Then several days later Walmart comes back to the supplier and says they want another 5 or 10% reduction in the price, take it or leave it, or Walmart will not stock your product. The supplier then has to decide if it is worth it to have his product in the Walmart system. I believe most individuals would agree that while this type of behavior occurs in the private sector, is not an acceptable behavior with public money by a government agency. We are paying for services to human beings, not for products stocked on a shelf. However, I see the Walmart Syndrome creeping into the CMOs philosophy on how they reimburse their providers. The CMOs have been put into a difficult situation of working with artificially created low capitation rates that do not reflect the true cost of care, and as a result, they are not able to pay a fair market rate to their providers and suppliers.

I have included in the appendix B, a chart with the capitation rates paid to the five counties between the year 2000 and 2004. You will note that the monthly capitation payment per enrollee for Milwaukee County for this year 2004 is $1,810.67 and has gone up only $88.94 in the past four years. That's only 4.91% increase over four years, yet the

overall Consumer Price Index went up 9.3% and the cost of medical care went up 16.6% during this same 4 year period (Appendix C). During the four year period (2000 to 2003), private non farm wages have gone up 14.5% (Appendix D). This correlates with the $1.50 per hour average increase in hourly wages that Senior Residential Care experienced over the past 24 months. Last year, our company liability insurance premiums doubled, and we were told that they may double again or go even higher at our next annual premium renewal date.

The capitation rates for the other four counties have stayed the same or decreased. Most everyone would agree that the cost of living is higher in the larger metropolitan areas such as Madison or Milwaukee, in contrast to the rural areas such as Portage. What I find hard to understand is why Portage County is currently receiving a capitation rate of $2,255.00 per enrollee, which comes out to $244.41 more than Milwaukee County, although essentially the same services should be performed in all five counties. If one really wants to know the market values of services provided to Family Care, you only need to look at the counties not in the Family Care program. Their COP funding costs per enrollee are approximately $300.00 or more per enrollee, as compared to Family Care's costs.

Does Family Care save money? Yes. Should Family Care be able to negotiate rates with its providers to lower its operating costs? Yes. Should Family Care be allowed to dictate reimbursement rates it will pay to its providers to the point where the providers are losing money? My answer is an emphatic no! This is not the type of behavior that should ever be permitted in the public sector.

No consideration is currently given to a provider for inflation or the changing medical status of a resident when that provider is locked into a fixed annual reimbursement rate. We know that as resident's age in place, their physical and medical needs increase. The elderly tend to be very frail, experience multiple falls with fractures, and have frequent hospitalizations, especially dementia residents. And as these residents age in place and approach the end of life, their needs for more services rapidly increase, including hospice care. As I discussed above, the capitation rates, as currently calculated do not reflect the true cost of care. To be fair, a formula of reimbursement that reflects the acuity and intensity of delivered services is needed.

My Mission

I will admit to the committee today that I am on a mission. My mission is to see that good quality care is provided in all the senior communities. Reimbursement plays a big role in keeping the level of the quality of care high. Our seniors brought us through though the depression and World War II. They deserve the best we can give them for making this country as great as it is.

I recently discovered that other assisted living providers had received increases in their annual rate, and I also found out that new providers had being accepted into the Milwaukee County Family Care program at significantly higher rates than what my company was receiving. This suggests that my company is being unfairly treated by the Milwaukee County Department on Aging. I continued to ask questions about the criteria

and procedures by which Family Care determines a provider's reimbursement rate. If the provider's reimbursement rate is not determined by the audited financial figures we are required as a provider to submit annually (because federal funds are involved), then what are the criteria? When I could not get sufficient answers, I had no alternative but to involve my legislators and county supervisors to get the answers. This apparently has made a number of individuals in the Department of Health and Family Services very upset. They do not appreciate getting calls from legislator's offices. On the local level, this past week, we called the Milwaukee Dept. on Aging to set up a meeting to review our reimbursement rates and were first told "We can't talk to you until the letter writing stops!" but then they backed off on that position when we questioned what that statement meant. They then agreed to schedule a meeting for February 17th. We have also noticed that they will not respond to our correspondence with written responses which suggests they may be trying to avoid leaving a paper trail. All responses have been verbal. So far, I still have not received any satisfactory answers by way of the written responses provided by officials in The Department of Health & Family Services to the legislators who have called on my behalf. One Dept. of Health and Family Services official sent an e-mail response to several legislators stating that I was wrong, that no assisted providers have been given a rate increase since year 2000 and that my company was being paid the same average rate as the other providers. This statement is not true. If this is the official position of the Department of Health and Family Services, then an investigation should be in order. I am asking the Joint Audit committee to take responsibility to do an in-depth investigation into the Family Care policies regarding CMO rate setting and provider reimbursement complaints as I have relayed them to you today.

In Summary

I am angry about the policies in the Department of Health and Family Services, more specifically, the Family Care program that has evolved as they exist today. Family Care needs to be held to consistent and fair reimbursement policies based on the provider's audit and cost of administering care, as the program was originally designed, rather than the non negotiable position currently presented to providers. If Family Care is being hailed as a new way to reform senior health care, you have a disaster waiting to happen. There could be a number of assisted living providers deciding to exit the program; similar to what happened with the Community Options Plan funding before Family Care. If such a disaster would occur, it would not adversely or directly affect you or me, but such a disaster would eventually displace many of Wisconsin's low income and elderly population from their homes, families, and neighborhoods into more costly programs or back to nursing homes. In reality, it is the residents who will suffer.

As a private citizen, I pay my personal, business and property taxes like any other citizen. However I object to my business being subjected to an additional form of taxation by being forced to subsidize a state budget crisis due to inadequate funding because I participate in the Family Care program.

Thank you again for allowing me to bring to your attention the serious defiencies that I have identified within the Family Care program. I trust that the committee will agree to conduct an investigation and attempt to find a resolution for these serious defiencies and problems as they exist today within Family Care program.

Family Care Provider Questionaire

Do you participate in the Family Care Program?	☐ Yes	☐ No
If you do not participate in the family Care Program, skip the rest of the questions and return the questionaire.		

How long have you been participating in the Family Care Program	☐ 1999 ☐ 2001 ☐ 2003	☐ 2000 ☐ 2002
Are you satisfied with your current reimbursement rate?	☐ Yes	☐ No
Is your current monthly reimbursement rate **above the cost** of caring for a resident in your facilities? (based on your most recent audit)	☐ Yes	☐ No
Is your current monthly reimbursement rate **below the cost** of caring for a resident in your facilities?(based on your most recent audit)	☐ Yes	☐ No
When did you get your last facility rate increase from Family Care.	☐ 1999 ☐ 2001 ☐ 2003	☐ 2000 ☐ 2002 ☐ None
Have you attempted to get a rate increase from your County Dept. on Aging?	☐ Yes	☐ No
Were you successful?	☐ Yes	☐ No
Have you made any attempt to contact your county board or state legislators to complain about Family Care reimbursement rates?	☐ Yes	☐ No
Do you feel Family Care rates should reflect the amount of care a resident needs, such as a differential rate for Frail Elderly vs. Alzheimer's, or high number of ADL's?	☐ Yes	☐ No

---

Optional

Your current average montly reimbursement rate:$____________

Are you interested in getting togeather with other providers in the Family Care Plan to lobby the State for fair and equitable reimbursement rates?	☐ Yes	☐ No
May I call you to discuss your concerns?	☐ Yes	☐ No

Name:______________________________ Company______________________________

Phone #:____________________________

Best time to call:______________________

Thank You for Participating in this survey

/ Care Provider Questionnaire Updated 2/12/04

Provider Name	County Located In	Average Current Rate/Month	Year Entered FC	Satisfied - Yes/No	Rate Above/Below Cost of Care	Year of Last Increase	Increase Amount	Asked For Increase - Yes/No	Received Increase - Yes/No	Should Rates Reflect Level of Care - Yes/No	Comments
Hilltop Manor	Fond Du Lac	2233	1999	No	Below	2003	2%	Yes	No	Yes	Spoke with Luther Olsen & Greg Unerheim - They said it was a county issue
*Lifeline Services	Fond Du Lac	3954									See attached letter written by Georgiann Froemke
Victorian Villa	Fond Du Lac	2300	2000	No	Below	None	N/A	No	N/A	Yes	
American House of Ripon	Fond Du Lac	1752, 2186	2003	No	Below	None	No	Yes	No	Yes	
MapleCrest Manor	Fond Du Lac	1524	1999	Yes	Below	2003	Not Given	Yes	Yes	Yes	
			2003	No	Below	None	N/A	Yes	Yes	Yes	
Residential Services	Fond Du Lac	See Comments	1999	Yes	Above	2004	Not Given	Yes	Yes	Yes	2 Homes - Private Rate = 1908 & 2307 / Semi-Private Rate = 1584 & 1916 / Shared = 1363 & 1458
Friendship Haven	Fond Du Lac	1723	2001	No	Below	None	N/A	Yes	No	Yes	They make us get an audit costing $4000 & then will not give us a rate equal to what private pay residents are expected to pay.
Helen House Operations	La Crosse	2280	1999	Yes	Equal to Co	2004	Not Given	Yes	Yes	Yes	Should be based on level of care per individual
Creative Living Environment	Milwaukee		2001	Yes	Above	None	N/A	Yes	No	Yes	Rate varies/home - see attached letter
Community Living Centers	Milwaukee	2400	1999	No	Below	None	N/A	Yes	No	Yes	
IRIS Manor	Milwaukee	2331	1999	No	Below	Multipe Answers	Not Given	Yes	Yes	Yes	Raise needed to increase employee wages
Oak Crest	Milwaukee		1999	No	No Answer	None	N/A	Yes	No	Yes	
Lake Drive Residence	Milwaukee	2736	1999	No	Below	None	N/A	Yes	No	Yes	Need to pay employees better salary - Is selling - retiring
Chai Point	Milwaukee	2374	1999	No	Below	2000	Not Given	Yes	Yes	Yes	
West Park Place	Milwaukee	2500	1999	Yes	Above	None	N/A	No	N/A	Yes	
Extendicare Health Services	Milwaukee	1893	2003	No	Below	N/A	N/A	N/A	N/A	Yes	
Ola's House	Milwaukee	2234	2000	No	Below	2001	Not Given	Yes	No	Yes	Just began contract
A Place for Miracles	Milwaukee		2003	No	Below	None	N/A	Yes	No	Yes	

Provider Name	County Located In	Average Current Rate/Month	Year Entered FC	Satisfied - Yes/No	Rate Above/Below Cost of Care	Year of Last Increase	Increase Amount	Asked For Increase - Yes/No	Received Increase - Yes/No	Should Rates Reflect Level of Care - Yes/No	Comments
Andes, LLC	Milwaukee	2501	1999	No	Below	None	N/A	Yes	No	Yes	Private Pay Rate = $2675 / Thank you for initiating this survey, I hope we can get somewhere!!
Home Living Services	Milwaukee	2966	2001	No	Below	None	N/A	Yes	No	Yes	
Not Provided	Milwaukee	2100	2000	No	Below	None	N/A	Yes	No	Yes	
Trinity Health Care	Milwaukee		2002	No	Below	None	N/A	Yes	No	Yes	
Park Hills	Milwaukee	2700	1999	No	Below	None	N/A	Yes	No	Yes	
Fox Point Manor	Milwaukee		2000	No	Below	None	N/A	Yes	No	Yes	
Not Provided	Oshkosh	2433	2001	No	Below	2003	Not Given	Yes	Yes	Yes	
Not Provided	Oshkosh	Variable Ra	2000	Yes	Equal to Co	2003	Not Given	No	Yes	Yes	The manipulation of clients is more of an issue than rates reflecting the amount of care a resident needs
Lutheran Homes & Health Ser	Oshkosh	Variable Ra	1999	No	Below	2003	Not Given	No	N/A	Not Give	MA rate for NH Care - approx $25/day below cost /CBRF - approx $18/dy difference with CMO & Private Pay rate / Therapy - MA Rate . The biggest challenge is relative to "effective date" and "available date" of service. This is difficulty with approval through the Resource Center - move slowly
Care Partners Assisted Living	Portage	2129	1999	No	Below	2003	Not Given	Yes	Yes	Yes	
Our House LLC	Portage	1700-1800	2001	No	Below	2003	Not Given	No	Yes	Yes	
Applewood Homes	Portage	2464	2001	No	Below	None	N/A	No	N/A		
Harvest Guest Home	Richland	1773	2002	Yes	Neither	Negotiating for 2004	N/A	No	N/A	Yes	I refuse to agree to set my rate on a known cost basis. I charge Family Care market rate less 4% discount. I'm strong advocate for market rate for Family Care. I don't see why it (rate) should depend on actual cost or profit - since the concept is CHOICE - and not KNOWN COST.

Provider Name	County Located In	Average Current Rate/Month	Year Entered FC	Satisfied - Yes/No	Rate Above/Below Cost of Care	Year of Last Increase	Increase Amount	Asked For Increase - Yes/No	Received Increase - Yes/No	Should Rates Reflect Level of Care - Yes/No	Comments
Schmitt Wooldland Hills	Richland	Variable Ra	2002	No	Below	2003	Not Given	N/A in Richland County	Yes Increase Denied in 2004	Yes	FC is limited to T-19 rates NH & other WI licensed providers. This sets up an artificial ceiling or cap for payments. The problem is real simple. This FC is a new benefit (entitlement) for a new group of beneficiaries (most recipients would not get admittted to a nursing home) in a zero sum game. Therefore, there is not enough money to support existing programs & new ones offered through FC.
Not Provided			1999	No	Below	None	N/A	Yes	No	Yes	
Oakton Manor			2001	No	Below	2003	Not Given	Yes	Yes	Yes	Increase was not what we needed
Not Provided			2002	No	Below	None	N/A	Yes	No	Yes	
HealthSpan-Lynnwood of Dela	Milwaukee	3600	Did **not** enter into FC contract in 2003 because initial contract was 30% below cost so they turned down the contract								
Seniorminium	Milwaukee	N/A	Is considering FC, because many of my residents are running out of funds & I do not want to lose them.								
Lori Knapp			Entered into FC in 1999. Did not fill out questionnaire but comments were "Lori Knapp provides housing for DD two groups --- Inconsistent and underfunded.								

4 Questionnairres were returned from providers who do not serve the frail or elderly. Did not fill out questionnaire.

***Provider for Adults with Developmental Disabilities**

Appendix B

2004

CMO County	Comprehensive	Intermediate
Fond du Lac	$1,881.07	$674.49
La Crosse	$1,764.17	$674.49
Milwaukee	$1,810.61	$674.49
Portage	$2,255.32	$674.49
Richland	$1,970.98	$674.49

2003

CMO County	Comprehensive	Intermediate
Fond du Lac	$1,945.08	$657.40
La Crosse	$1,802.23	$657.40
Milwaukee	$1,767.57	$657.40
Portage	$2,367.65	$657.40
Richland	$1,975.77	$657.40

2002

CMO County	Comprehensive	Intermediate
Fond du Lac	$1,870.62	$640.74
La Crosse	$1,732.91	$640.74
Milwaukee	$1,710.76	$640.74
Portage	$2,468.36	$640.74
Richland	$1,912.79	$640.74

2001

CMO County	Comprehensive	Intermediate
Fond du Lac	$1,844.30	$628.79
La Crosse	$1,709.12	$628.79
Milwaukee	$1,721.77	$628.79
Portage	$2,516.51	$628.79
Richland	$1,910.15	$628.79

Revised: *February 11, 2004*

Appendix C

Consumer Price Index Summary

FOR TECHNICAL INFORMATION:
Patrick C. Jackman (202) 691-7000
CPI QUICKLINE: (202) 691-6994
FOR CURRENT AND HISTORICAL
INFORMATION: (202) 691-5200
MEDIA CONTACT: (202) 691-5902
INTERNET ADDRESS:
http://www.bls.gov/cpi/

USDL-04-29
TRANSMISSION OF
MATERIAL IN THIS
RELEASE IS EMBARGOED
UNTIL 8:30 A.M. (EST)
Thursday, January 15, 2004

CONSUMER PRICE INDEX: DECEMBER 2003

Percentage change 12 months ended in December

	1996	1997	1998	1999	2000	2001	2002	2003
All items	3.3	1.7	1.6	2.7	3.4	1.6	2.4	1.9
Food and beverages	4.2	1.6	2.3	2.0	2.8	2.8	1.5	3.5
Housing	2.9	2.4	2.3	2.2	4.3	2.9	2.4	2.2
Apparel	-.2	1.0	-.7	-.5	-1.8	-3.2	-1.8	-2.1
Transportation	4.4	-1.4	-1.7	5.4	4.1	-3.8	3.8	.3
Medical care	3.0	2.8	3.4	3.7	4.2	4.7	5.0	3.7
Recreation	3.0	1.5	1.2	.8	1.7	1.5	1.1	1.1
Education and communication	3.4	3.0	.7	1.6	1.3	3.2	2.2	1.6
Other goods and services	3.6	5.2	8.8	5.1	4.2	4.5	3.3	1.5
Special indexes								
Energy	8.6	-3.4	-8.8	13.4	14.2	-13.0	10.7	6.9
Energy commodities	13.8	-6.9	-15.1	29.5	15.7	-24.5	23.7	6.9
Energy services	3.8	.2	-3.3	1.2	12.7	-1.5	.4	6.9
All items less energy	2.9	2.1	2.4	2.0	2.6	2.8	1.8	1.5
Food	4.3	1.5	2.3	1.9	2.8	2.8	1.5	3.6
All items less food and energy	2.6	2.2	2.4	1.9	2.6	2.7	1.9	1.1

Appendix D

Inflation and Wages								
Price Indexes								
Consumer Price Index	156.9	160.6	163.1	166.7	172.3	177.1	179.7	183.0
- % Change	2.9%	2.3%	1.6%	2.2%	3.4%	2.8%	1.5%	1.8%
Less Food & Energy	165.8	169.7	173.7	177.3	181.7	186.4	190.0	193.0
- % Change	2.7%	2.4%	2.3%	2.1%	2.5%	2.6%	1.9%	1.6%
Producer Prices	127.7	127.6	124.4	125.5	132.7	134.2	130.8	133.7
- % Change	2.3%	-0.1%	-2.5%	0.9%	5.8%	1.1%	-2.5%	2.2%
Wages								
Average Hourly Earnings (Mfg) $	$12.77	$13.16	$13.49	$13.91	$14.51	$15.09	$15.62	$16.09
- % Change	3.2%	3.1%	2.5%	3.1%	4.3%	4.0%	3.5%	3.0%
Private Non-Farm Compensation	3.1%	3.6%	5.3%	4.7%	4.9%	5.7%	3.9%	2.9%

Data Sources: New England Economic Project (NEEP); National Association of Business and Economics (NABE); U.S. Government and other sources.

CREATIVE LIVING ENVIRONMENTS

January 28, 2004

Gerald J. Kallas M.D.
2060 South 61st St.
West Allis, WI 53219

Dear Dr. Kallas,

I was so pleased to receive your questionnaire regarding the satisfaction of providers with the Family Care Program. There are many providers who share your frustration and question if they will be able to realistically accept Family Care clients without jeapardizing their financial stability.

I recently changed my capacity at two of my homes which resulted in an increase in the rate. This demonstrates that providers are penalized for having empty beds. I can appreciate that the County does not wish to pay for all empty beds. However their calaculating our profits based on 100% occupancy is ridiculous.

Although we have not had an increase in 2 years, I could actually live with that if it weren't for what is my bigger problem: The County coming back two years after the fact and wanting a payback. The problem definitely stems from the outdated "Allowable Cost Manual" which does not recognize such items as rents to a related party, advertising, etc. When I've been approacted for a payback, I could cry. I give my very best to each resident, I do not expect money back with any of my Family Care residents who require more than the contracted rate. Yet the thought that the County can come back two to three years after the fact and *demand* the "overpayment" back or they will withhold further payments, is totally unjust. I have needed to put off major repair problems because of a financial crunch...I wonder where is this "phantom" profit...if it was truly there, I could have afforded to do those things that I put off.

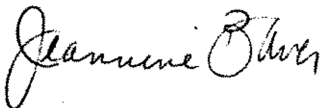
I believe that the payment received should reflect the level of care of the individual client. An Alzeimer resident with the tendency to wander definitely needs more care and supervision than a frail elderly resident who needs meals and medication monitoring. There was some talk of setting up a committee to look at this type of payment system.

P.O. Box 26083 • Milwaukee, WI 53226 • Phone (414) 258-9955 • Fax (414) 258-9584

Dr. Kallas, I happen to be on the Board of Directors for RSA- Residential Services Assn. of Wisconsin. We have identified our goals for the year and one of them happens to be the review of the Allowable Cost. I suspect that your organization would benefit from our efforts. I would hope that you would consider joining us in our endeavors. Where there is unity, there is strength.

I am enclosing the survey as well as a brochure on RSA. I would welcome the opportunity to discuss this further with you.

Sincerely,



Jeannine Baver

P.S. RSA's Office will be sending you information directly.

/

Lifeline SERVICES

13 Sixth Street • Fond du Lac, WI 54935 • Phone: (920) 922-4068 • Fax: (920) 922-0549

January 28, 2004

Dear Dr. Kallas,

It was such a pleasant surprise to receive your questionaire! I have felt left out on a limb for sometime now, now knowing what to do to both support the residents I am committed to and yet assure that I can stay in business.

I know you are focusing on the elderly and not the developmentally disabled. However, I completed this form anyway. Just put it aside and move on to that category!

Although I have residents who are Milwaukee County residents, Milwaukee County is not my biggest problem. I am able to work things out with them. My biggest problem is the CMO here in Fond du Lac County. They have dug their heels in and do not bend one inch when it comes to increasing rates. The problem is being caught between what is demanded by the state people and case managers to provide the proper support for our residents and the cost that the county refuses to pay for.

I am dealing with that situation right now. I showed them that for the last two years (actually three), I have run at a substantial loss at homes where we serve primarily Fond du Lac County people. Fortunately, we do have residents from out of county who pay the appropriate rate. If not for that I would have to have extremely deep pockets to continue on.

I have seven group homes with 30 residents right now. I have been doing this for the past 15+ years. My original career was as a Social Worker.

May I suggest that you contact providers in all the counties served by the Family Care Program, particularly Fond du Lac County. If I can be of some help in the survey, please let me know.

Sincerely,

Georgiann M. Froemke

Family Care CMO Enrollment Data

The table below presents CMO enrollment as of February 1, 2004.

CMO County	Total
Fond du Lac	916
La Crosse	1,496
Milwaukee	4,758
Portage	674
Richland	286
Total	8,130

Last Revised: *February 04, 2004*

Dave Ogden

Family Care:

A Leading Edge Long Term Care Program With Innovative Financial Tools

by David F. Ogden, FSA
Consulting Actuary

Wisconsin began the Family Care program in 2000 to provide more flexibility, increased access, and cost efficiency for long term care services for Medicaid eligibles (and a small population not financially eligible for Medicaid). It expands upon a state/county partnership that provides community-based long term care services to Medicaid eligible individuals at the nursing home level of care.

The Family Care benefit package includes the services in the 1915(c) Medicaid waiver programs, as well as some Medicaid state plan services, including nursing home care. Historically, nursing home care for eligible individuals has been an entitlement under Medicaid; with Family Care, access to community-based care also becomes an entitlement. Participating counties formed Care Management Organizations (CMOs) to manage and deliver the Family Care benefit and take financial risk for the program.

A second organizational component of Family Care is the Aging and Disability Resource Centers, administered by the counties, which offer the general public a single entry point for information and assistance on issues affecting older people, people with disabilities, or their families. Resource Centers also determine functional eligibility for publicly-funded long term care, and enroll individuals in the CMO. Family Care is a pilot program, with both Resource Centers and CMOs operating in five counties. An additional four counties have Resource Centers but no CMOs.

Functional Screen

The functional screen, a key part of Family Care, is a tool administered at the local Resource Centers to determine the functional eligibility (level of care) of those applying to Family Care. Applicants must also meet financial eligibility requirements. The screen is an "inventory of needs," a list of the tasks individuals can perform for themselves or need to have performed for them, in the course of their every day activities. Rigorous training and a comprehensive quality assurance program are used to ensure consistency in application of the screen throughout the counties where it is used. Besides determining functional eligibility, the functional screen provides a wealth of data about the functional and health status of long term care recipients; since functional eligibility needs to be re-determined annually, screen results also provide data about the changing functional status of Family Care members.

Capitation Structure

The capitation rate paid by the State of Wisconsin Medicaid program to CMOs is specific to each CMO and the needs (risk characteristics) of the population enrolled. The precise basis for the capitation has evolved as the program has evolved. Milliman assisted in the design and calculation of the capitation rates and other financial structures for Family Care.

The capitation rates for the first two years of the program were based on the prior fee-for-service cost experience (for Family Care covered services) of those enrolled in Family Care in each county. A number of adjustments were applied to the experience, including:

- Trend
- Expected changes in level of need ("acuity") for individuals
- State administrative costs
- 2% discount from fee-for-service

Milliman used historical experience in the fee-for-service program to develop adjustment factors for individuals without prior fee-for-service history. Individuals newly enrolled in the fee-for-service program had a much lower level of need than average, since they had only recently become eligible for long term care services. The experience of these individuals relative to continuing fee-for-service enrollees was used to apply a rate adjustment for the equivalent cohort of new enrollees in Family Care.

We also reviewed longitudinal data to determine how the level of need and cost per capita increased for individuals continuing in the fee-for-service program. We observed the rate of increase for the elderly population was much higher than the disabled, which is understandable since the disabled generally receive community long term care services for many more years than the elderly. The elderly also tend to be very frail and are frequently approaching the end of life, with rapidly increasing needs and service costs.

Once Family Care cost data from the CMOs were available, it was combined with functional screen information on the individuals enrolled in the program to develop rates tied to functional needs.

-More-

Some of the functional indicators used include:

- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)
- County of residence
- Measure of required skilled nursing services
- Behavioral variables

The rate structure for 2002 and 2003 included functional information. The structure for 2003 was more sophisticated than 2002, since a greater volume of enrollee cost experience was available in the second year and there was a greater appreciation of the factors in the rating structure by the users of the rates so more factors could be included.

The capitation rate for 2003 has 50% weight applied to prior fee-for-service history trended forward and 50% weight applied to the functional based rate. We expect the rates to be fully based on functional needs in 2005.

Risk Management

Wisconsin provided a number of risk management tools to the CMOs because of their relative inexperience with managing risk. The CMOs have many of the characteristics of small insurance companies, in addition to being county-based social service agencies. Similar to licensed insurance companies, they are required to meet specific financial targets to remain in the program.

We helped the State design and price the following tools which were available to the CMOs:

- Risk Corridors: State sharing in gains/losses in specific corridors
- Stop Loss Reinsurance: Reimbursement if the annual cost per person exceeds a specific amount
- Aggregate Reinsurance: Reimbursement if losses for the entire CMO exceed a specific amount

To date, the CMOs have made limited use of these tools. This result may be partly due to a difficulty in projecting an expected reimbursement to offset against the premium charged for the reinsurance, or partly due to a perception that random fluctuations may not be as significant in long term care services as in acute care services.

Family Care enrollment has recently reached 7,000 and continues to grow. The functional needs of the population will receive increasing weight in future capitation rates until it is the only factor used. The Governor's budget proposal for the 2003-05 biennium includes funds for expansion of Family Care to additional counties to provide more flexible services cost efficiently.

Dave Ogden is a Consulting Actuary in Milliman's Milwaukee office. He can be reached by email at dave.ogden@milliman.com or by calling +1 262 796.3419.

Email dave.ogden@milliman.com

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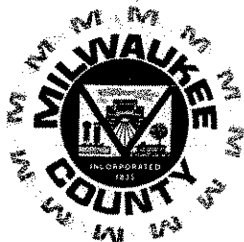

DEPARTMENT ON AGING

Milwaukee County

STEPHANIE SUE STEIN Director
(414) 289-5950
sstein@milwaukeecounty.com

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TTD: (414) 289-8591
ELDER LINK: (414) 289-6874
www.milwaukeecounty.com

Milwaukee County
Commission on Aging

Edna Lonergan
Chairperson

December 14, 2001

Senior Residential Care of America, Inc.
Mr. Michael Robertson
2060 S. 61st St
West Allis WI 53219

Re: Windsor House

Dear Mr. Robertson,

After reviewing your application, we are offering you a CBRF Service Contract for 2001 through 2002. Your base unit rate of $3,042 is effective October 1, 2001.

Enclosed are two (2) copies of the Family Care contract between Milwaukee County Department on Aging (MCDA) and (Senior Residential Care of America, Inc.– Windsor House). Please sign each copy on the indicated line on page 14. Return both (2) copies to me at MCDA and when the director signs the copies, a completed original will be returned to you.

Please note, a contract with the Department on Aging means that your CBRF will be expected to comply with the Department's Service Requirements and other obligations outlined in the CBRF Contract. These include: providing services at a rate that reflects only allowable and reasonable costs computed based on licensed beds, maintaining minimum insurance coverage, maintaining a license in good standing with the Department of Health and Family Services and submitting an annual audit to the Department on Aging.

A contract with MCDA does not guarantee resident referral. Client choice is a requirement of CBRF Contractual Services. This means that the county must provide all clients with a list of contracted CBRFs serving the type of needs appropriate for the client's needs from among whom the clients are free to choose their provider of services.

We look forward to working with you, if you have additional questions or comments, I can be reached at (414) (289-6281).

Sincerely,

Ed Gillman
Contract Specialist
Encl.:
Cc: Mark Lucoff, Contract Administrator
Mary I Martinez

DEPARTMENT ON AGING

Milwaukee County

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(414) 289-5950
sstein@milwaukeecounty.com

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TTD: (414) 289-8591
ELDER LINK: (414) 289-6874
www.milwaukeecounty.com

Milwaukee County
Commission on Aging

Edna Lonergan
Chairperson

December 14, 2001

Senior Residential Care of America, Inc
Mr. Michael Robertson
2060 S 61st St
West Allis WI 53219

Re: Windsor House Glendale East

Dear Mr. Robertson,

After reviewing your application, we are offering you a CBRF Service Contract for 2001 through 2002. Your base unit rate of $3,166 is effective October 1, 2001.

Enclosed are two (2) copies of the Family Care contract between Milwaukee County Department on Aging (MCDA) and (Senior Residential Care of America, Inc– Windsor House Glendale East). Please sign each copy on the indicated line on page 14. Return both (2) copies to me at MCDA and when the director signs the copies, a completed original will be returned to you.

Please note, a contract with the Department on Aging means that your CBRF will be expected to comply with the Department's Service Requirements and other obligations outlined in the CBRF Contract. These include: providing services at a rate that reflects only allowable and reasonable costs computed based on licensed beds, maintaining minimum insurance coverage, maintaining a license in good standing with the Department of Health and Family Services and submitting an annual audit to the Department on Aging.

A contract with MCDA does not guarantee resident referral. Client choice is a requirement of CBRF Contractual Services. This means that the county must provide all clients with a list of contracted CBRFs serving the type of needs appropriate for the client's needs from among whom the clients are free to choose their provider of services.

We look forward to working with you, if you have additional questions or comments, I can be reached at (414) (289-6281).

Sincerely,

Ed Gillman
Contract Specialist
Encl.:
Cc: Mark Lucoff, Contract Administrator
Mary I Martinez

DEPARTMENT ON AGING

Milwaukee County

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(414) 289-5950
sstein@milwaukeecounty.com

FAX: (414) 289-8590
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ELDER LINK: (414) 289-6874
www.milwaukeecounty.com

Milwaukee County
Commission on Aging

Edna Lonergan
Chairperson

December 14, 2001

Senior Residential Care of America, Inc
Mr. Michael Robertson
2060 S 61st St
West Allis WI 53219

Re: Windsor House St Francis II

Dear Mr. Robertson,

After reviewing your application, we are offering you a CBRF Service Contract for 2001 through 2002. Your base unit rate of $3,288 is effective October 1, 2001.

Enclosed are two (2) copies of the Family Care contract between Milwaukee County Department on Aging (MCDA) and (Senior Residential Care of America, Inc– Windsor House St Francis II). Please sign each copy on the indicated line on page 14. Return both (2) copies to me at MCDA and when the director signs the copies, a completed original will be returned to you.

Please note, a contract with the Department on Aging means that your CBRF will be expected to comply with the Department's Service Requirements and other obligations outlined in the CBRF Contract. These include: providing services at a rate that reflects only allowable and reasonable costs computed based on licensed beds, maintaining minimum insurance coverage, maintaining a license in good standing with the Department of Health and Family Services and submitting an annual audit to the Department on Aging.

A contract with MCDA does not guarantee resident referral. Client choice is a requirement of CBRF Contractual Services. This means that the county must provide all clients with a list of contracted CBRFs serving the type of needs appropriate for the client's needs from among whom the clients are free to choose their provider of services.

We look forward to working with you, if you have additional questions or comments, I can be reached at (414) (289-6281).

Sincerely,

Ed Gillman
Contract Specialist
Encl.:
Cc: Mark Lucoff, Contract Administrator
Mary I Martinez

235 West Galena Street, Suite 180 • Milwaukee, WI 53212-3948

The mission of the Milwaukee County Department on Aging is to affirm the dignity and value of older adults of this county by supporting their choices for living in and giving to our community.

DEPARTMENT ON AGING

Milwaukee County

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Milwaukee County
Commission on Aging

Edna Lonergan
Chairperson

December 14, 2001

Senior Residential Care of America, Inc
Mr. Michael Robertson
2060 S 61St
West Allis WI 53219

Re: Windsor House St. Francis

Dear Mr. Robertson,

After reviewing your application, we are offering you a CBRF Service Contract for 2001 through 2002. Your base unit rate of $3,423 is effective October 1, 2001.

Enclosed are two (2) copies of the Family Care contract between Milwaukee County Department on Aging (MCDA) and (Senior Residential Care of America, Inc– Windsor House St. Francis). Please sign each copy on the indicated line on page 14. Return both (2) copies to me at MCDA and when the director signs the copies, a completed original will be returned to you.

Please note, a contract with the Department on Aging means that your CBRF will be expected to comply with the Department's Service Requirements and other obligations outlined in the CBRF Contract. These include: providing services at a rate that reflects only allowable and reasonable costs computed based on licensed beds, maintaining minimum insurance coverage, maintaining a license in good standing with the Department of Health and Family Services and submitting an annual audit to the Department on Aging.

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Joint Legislative Audit Committee Testimony
Wisconsin Family Care Program
February 13, 2004

Chairpersons Roessler and Jeskewitz, members of the Joint Audit Committee, thank you for the opportunity to present you with the findings from the APS Independent Assessment of Family Care. I am Amie Goldman, Manager of Research and Evaluation for APS and with me is Ed Hickey who is the primary analyst for the assessment.

The Centers for Medicare and Medicaid Services (CMS) required an Independent Assessment of Family Care as a condition of Wisconsin's waiver renewal request. DHFS contracted with APS Healthcare in the Fall of 2002 to conduct the assessment.

The goal of the Independent Assessment is to evaluate the impact of Family Care on long-term care (LTC) services in Wisconsin. APS evaluated access, quality and cost-effectiveness. The scope of the analysis was limited to the five Family Care Care Management Organizations (CMOs), including Fond du Lac, Lacrosse, Milwaukee, Portage and Richland counties.

We spent one year collecting and analyzing data for the assessment. Quantitative and qualitative data were collected from a variety of sources including Medicaid claims data, CMO encounter data, waiver service data and interviews with DHFS, Resource Center and CMO staff.

Today I will highlight some of the key findings from the access and quality sections of the report and then spend some time describing the significant cost-effectiveness findings.

First, important findings on Access:

- Waiting lists in the five CMO counties were eliminated by the end of calendar year 2002, thereby improving access to health and long-term care services. Individuals in need of services in the CMO counties could begin receiving them soon after application for Family Care, as opposed to waiting what could be months or years in non-Family Care counties.
- CMOs indicated an ability to increase the number of providers in their network given the new flexibility afforded to them for setting payment rates and other contracting requirements. For example, the CMOs reported better access to services for members with developmental disabilities. They also reported increases in skilled nursing services, which had been reported as an unmet need prior to Family Care.
- The use of independent, third-party, "Enrollment Consultants" was found to be beneficial to individuals considering Family Care enrollment. Enrollment Consultants ensure that potential members and/or their representatives fully understand the Family Care program and the other options available prior to enrollment.

10 East Doty Street ♦ Suite 210 ♦ Madison, WI 53703 ♦ Tel 608.258.3350 ♦ Fax 608.258.3359

Second, key findings from the Quality section of the report:

- All five CMO pilot counties demonstrated strong "member centered" orientation and strengths in care management.
- Family Care members saw significant reductions in primary care office visits on a per member per month (PMPM) basis over the study period and the frequency of visits declined at a more rapid rate for those individuals who were in the program longer. Family Care's interdisciplinary team approach, which includes a nurse, is likely responsible for this change. It was also found that Family Care members' emergency room utilization did not change significantly.
- Member outcomes and supports are used by the Department as one tool for assuring quality and are measured through member and care manager interviews. They include items related to health, safety, privacy and self-determination. We found that the more time an individual spends on Family Care the greater the presence of the 14 member outcomes and supports. This suggests that care managers are successful in their efforts.

The cost-effectiveness study design and analysis are very technical and are detailed extensively in the report. For today, I will give a high level overview to provide a context for our findings.

In order to evaluate the cost effectiveness of the program, changes in members' expenditure and utilization patterns were compared with those of a statewide comparison group. The study was designed to look at changes in **total LTC costs** for these two groups over time. APS also analyzed selected LTC and primary and acute service costs and utilization:

Long-term Care Services

- State Center for Developmentally Disabled
- Home Health Care
- Intermediate Care Facilities serving persons with Mental Retardation (ICF-MR)
- Nursing Home
- Personal Care
- Residential Care Facilities (CBRF)
- Supportive Home Care

Primary and Acute Services

- Emergency Room Visits
- Inpatient Hospital Admissions
- Inpatient Hospital Days
- Outpatient Hospital Visits
- Physician Office Visits
- Prescription Drugs

Family Care members included in the cost effectiveness study represent all five CMO counties and met two qualifications. One, participation in the program during calendar year 2002, and two, 12 months of continuous Family Care enrollment.

A statistically valid comparison group was developed. The comparison group was comprised of individuals with the same characteristics as Family Care beneficiaries, except they were not in the program. Members of the group represented 68 of Wisconsin's 72 counties, including Milwaukee County. The comparison group members were matched to Family Care participants

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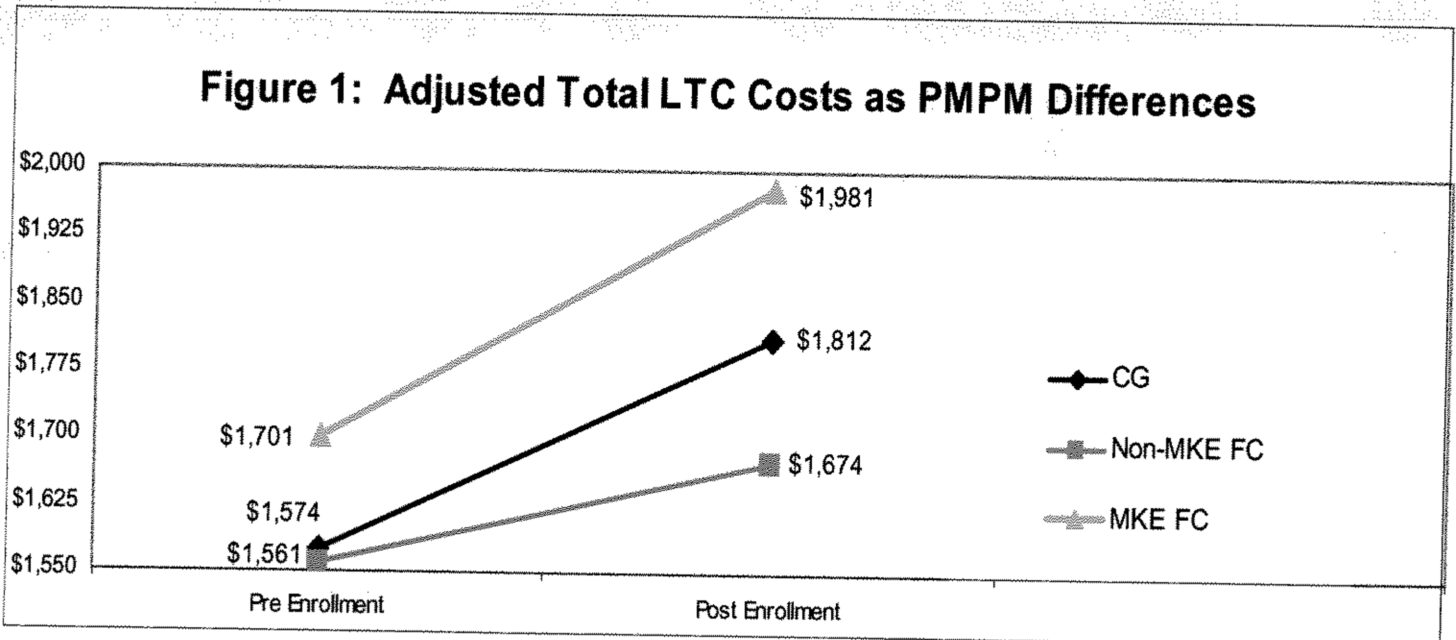
by age, sex, geographic location, disability and prior experience with Medicaid LTC waivers. A "pseudo enrollment date" was randomly chosen for comparison group members by matching these individuals to Family Care members' enrollment dates so that pre-/post- analyses could be conducted.

A number of other statistical controls were used to isolate the effect of Family Care from the many other variables that could impact health care utilization and expenditures, including:

- Illness burden
- Program participation (Medicare Dual Eligibility, Waiver Eligibility, and/or Institutionalization)
- Functional Status Impairment
- Community type (rural vs. urban)
- Disability category (elderly, physically disabled, developmentally disabled)
- Last year of life
- Enrollment year

Milwaukee County was evaluated separately from the other four CMO counties to meet federal waiver renewal requirements. APS utilized a statistical technique to separate individual level program effects from county-level effects allowing us to reliably estimate differences between the comparison group, Milwaukee CMO members and non-Milwaukee CMO members.

The figure below presents adjusted (values after statistical controls are utilized) PMPM total LTC costs during the pre- and post-enrollment periods. The pre-enrollment period consisted of the six months prior to enrollment. The post-enrollment period was the seven to 12 months after enrollment.



The rate of change in LTC costs between the pre- and post-periods was highest for Milwaukee CMO members ($280 PMPM), the comparison group experienced a lower rate of change ($238

PMPM) and the non-Milwaukee CMO members experienced a rate of change that was less than half of the other two groups ($113 PMPM).

While total LTC costs increased for all groups analyzed over the study period, the costs for the four non-Milwaukee county CMOs increased at a statistically significant lower rate relative to the statewide comparison group. **In other words, for members of these four CMOs, costs for long-term care services increased less than the costs of individuals who were not participating in Family Care.** The difference between the Milwaukee CMO and the comparison group was not statistically significant.

The following table provides more detail on the specific long-term care and primary and acute health care services examined. As you can see, home health care was the only long-term care service where the non-Milwaukee CMO members had a significant increase in costs relative to the comparison group. There were no significant increases in costs for primary and acute services. However, members of the four non-Milwaukee CMOs had significantly reduced costs for personal care, residential care (CBRF), physician services and prescriptions drugs.

The Milwaukee CMO experienced a significant increase for residential care (CBRF) and outpatient hospital services relative to the comparison group and a decrease in emergency room costs.

Table 1: Statistically Significant Changes Over Time Relative to the Statewide Comparison Group (CG)

Services Studied	Non-Milwaukee CMO Counties (Fond du Lac, La Crosse, Portage, Richland)	Milwaukee County CMO
	Change in Cost	**Change in Cost**
Total LTC Costs	↓	—
Selected LTC Services		
State DD Center	—	—
Home Health Care	↑	—
ICF-MR	—	—
Nursing Home	—	—
Personal Care	↓	—
Residential Care (CBRF)	↓	↑
Supportive Home Care	—	—
Selected Primary and Acute Services		
Emergency Room	—	↓
Outpatient Hospital	—	↑
Inpatient Hospital	—	—
Hospital Admission Rate	N/A	N/A
Outpatient Physician	↓	—
Prescription Drugs	↓	—

↓: Statistically Significant Decrease
↑: Statistically Significant Increase
—: No Statistically Significant Change

Finally, we conducted an analysis to explore the program's impact on nursing home utilization. In our other analyses, we controlled for whether or not the individual resided in an institutional setting at different points in time. By controlling for this and holding changes in institutional residence equal across the groups, we were able to make a fair comparison between the Family Care members and the comparison group.

However, this limited our ability to measure the effect of Family Care on institutional residence. When we did not control for institutional residence, we discovered that Family Care members had significantly lower nursing home expenditures and utilization than the comparison group. We also found that Family Care members experienced greater decreases in nursing home use and spending over time, relative to the comparison group.

We found that an indirect effect of the Family Care program was to reduce spending through improvements in members' functional status and decreased institutional residence. These findings were consistent with the idea that Family Care has the potential to affect cost savings by improving health care status and outcomes. However, at this time, it appears that the indirect savings are not yet sufficient to fully offset the direct increase in costs for other services.

In summary, we found that Family Care increased access to health and long term care services, improved the quality of members' lives and demonstrated cost restraint in most of the counties.

Thank your for your time and we would be happy to answer your questions.

Copies of the Family Care Independent Assessment may be obtained from the Family Care program's website [http://www.dhfs.state.wi.us/LTCare/ResearchReports/IA.HTM].

JUDY A. BABLITCH, DIRECTOR
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E-MAIL: pchhsd@co.portage.wi.us

RUTH GILFRY HUMAN RESOURCES CENTER
817 WHITING AVENUE
STEVENS POINT, WI 54481-5292

MEMO

TO: Members of the Wisconsin State Legislature - Joint Audit Committee

FROM: Jim Canales, Director
Community Care of Portage County
Care Management Organization - Family Care

DATE: February 12, 2004

RE: Family Care Testimony

Thank you for the opportunity to testify in regards to the successful development and implementation of Family Care in the counties of Portage, Richland, LaCrosse, Fond du Lac, and Milwaukee.

My name is Jim Canales. I am the Director of Community Care of Portage County, which is the Care Management Organization located in Portage County. I am testifying on behalf of all the Care Management Organizations as to our observations and perceptions about the success of Family Care as it has developed from April 2000 through today. Following my testimony, my colleagues will provide some participant specific information related to their experience with Family Care.

1. First and foremost, the availability of Family Care funding to functionally and financially eligible residents of our counties has resulted in no waiting lists for long term care services.

2. Seniors and adults with physical or developmental disabilities now can choose to live in their own home with supports, other community based living arrangements, or a nursing home. Family Care is an entitlement to living where people want to live ... in the 67 counties without Family Care, the only entitlement is to live in an institution.

3. Care Management Organizations have been very successful in allowing participants residing in institutions the opportunity and support to relocate to a community based residence of their choice.

4. Family Care and its emphasis on meeting individual outcomes has directly resulted in:

   - Increased consumer satisfaction
   - Increased consumer choice of services and goods received
   - Increased consumer control through the use of a self-directed supports option
   - Increased county accountability in achieving measurable participant outcomes
   - Increased contracted vendor oversight and higher quality expectations of all service providers
   - Monitor and evaluated a system where taxpayer funded care and support is driven by identified participant outcomes.

5. Care Management Organizations have been able to meet identified member outcomes, provide reasonable reimbursement to our contracted providers, meet quality standards as set by the Department of Health and Family Services, and pay for all organizational costs while living within the capitation rate assigned to each county's CMO. This continues to occur without the use of county tax levy revenue.

6. Care Management Organizations have been able to negotiate lower prices, obtain higher quality goods, and respond quicker to participant need as the local authorizing agent for durable medical supplies and disposable medical equipment. Previous authorization came from Madison through the Medical Assistance program.

7. Long term care service vendor choice for both Family Care and non-Family Care residents in our counties has grown at a more rapid rate as compared to non-Family Care counties.

8. Introduction of the Interdisciplinary Service Coordination model, employing both registered nurses and social workers as teams assigned to each participant, has provided our membership with immediate access to health care. We believe that this access will reduce future acute health care costs paid by Medicaid and Medicare, that are associated with chronic conditions such as diabetes and congestive heart failure.

   This belief is in line with the APS Health Care report, which found that after enrollment in four Family Care counties, participants incurred less visits to their physicians, a reduction of hospital outpatient visits, shorter inpatient hospital lengths of stay, and lower prescription drug costs. Family Care has also begun to introduce health management and preventative care to disabled populations

who typically don't seek or use such care.

9. Finally, operating as a managed care entity has caused CMO counties to use business practices not typically found in local government Human Services operations. These business practices have increased our effectiveness in serving a wide range of county residents with long term care needs.

   Included in these business practices are risk management, utilization review, cost containment, purchasing negotiation advances, and information technology development.

Portage County remains very pleased to have been selected as one of five Care Management Organization sites in 1998. If given the chance to do it all over again, in spite of the daunting challenges that Family Care development and implementation has and continues to pose, we would not hesitate to do so.

Thank you.

JNTAUDIT.APR

Testimony to the Joint Audit Committee of the Wisconsin Legislature
by Stephanie Sue Stein, Director of the Milwaukee County Department on Aging
Friday, February 13, 2004

Senator Roessler, Representative Jeskewitz and members of the Joint Audit Committee of the Wisconsin Legislature:

I am sorry I am not able to testify in person but would like my remarks to be submitted for the record.

Family Care is simply the best program for older people ever to be instituted in the State of Wisconsin.

None of us who operate Family Care in our counties can conceive of going back to doing business the way it is done in the rest of Wisconsin.

Non-care managed service, no nurses on teams, and long waiting lists are the norm elsewhere. In Milwaukee, Fond du Lac, Portage, La Crosse and Richland Counties people who qualify are served when they need help with what they need -- no more, no less.

Since July 1, 2000, we have developed interdisciplinary teams, provider networks, quality standards and outcomes-based care plans, and we have eliminated waiting lists. In Milwaukee County, the only Family Care county to serve only persons aged 60 and over, this has meant incredible planning, recruitment, training and community education. We have yet to meet the top of our cycle in growth and maturity. Still we have grown and served and succeeded.

We are a diverse community. We have had to develop acceptable and culturally competent services for our seniors who live in nineteen separate municipalities, who

represent many ethnic and racial groups, and who have special issues, such as mental illness and developmental disability, and we have done so.

Growth has been rapid and unrelenting. We have met the needs of elders and now must meet the standards of cost effectiveness, and we ***will***.

Without sacrificing quality and availability, we are embarking on shrinking our provider networks in instances where the supply is overabundant, and adding new providers where we need to foster competition.

This is no small task. Just as the nursing home industry grew and prospered based on public funds and Medicaid rules, so will an alternate residential care industry bank on Family Care if we are not careful. We cannot allow private providers to demand public dollars for their businesses which were built for the private-pay market.

Family Care is great but can be improved. Like our neighboring state Minnesota, we can demand and legislate mandatory preadmission screening for ***all*** potential long term care residents and offer those persons and their families the real promise of community support.

In the past three years dozens of federal officials and officials from other states have studied and marveled at Family Care. They realize we have created a new system with fairer rules, better access through our resource centers, and real long term care reform for our state.

It's time we recognized it too!

I urge you to applaud what we have done and demand the expansion of this wonderful program to all citizens of our state.

In Milwaukee County, 124th Street, County Line Road, and Oakwood Road define our county boundaries and the boundaries where hope and despair, service and waiting lists collide.

Please join with me in obliterating those lines. Family Care is hope. You can foster that hope.

Stephanie Sue Stein, Director
Milwaukee County Department on Aging
235 W. Galena Street, Suite 180
Milwaukee, WI 53212-3948
Phone: 414-289-6876
e-mail: sstein@milwaukeecounty.com

Testimony of Helene Nelson
Secretary, Department of Health and Family Services

Lewin and APS Evaluation Reports on Family Care Program

Joint Committee on Audit
February 13, 2004

Greetings, Chairperson Roessler, Chairperson Jeskewitz, members of the Committee, and thank you for this opportunity to appear before you to discuss the Family Care program, the results of these two independent studies, and the future of long-term care in Wisconsin.

Wisconsin's bipartisan tradition of support for long-term care innovations

Wisconsin has been a national leader in innovative long-term care systems for the past two decades, with steady support from both Democratic and Republican Administrations and legislators. The Family Care program, which was authorized in legislation not quite five years ago is the latest initiative in this strong tradition. Now, we are learning from the strengths and the difficulties of the Family Care program, and are committed to continuing to improve long-term care systems for Wisconsin's residents.

Just three short years ago, in January 2001, the last of five Family Care care management organizations (CMOs) opened its doors. Since then, in these five counties, adults with the frailties of aging, physical disabilities, or developmental disabilities have been provided with a comprehensive package of managed long-term care services, including both institutional and community-based care.

Demographic and fiscal challenges -- no turning back

When Family Care was authorized in 1999, it was hard to overstate the stakes of successful long-term care reform as we face the challenge of the baby boomers' retirement years. Long-term care reform is critical for the well-being of Wisconsin's growing elderly and disabled population, for their families, and for the taxpayers who have supported Wisconsin's commitment to these residents.

With the additional fiscal challenges of the past few years, however, it must be clear to all that there can be no turning back on long-term care reform. We must learn from this ambitious experiment, and find ways to deliver long-term care more cost-effectively to more people in the coming decades.

Value of the Lewin and APS Reports

Taken together, the Lewin report and the APS report provide an interesting and informative picture of Family Care. The Lewin report documents the Family Care program during its challenging start-up period, when the local agencies were beginning the transition from county human services departments to managed care organizations. The APS report examines a later period when, as the CMO directors put it recently, "we first got our feet underneath us," and the first significant program results were becoming apparent.

While the Department and the Family Care counties are, of course, pleased that these reports found that several of the desired results of long-term care reform are being advanced by Family Care, we and the Family Care counties believe that, with the lessons we've learned, additional beneficial results can be achieved in the future.

A balanced entitlement is key to appropriate long-term care.

One key element of Family Care that we hope to preserve in future long-term care initiatives is entitlement to a comprehensive package of benefits—both nursing facility and community care—within a managed care program. It is illogical, inefficient, and inhumane to continue to provide Wisconsin's most vulnerable residents with an entitlement only to institutional long-term care, while creating waiting lists for care in the community.

With an entitlement program, we can get rid of the COP waiting lists that have caused so much pain, heartbreak, and unnecessary use of residential facilities.

For years preceding Family Care, staff of the Milwaukee County Department of Aging heard a dull thud every night, when they closed filing cabinets full of the records of more than 3,000 elders who were hoping that they could hang on in their homes and apartments until the COP waiver program found them a slot. In June 2002, those county staff had tears of relief in their eyes as they shut those filing cabinets for the last time and heard nothing but the clean clang of empty drawers.

Entitlement to an integrated long-term care benefit helps to prevent deterioration of the consumers' functional abilities and of their informal support networks, which is valuable in itself for the individuals and their families, and has additional benefits for longer-term cost control. We were pleased to see in the APS report encouraging evidence of better results for consumers—fewer visits to physicians, less use of nursing homes, less time in hospitals, improved functional abilities of members, and achievement of consumers' personal outcomes.

Can we afford entitlement?

But if we adopt a program of entitlement that is not limited to nursing facility care, we need to be prepared to serve more people, and that will entail a one-time boost in costs when we admit the people on the waiting lists along with an additional, smaller number of people who may not have otherwise sought services.

In the current fiscal climate, that additional funding is not in sight. However, it should remain our goal.

What we—the Department of Health and Family Services and the current Family Care counties—must do is to continue to focus our efforts on more complete fulfillment of the potential cost-effectiveness of managed long-term care.

The Family Care program, with its capitated payments, managed care structure, and comprehensive, flexible benefit package, succeeds in providing the local agencies with both

the incentive and the ability to provide cost-effective long-term care. We are pleased that four of the five CMOs—Fond du Lac, La Crosse, Portage and Richland—are beginning to deliver long-term care at a lower per-person cost than counties that do not have Family Care. We are reassured that these four counties are more similar to the remainder of the State than is Milwaukee County, where Family Care has not yet achieved the intended effects on the cost of long-term care.

We will identify and correct the causes of the Milwaukee CMO's less desirable cost-effectiveness results. Certain features of that community and of the clientele it serves make it possible that, even with the best local management, it may have taken longer to achieve the desired cost effects in Milwaukee County. However, the Department and the Milwaukee CMO believe that management of that CMO can be improved to achieve better cost effectiveness. The county has completed an assessment that outlined several areas in which management practices can be improved; by March 1, the CMO will have in place a Chief Operations Officer and a Chief Financial Officer to carry out these improvements. Cost-effectiveness can and will be achieved in Milwaukee County.

Response to incentives—County organizations had to change

We can also do better in the four Family Care counties that are already showing improved cost-effectiveness; we are not satisfied that a savings of $113 per member per month is the best that can be achieved.

Family Care provides local agencies with both the incentive and the ability to control costs, but incentives themselves do not achieve significant cost savings. As newly created managed-care organizations, the local agencies have had to respond to these incentives. They have had to identify, develop, and implement vastly different ways of doing business than those they practiced as county human services agencies.

Fiscal management and computer information systems are two areas in which operating as a managed care organization requires very different processes, practices, and management skills than those that are required for a county department. Other changes extend from concerted efforts to develop networks of cost-effective providers to the day-to-day work of the care managers, who operate differently as comprehensive managed care providers than they did when they managed only COP- and CIP-funded services.

These organizational changes take a few years. The Lewin report noted, after studying cost performance in 2001, "Impacts of the program would not be expected to be realized until three to four years following start-up." The APS report examined the CMOs' costs through 2002, which included the CMOs' second and third years of operation.

Since then, however, the CMOs have continued to improve their cost-management practices throughout 2003 and into the present. In nearly every visit and meeting we have with the CMOs, we hear of additional progress and innovations that will likely improve their performance in providing cost-effective long-term care, and Department staff continue to improve their ability to monitor cost-effectiveness and provide needed support and direction. The CMOs' following testimony will include additional explanation of the journey they have made and continue to make.

The necessary solution is bigger than Family Care CMOs

Our Administration firmly supports Family Care and is committed to its continued improvement and eventual expansion. However, we also recognize that it is not the solution to every consumer's needs and situation. The Partnership Program, which goes a step further to integrate primary and acute care into a comprehensive managed-care benefit for long-term care consumers, presents another promising alternative for some consumers. I have created a long-term care reform council to provide this Administration with guidance on expansion of these and other possible models and policy initiatives.

Neither can Family Care CMOs help us restrain the growing demand for long-term care. We must go beyond inventing better ways to deliver publicly-funded long-term care to finding ways to reduce the need for it. Given the size of the demographic challenge facing us, we must devote more effective efforts to keeping Wisconsin residents healthy. Given the need to restrain the daunting Medical Assistance budget, we must also find ways to improve the ability of the middle class to save for, and afford, the care and support they will need.

The Family Care resource centers demonstrate one starting point. They provide disability prevention services to Wisconsin residents, regardless of income, to help them stay healthy and fit. The resource centers are also providing information and counseling to all who seek to find cost-effective alternatives to meet their long-term care needs, regardless of their current need for publicly funded services. The resource center directors are here and will be able to tell you more about their valuable service, which helps many Wisconsin residents manage their private resources wisely and avoid reliance upon Medical Assistance.

This Administration will continue our support for these functions and will seek ways to make them available to more Wisconsin residents. We also intend to explore other policy alternatives that might provide effective incentives to Wisconsin residents to take care of themselves and plan effectively for their own long-term care needs.

Additional information about the Family Care program is attached to my written testimony, and I will be happy to answer any questions you have.

Thank you.