M

Family Care Enrollment, by CMO and Target Group
January 31, 2004

	Individuals with developmental disabilities	Frail elders	Individuals with physical disabilities	Total
Fond du Lac	319	450	151	920
La Crosse	430	557	523	1,510
Milwaukee	*	4,836	*	4,836
Portage	202	329	144	675
Richland	90	126	71	287
Total	1,041	6,298	889	8,228

* The Milwaukee CMO serves only frail elders.

Care Management Organization Start-up dates And Cumulative Membership through 2003

	Start-up date	Individuals served through 2003	Monthly Capitated rate (comprehensive level)
Fond du Lac	February 2000	1,346	$ 1,881.07
La Crosse	April 2000	2,051	$ 1,764.17
Milwaukee	July 2000	6,672	$ 1,810.61
Portage	April 2000	969	$ 2,255.32
Richland	January 2001	396	$ 1,970.98
	Total	11,434	

Additional information, including The Lewin Report and the APS Independent Assessment, can be viewed by visiting: http://www.dhfs.state.wi.us/LTCare/ResearchReports/Index.htm

Selected Family Care Program Features and how each promotes access, quality and effectiveness, and cost restraint

Program Feature	How does this promote **Access?**	How does this promote **Quality/ Effectiveness?**	How does this promote **Cost Restraint?**
Entitlement Eligible Wisconsin residents are enrolled in Family Care when they need services, and are not put on waiting lists.	Prevents waiting lists	Provides care at critical points when consumers seek long-term care; timely managed services can prevent avoidable deterioration.	Timely managed services can prevent deterioration and avoid demands on services more costly to MA.
Capitated payment to local organization that is at risk for the full cost of care. Local agencies are provided with flat monthly payment per member, calculated by taking into account the functional status of their membership. No additional funds are provided if care costs exceed amount provided through this rate.	Provides adequate financing appropriate for members' functional status; enables local agencies to establish viable, continuing care management organizations.	Creates incentive for local program to keep members as healthy and functional as possible.	Creates incentive to make cost-effective choices at the point where the critical service choices are made.
Managed Care with Comprehensive benefit package CMOs administer benefit package that includes both HCBS and residential care, and are allowed flexibility to provide innovative, individualized services as needed to meet their members' needs cost-effectively.	Once enrolled in Family Care, members work with care management team to meet all their long-term care needs. Reduces fragmentation from uncoordinated sources of care.	Services can be tailored to members' individual needs. All the services each consumer needs. Local responsibility for oversight of quality of providers. Enables inclusion of preventive measures.	Services can be tailored to members' individual needs. Only the services each consumer needs. Reduces inefficiency from uncoordinated provision of services.

Program Feature	How does this promote **Access?**	How does this promote **Quality/ Effectiveness?**	How does this promote **Cost Restraint?**
Member-centered care management The CMOs accept an organizational mission not of 'providing services' but of supporting individuals' personal and unique outcomes; Individuals participate on own care management team	Individuals participating in care planning are enabled to make sure care plan meets all active needs. Members can identify own informal supports and other providers.	Care plans and services are selected and operate within the context of supporting the member's individual needs and preferences.	Care plans provide no services the members do not want, need, or find satisfactory.
Nurses on care management teams In traditional waiver programs, care managers are social workers. In Family Care, each member is on a care management team, which includes a social worker and a nurse, and possibly others, as needed.	Provides identification of medical needs; helps consumers get appropriate medical services.	Provides basic medical services; coordinates long-term and medical care; provides advocacy with medical care providers.	Provides basic medical services; assists in teaching informal care-givers to provide routine medical care.
RAD The 'Resource Allocation Decision-making Method' is a routinized process that ensures care managers identify consumer outcomes, services alternatives, and cost.	Prompts creative identification, consideration of all possible ways to meet members' needs	Involves consumer in services planning	Incorporates cost considerations into service choices; promotes the selection of the least costly service from among the effective alternatives.

Key Findings from the Family Care Implementation and Outcomes Study

Lisa Alecxih

February 13, 2004

Implementation Report Methods

- Site visits to counties with both a CMO and a RC
  - Fond du Lac, La Crosse, Milwaukee, Portage, and Richland
  - Once annually from 2000 to 2002
- Telephone communication with DHFS staff
- Documentation and data provided by DHFS and CMOs
  - Provider networks
  - Enrollment
  - Contracts
  - Quality review reports
- Provider telephone interviews

Cost & Outcomes Methods

- Data
  - Medicaid Management Information System (MMIS)
  - Human Services Reporting System (HSRS) Long-term Support (LTS) Module
  - Nursing Facility Minimum Data Set (MDS)
  - Long-term Care (LTC) Functional Screen
  - Community Options Program (COP) and DD Functional Screens
  - Member Outcome Tool
- 10/1999-3/2000 (pre); 1/2001-6/2001 (post)
  - Timeframe dictated by claim lag
- Comparison – remainder of state and matched counties

Major Implementation Achievements

Access

- Established nine Resource Centers (RC)
- Use single web-based functional screen for all three target groups
- Eliminated wait lists in CMO counties

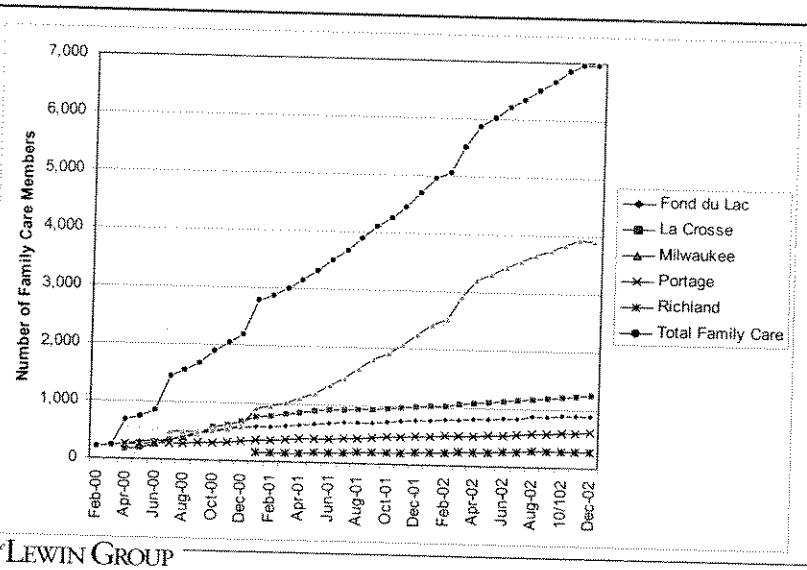
Cost

- Introduced procedures for institutional diversion
- Created five Care Management Organizations (CMO)

Quality

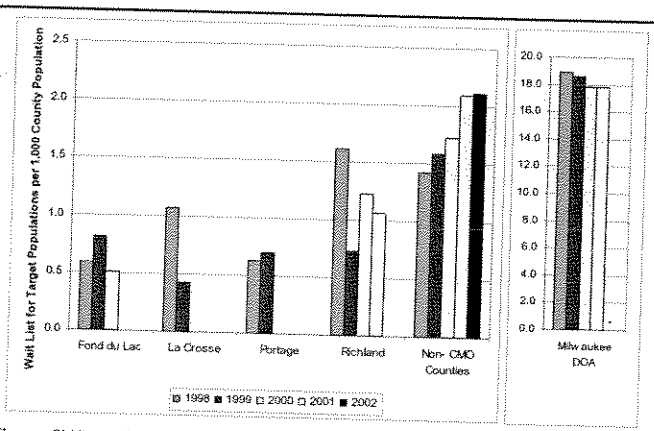
- Instituted interdisciplinary care management teams
- Increased consumer involvement
- Developed innovative quality assurance & improvement system

Increased CMO Enrollment



The LEWIN GROUP

Elimination of Wait Lists



Note: The non-CMO counties include individuals under age 60, while the scale for Milwaukee only includes individuals age 60 and over. The estimates for non-CMO counties and the CMO counties other than Milwaukee prior to the elimination of the wait list include children with physical disabilities or developmental disabilities.

Source: The Lewin Group calculations based on DHFS provided wait list data.

The LEWIN GROUP

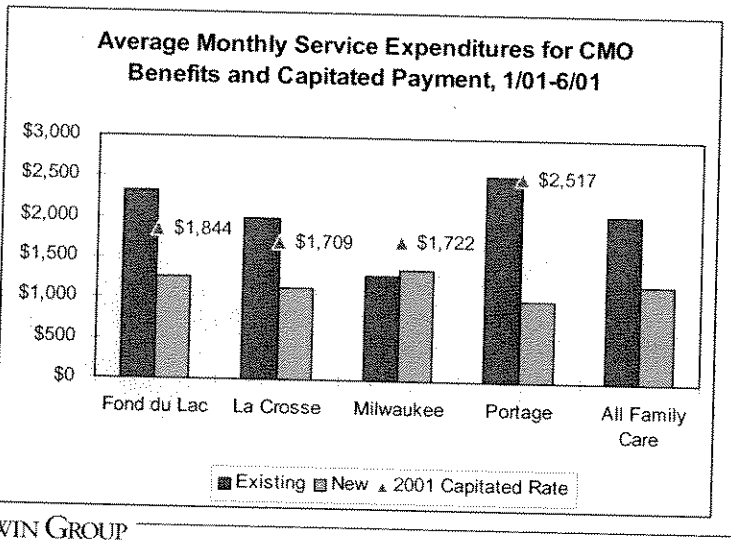
Resource Centers

- Provide a single source for:
  - easy access to information, referral, and options counseling
  - access to publicly funded programs for the target populations
- Met the challenge of developing/enhancing local information and referral resources
- Actively and creatively conducted outreach campaigns
- In most cases, met or exceeded target population contacts per eligible standards (8.0 per 1,000)
  - Elderly – all met, up to 22 per 1,000
  - Physical Disabilities – all met, 27 to 230 per 1,000
  - Developmental Disabilities – all but two met (Kenosha and Marathon), up to 36 per 1,000

Care Management Organizations

- Built upon existing county LTC functions of service brokerage and contracting
- Adopted interdisciplinary care management teams that
  - consider acute and primary care needs, in addition to chronic care
  - strive to balance consumer preference and cost
- Built provider networks
- Managed services within the capitated rates
- Began to consider a prevention focus

New CMO Enrollees Average 40% Less Spending



Increased Consumer Involvement

- Advisory roles on boards and committees
- CMOs established self-directed supports options
- Member-centered support planning
  - shift from providing services to clients to being responsive to customers
- Consumer-defined outcomes

Issues Encountered

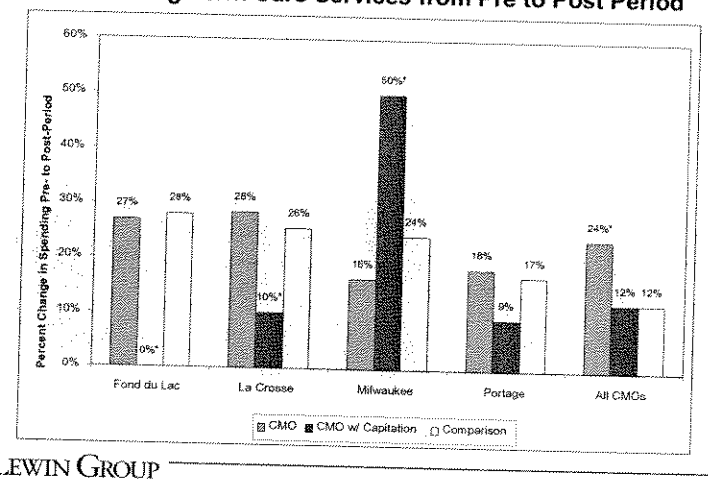
- Federal approval and requirements
- Failure to initially involve staff of Economic Support units
- Disparate information technology systems at the county and state level
- CMO struggles to hire ahead of member enrollment
- Loss of the independent advocates in Fall 2001
- Freezes on non-Medical Assistance CMO enrollment

Preliminary Outcomes

- Substantially met the goals of:
  - increasing choice and access
  - improving quality through a focus on social outcomes
- No decline in service levels for existing enrollees
- Too early to draw long-term cost-effectiveness conclusions

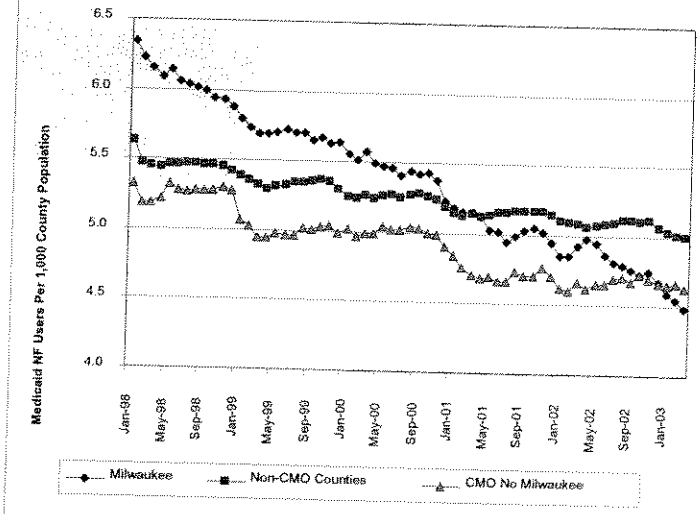
Pre-Post Spending Results Depend on Measure and Comparison

Change in Per Member Per Month Payments for Long Term Care Services from Pre to Post Period



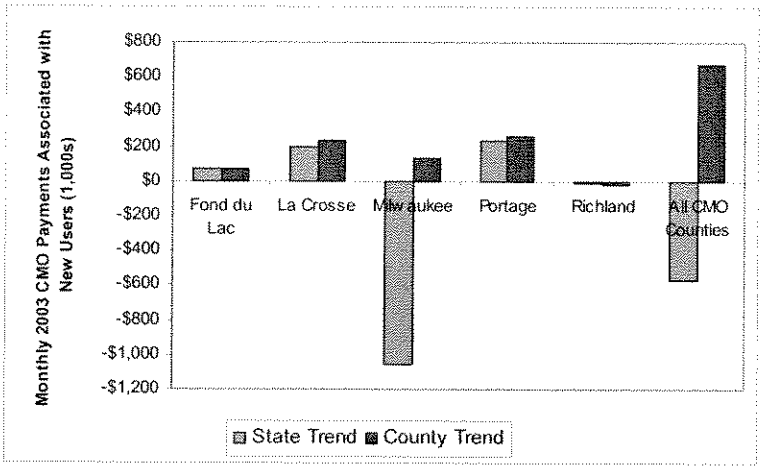
The LEWIN GROUP

Declines in Medicaid Nursing Facility Use

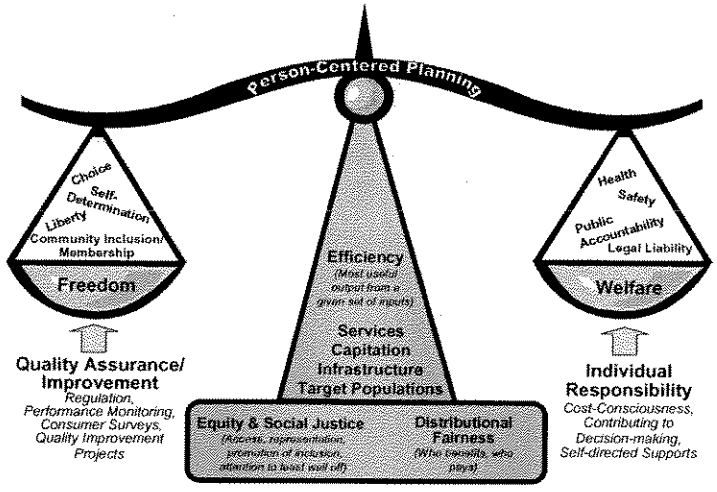


The LEWIN GROUP

Estimate of New Enrollees in Milwaukee Drive Change in Overall Spending



Balancing the Family Care Philosophy



Family Care Pilot Contact Sheet (CMO: FDL, LaCrosse, Milwaukee, Portage, Richland)

Fond du Lac County (CMO/RC):

1. Ed Schilling, Director
   920-929-3400
   ed.schilling@co.fond-du-lac.wi.us
2. James Meisinger, CMO Director
   920-906-5104
   james.meisinger@co.fond-du-lac.wi.us
3. Kay Krause, CMO Deputy Director
   920-906-5122
   kay.krause@co.fond-du-lac.wi.us
4. Sandy Tryon, Resource Center Supervisor
   920-929-7045
   sandy.tryon@co.fond-du-lac.wi.us

LaCrosse County (CMO/RC):

1. Gerald Huber, LaCrosse County Human Services Director
   608-785-6050
   huber.gerald@co.la-crosse.wi.us
2. Mary Faherty, CMO Manager
   608-785-6050
   faherty.mary@co.la-crosse.wi.us
3. Peggy Herbeck, Resource Center Supervisor
   608-785-6050
   herbeck.peggy@co.la-crosse.wi.us
4. Audra Martine, Resource Center Supervisor
   608-785-6050
   martine.audra@co.la-crosse.wi.us

Milwaukee County (CMO/RC):

1. Stephanie Sue Stein, Director Department on Aging
   414-289-6876
   sstein@milwaukeecounty.com
2. Annie Weisen, Ast. to Stephanie Sue Stein (help w/any coordination)
   414-289-6010
   awiesen@milwaukeecounty.com
3. Meg Gleeson, CMO Director
   414-289-5908
   mgleason@milwaukeecounty.com
4. Chester Kuzminski, Resource Center Manager
   414-289-6626
   ckuzminski@milwaukeecounty.com

Portage County (CMO/RC):

1. Judith Bablitch, Health and Human Services Director
   715-345-5350
   bablitcj@co.portage.wi.us
2. Jim Canales, CMO Director
   715-345-5800
   canalesj@co.portage.wi.us
3. Janet Zander, Department of Aging Director
   715-346-1415
   zanderj@co.portage.wi.us
4. Dana Cyra, Resource Center
   715-346-1412
   cyrad@co.portage.wi.us

Richland County (CMO/RC):

1. Marianne Stanek, Department Head
   608-647-8821 Ext. 286
   stanekm@co.richland.wi.us
2. Kim Enders, Resource Center Supervisor
   608-647-4616
   endersk@co.richland.wi.us
3. Randy Jacquet, Director HHS
   608-647-8821
   jacquetr@co.richland.wi.us
4. Teri Buros, Director CMO
   608-647-8821
   burost@co.richland.wi.us
5. Linda Overbeek, CMO Program Assistant
   608-647-8821
   rcltcare@co.richland.wi.us

Kenosha County (RC):

1. Dennis Schultz, Human Services Director
   262-697-4509
   dschultz@co.kenosha.wi.us
2. LaVerne Jaros, CMO Division of Aging Services Director
   262-605-6646
   ljaros@co.kenosha.wi.us
3. Ron Frederick, CMO Division of Disability Services Director
   262-605-6680
   rfrederi@co.kenosha.wi.us
4. Martha McVey, Resource Center Divison of Aging Services
   262-605-6646
   mmcvey@co.kenosha.wi.us
5. Susan Regan, Resource Center Division of Disability Services
   262-653-3880
   sregan@co.kenosha.wi.us

Marathon County (RC):

1. Tim Steller, North Central Health Care CEO
   715-848-4402
   tsteller@norcen.org
2. Larry Hagar, Marathon County Dept. Social Services Director
   715-261-7500
   lghagar@mail.co.marathon.wi.us
3. Deb Menacher, Resource Center Marathon County Aging and Disability
   715-261-6070
   damenacher@mail.co.marathon.wi.us
4. Amy Abel
   715-261-6070
   alabel@mail.co.marathon.wi.us

Jackson County (RC):

1. Todd Bowen, Jackson County DHHS Interim Director (Kevin Mannel no longer)
   715-284-4301
   tbowen@jacksoncountydhhs.org
2. Beth Smetana, Resource Center Manager Aging Unit
   715-284-4301
   blsmetana@jacksoncountydhhs.org

Trempealeau County (RC):

1. Joanne Abrahamson (not directly involved in the mtgs)
2. Stacey Garlick, Trempealeau County Director of Social Services
   715-538-2311
   garlicks@tremplo.com
3. Kathy Gauger, Director Long Term Support Unit and Resource Center
   715-538-2311
   gaugerk@tremplo.com
4. Becky Severson, Resource Center Coordinator
   715-538-2311
   seversonb@tremplo.com

November 2003

AGENCY	ADDRESS	PHONE/FAX NUMBERS	EXECUTIVE DIRECTOR	PRIMARY CMO CONTACT	PRIMARY RESOURCE CENTER CONTACT
RICHLAND CTY CONT. www.co.richland.wi.us/departments/hhs/familycare	**Community Services Bldg** 221 W. Seminary Street Richland Center, WI 53581	608/647-8821-Gen 608/647-6611-Fax	Randy Jacquet, Director HHS	Teri Buros Linda Overbeek (Program Assistant)	
KENOSHA COUNTY *(alt. CMO, RC)*	**Dept. of Human Services** 8600 Sheridan Road Kenosha, WI 53143	262/697-4509-Gen 262/697-4655-Fax	Dennis Schultz		
	Kenosha County ADRC 8600 Sheridan Rd, Suite 500 Kenosha, WI 53143	262/605-6646-Gen 262/605-6649-Fax		LaVerne Jaros	Martha McVey *AGING & DISABILITY RESOURCE CENTER OF KENOSHA COUNTY*
	Division of Disability Services 3508 Washington Road Kenosha, WI 53144	262/653-3880-Gen 262/653-3875-Fax		Ron Frederick	Susan Regan *DEVELOPMENTAL DISABILITIES RESOURCE CENTER OF KENOSHA COUNTY*
MARATHON COUNTY *(alt. CMO, RC)*	**North Central Community Services** 1100 Lake View Dr. Wausau, WI 54403	715/848-4402-Gen 715/848-2362-Fax	Tim Steller CEO NC Health Care Tsteller@norcen.org		
	Marathon County Dept Social Services 400 East Thomas Ave Wausau, WI 54403	715/261-7500-Gen 715/261-7510-Fax	Larry Hagar		
MARATHON CTY CONTD. www.adrc.co.marathon.wi.us	**Aging & Disability Resource Center of Marathon County** Lake View Center 1000 Lake View Dr. Wausau, WI 54403	715/261-6070-Gen 715/261-6090-Fax	Deb Menacher Susan Coleman, Assistant Director	No CMO	Amy Abel *AGING & DISABILITY RESOURCE CENTER OF MARATHON COUNTY*
JACKSON COUNTY *(RC only)*	**DHHS** P.O. Box 457 Black River Falls, WI 54615	715/284-4301-Gen 715/284-7713-Fax	~~Kevin Manner~~ Todd Bauer Interim	No CMO	Beth Smetana *HELP LINK AGING & DISABILITY RESOURCE CENTER*

November 2003

AGENCY	ADDRESS	PHONE/FAX NUMBERS	EXECUTIVE DIRECTOR	PRIMARY CMO CONTACT	PRIMARY RESOURCE CENTER CONTACT
TREMPEALEAU COUNTY *(RC only)*	**DSS** 36245 Main St P.O. Box 67 Whitehall, WI 54773	715/538-2311-Gen 715/538-4210-Fax	Joanne Abrahamson, Director of Senior Services Stacey Garlick, Director of Social Services Connie Herman, Trempealeau County Unified Board	No CMO	Becky Severson *AGING & DISABILITY RESOURCE CENTER OF TREMPEALEAU COUNTY*

DEPARTMENT OF HEALTH AND FAMILY SERVICES

AGENCY	ADDRESS	PHONE/FAX NUMBERS	PERSONNEL
DIVISION OF DISABILITY AND ELDER SERVICES	**DHFS/DDES** 1 W Wilson Street, Rm. 850 PO Box 7851 Madison WI 53707-7851	608/266-2000-Gen 608/264-9832-Fax	Sinikka McCabe, Administrator Judith Frye, Associate Administrator, Long-Term Support
CENTER FOR DELIVERY SYSTEMS DEVELOPMENT	**DHFS/DDES/CDSD** 1 W Wilson Street, Rm. 518 P.O. Box 7851 Madison, WI 53707-7851	608/267-7286-Gen 608/266-5629-Fax	Monica Deignan, Family Care Program Manager Alice Mirk, RC/CMO Implementation & Technical Assistance Greg Robbins, Fiscal & IT Karen McKim, Quality & Research Manager
BUREAU OF INFORMATION SYSTEMS (BIS) IT FAMILY CARE STAFF	**DHFS/DMT/BIS** 1 W. Wilson St, Rm. B150 P.O. Box 7850 Madison, WI 53707-7850	608/266-1346-Gen 608/267-3600-Fax	Dana Parpart Ron Wollner Marie Eichinger Steve Harvancik Jill Hoskins Russ Lutz Marcie Perkins

November 2003

AGENCY	ADDRESS	PHONE/FAX NUMBERS	PERSONNEL
BUREAU OF AGING & LONG TERM CARE RESOURCES (BALTCR)	**DHFS/DDES/BALTCR** 1 W. Wilson St., Rm. 450 P.O. Box 7851 Madison, WI 53707-7851	608/266-2536-Gen 608/267-3203-Fax	Donna McDowell, Director Janice Smith, Assistant Director Gail Schwersenska, Aging Network Section Chief Gail Propsom Dan Johnson Susan Abbey Jessica Gilkison
BUREAU OF DEVELOPMENTAL DISABILITY SERVICES (BDDS)	**DHFS/DDES/BDDS** 1 W. Wilson St, Rm. 418 P.O. Box 7851 Madison, WI 53707-7851	608/266-0805-Gen 608/261-6752-Fax	Michael Linak, Interim Director Tom Swant Christy Pomerening
BDDS CIS STAFF	**BDDS/DDES/DHFS** P.O. Box 1140 Campbellsport, WI 53010-1140 *(Areas served: Fond du Lac & Portage)*	920/533-8429 -Gen 920/922-6927-Fax	Pam Groeschl
	Western Regional Office 610 Gibson Street, Suite 1 Eau Claire, WI 54701-3687 *(Area served: La Crosse)*	715/836-6761-Gen 715/836-2535-Fax	Diana Adamski
	Southeastern Regional Office 141 NW Barstow Street Room 209, Waukesha, WI 53188 *(Area served: Milwaukee)*	262/548-8694-Gen 262/521-5293-Fax	Patty Byrne
	Southern Regional Office 2917 International Lane, Suite 240 Madison, WI 53704 *(Area served: Richland)*	608/243-2429-Gen 608/243-2426-Fax	Marge Steingraber
BUREAU OF QUALTY ASSURANCE (BQA)	**DHFS/DDES/BQA** P.O. Box 2969 Madison, WI 53701-2969	608/266-8481-Gen 608/267-0352-Fax	Susan Schroeder, Director Deb Bursaw

November 2003

AGENCY	ADDRESS	PHONE/FAX NUMBERS	PERSONNEL
BUREAU OF HEALTH CARE ELIGIBILITY	**DHFS/DHCF/BHCE** 1 W. Wilson St. P.O. Box 309 Madison, WI 53701-0309	608/261-7787-Gen 608/261-6861-Fax	Cheryl McIlquham, Director Jim Jones, Deputy Director Margaret Rosenthal, Program Policy Analyst
BUREAU OF HEALTH CARE SYSTEMS & OPERATIONS	**DHFS/DHCF/BHCSO** 1 W. Wilson St, Rm. 472 P.O. Box 309 Madison WI 53701-0309	608/266-9152-Gen 608/261-7793-Fax	Kenneth Dybevik, Director Jean Feinstein-Lyon, Chief, Systems and Reporting Sect. Heidi Herziger, CMO Enrollment Systems
OFFICE OF STRATEGIC FINANCE - AREA ADMINISTRATION	**DHFS/OSF/AA** One W. Wilson St., Room 631 P.O. Box 7850 Madison, WI 53707-7850	608/267-8928-Gen 608/266-8278-Fax	Diane Waller-Director
	Northeastern Region 200 N. Jefferson, suite 411 Green Bay, WI 54301 *(Area served: Fond du Lac)*	920/448-5312-Gen 920/448-5306-Fax	Julie Kudick-Primary Gary Tilkens-Back-up
	Northern Region P.O. Box 697 Rhinelander, WI 54501 *(Areas served: Portage, Marathon)*	715/365-2500-Gen 715/365-2517-Fax	Bob Carl-Primary Patrick Cork-Back-up
	Southeastern Region 141 NW Barstow Waukesha, WI 53188 *(Areas served: Milwaukee, Kenosha)*	262/521-5100-Gen 262/521-5293-Fax	Cheryl Marek Domrose-Primary Carolyn Lien, Back-up
	Southern Region 2917 International Lane, Suite 130 Madison, WI 53704 *(Area served: Richland)*	608/243-2400-Gen 608/243-2426-Fax	Jan Devore-Primary Patty Hammes-Back-up
	Western Region 610 Gibson St, Suite 2 Eau Claire, WI 54701-3687 *(Areas served: La Crosse, Jackson & Trempealeau)*	715/836-3415-Gen 715/836-2516-Fax	Vince Maro-Primary Audrey Roecker-Back-up

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OTHER CONTACTS

ENROLLMENT CONSULTANTS

SOUTHEASTERN WISCONSIN AREA AGENCY ON AGING	**SEWAAA** 125 N. Executive Drive, Suite 102 Brookfield, WI 53005	262/821-4444-Gen 262/821-4445-Fax 866-373-8050-Toll Free	Helen Ramon, Executive Director John Schnabl (Milwaukee & Fond du Lac) Linda Dreyer (Milwaukee & Fond du Lac) Alden Luzi (Milwaukee & Fond du Lac)
	SEWAAA c/o LA CROSSE COUNTY HUMAN SERVICES 300 North 4th Street P.O. Box 4002 La Crosse, WI 54601	608/785-6050-Gen 608/785-5926-Fax 866-807-6907-Toll Free	Jenny Bielefeldt (La Crosse, Portage & Richland)

METASTAR and APS

METASTAR	**MetaStar** 2909 Landmark Place Madison, WI 53713	608/ 274-1940-Gen 608/274-5220-Fax	Sherrel Walker
APS HEALTH CARE, INC. (Formerly Innovative Resources Group, IRG)	**APS** 10 E. Doty Street, Suite 210 Madison, WI 53562	608/258-3350-Gen 608/258-3359-Fax	Amie Goldman Ed Hickey

Family Care Folder Contents:

Lewin Group	Summary sheets	red flag is the conclusions
Lewin Group	Overview of the Evaluation	
Lewin Group	Summary of Key Outcomes & Cost Analyses	
Lewin Group	LAB Summary	
Lewin Group	DHFS letter	
Lewin Group	LAB letter to previous co-chairs	
APS Healthcare	Summary sheets	red flag are the lessons learned

Lewin Group:

LAB summary of Lewin Report:

- First 3 reports focused on state and county-level implementation of the program, including both Resource Centers and CMOs
- Final report examines the early outcomes and cost-effectiveness of the program – released May 1 2003
- Lewin did not complete report within time frame required by our contract
- Lewin concluded the program has substantially met the goals of increasing choice, access and improving quality through a focus on social outcomes.
- But through 2001, had yet to demonstrate health quality for its participants.
- Too early to draw conclusions regarding program's long-term cost-effectiveness.

- FY 2002-03 budget $155.9 million
  - $142.4 million - CMOs
  - $8.3 million - Resource Centers
  - $5.2 million – Other costs
  - Funded by mix of fed funds and GPR (FY 02-03 approx. $71.9 million GPR)

Access to Service and Information:

- Contact goals for the elderly and physically disabled were met in all counties.
- Contact goals for developmentally disabled – only Marathon and Kenosha counties failed to meet.
- Waiting lists were eliminated in all 5 CMO counties by end of 2002.
- Rest of state, waiting lists for waiver services have continued to grow. All CMO counties persons found financially and functionally eligible were offered access to benefits.
- Enrollment CMOs 6,966 (12-02)
- 12-01 to 12-02 enrollment grew by 48% (FDL 17% (low) to 74% Milwaukee (high))
- 76% of CMO enrollees statewide were elderly in December 02 – percentage of elderly would fall to 47% if Milwaukee excluded.
- Program's provider network has generally increased over time

Infrastructure Development:

- Electronic 'functional screen' developed by DHFS uniformly used to determine the functional status and eligibility of individuals.
- Resource Centers use different to record referrals and all 5 CMOs use 4 different software systems
- CMOs facing staffing challenges

Quality of Life and Quality of Care:

- DHFS developed an interview tool
- Family Care participants reported more positive outcomes than the others surveyed in 3 areas:
  - Choice and self-determination
  - Community integration
  - Health and safety
- Report notes slightly lower levels of hospital and ER use, diagnosis of decubitis ulcer, and death for Family Care recipients, but not statistically significant differences.

Expenditures:

- Department pays CMOs fixed amount per participant per month for CMO-covered services
- Compared 6 months before pilot and 6 months after pilot started:
  - Found greatest cost increase in CMO counties
  - CMO Counties average monthly expenditures increased 25.2% ($2,001 to $2,505)
  - Rest of state average monthly expenditures increased 10.9% ($2,160 to $2,395)
- Compared average pre-Family Care expenditures to capitated payments made to the CMOs
  - Elderly expenditures:
    - Statewide - increased 21%
    - CMOs - increased 29%
  - Physically disabled expenditures:
    - Statewide - decreased 13%
    - CMOs - increased 15%
  - Developmentally disabled expenditures:
    - Statewide – increased 14%
    - CMOs - increased 24%

Comparison of Community and Nursing Facility Costs:

- Compared Family Care expenditures for care in the community to costs associated with care provided in nursing facility
- More data on service costs per individual are available for Family Care participants than for individuals in nursing facilities
- Expenditures were lower for community care services under Family Care than for nursing home care
- When functional status was considered, average spending for long-term care services in the community was 74.3% of nursing home spending.
- If level of care was considered, the difference diminished as the level of care increased
  - Intermediate care:
    - Community costs 49.8% of nursing home costs ($1,048)
    - Nursing home ($2,104)
  - Skilled care:
    - Community costs 65.3% of nursing home costs ($1,658)
    - Nursing home ($2,538)
  - Intensive skilled care:
    - Community costs 95% of nursing home costs ($2,827)
    - Nursing home ($2,976)

Lewin Report

Program overview (pg. 2) pilot info and goals
Eligibility chart (pg. 3) target populations and functional and financial criteria
Enrollment chart (pg. 4-5) increased significantly only recently leveling off
Functions & roles (pg. 7) flowchart of all entities in Family Care process
Long term care service (pg. 9) CMO vs. Medicaid fee-for-service
DHFS quality plan (pg. 13)
Waivers (pg. 15)
Funding (pg. 16)
Family Care timeline (pg. 32)
Enrollees by target population (pg. 53)
CMO disenrollment (pg. 55)
Providers contracting (pg. 56)
Case vs. care management (pg. 63)

Achievements of particular note include: (pg. 32)

- The establishment of nine Resource Centers that provide a single source across populations (in all but Milwaukee) for easy access to information, referrals, options counseling, and, in the CMO counties, coordination of the CMO enrollment process.
- The use of a single web-based functional screen for all three target groups that was recently instituted statewide.
- The introduction of procedures for institutional diversion through requiring providers to submit pre-admission consultation (PAC) referrals to the RCs for individuals inquiring about nursing home care.
- The creation of five Care Management Organizations that built upon the existing county long term care functions of service brokerage and contracting and added provider development, enhanced care management, and quality assurance and improvement.
- The elimination of wait lists for home and community-based services (HCBS) and the establishment of an entitlement to HCBS in the CMO counties.
- The institution of interdisciplinary care management teams that, in addition to long-term care, consider acute and primary care needs and strive to balance consumer preference and cost.
- Increased consumer involvement through a self-directed supports option at the CMOs, active participation of consumers in the care management process, governing boards for the RCs and CMOs, and state and local long-term care councils.
- Development of an innovative quality assurance and improvement system that improves upon the traditional process measures by seeking direct input from members through the Member Outcome Tool.

Issues encountered of particular note include: (pg. 33)

- Delays in the approval of the initial Medicaid waivers to establish the mandatory enrollment and limit the allowable providers to the CMOs due to federal concerns regarding potential conflict of interest involved in the enrollment process because the RCs and CMOs are both county entities.
- Failure to involve the staff of Economic Support Units, which determine financial eligibility for CMO enrollment, calculate cost-share requirements, and enter enrollment information into the administrative systems, in the planning of the CMO enrollment process. As a result, ESUs were inadequately staffed for the initial conversion of existing waiver enrollees to the CMOs.
- Disparate information technology (IT) systems at the county and the state level, making automation of some functions difficult and electronic transfer of data cumbersome.
- CMO struggles to hire ahead of member enrollment due to uncertainty regarding enrollment trends and some County Boards' reluctance to permit additional staff, particularly while other county agencies had hiring freezes.
- Loss of the independent advocates in the fall of 2001 due to budget cuts, thereby eliminating a formal, independent avenue to address CMO member issues and grievances.
- Freezes on non-Medical Assistance CMO enrollment also due to budget situations which restricts new enrollment to those functionally eligible with limited financial resources.

CONCLUSIONS:

GOALS (4):

1. **CHOICE:** Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
    - What services to receive
    - Who provides the service
    - Where to live and receive services
    - How services are delivered

- The redesigned system will provide individuals and families with meaningful choices of supports, services, providers, and residential settings, as long as such care or support is necessary, meets an adequate level of quality, is cost-effective, is consistent with the individual's values and preferences, and can be provided within available resources.
- The member outcome interviews from 2001 indicated that approximately one-half of CMO members indicated that they could choose their services. While only half may seem low for a program that emphasizes choice, the outcome interviews occurred early in the program's implementation. (remember high volume of waiver rollovers.)
- One-half higher than one-third in waiver program in remainder of state
- Face several issues:
    - **Loss of the independent advocate** – without an advocate for the disability community members lack important voice for expressing their choices. Lewin suggests that stakeholders consider a multi-function, consumer-oriented position that encompasses the activities of the independent advocate, enrollment consultant and staff support for the local LTC Council.
    - **Full realization of a self-directed supports option** – when the consumer receives a budget allocation to be spent as desired CMOs have difficult task of devising method for setting budgets consistently, fairly and adequately without exceeding resources.

2. **ACCESS:** Improving access to services.

- Elimination of wait lists and ability to serve more individuals
- Face several issues:
    - **Increased enrollment –** Challenge of hiring and training additional staff which will require ongoing initial training and refresher courses
    - **Selective contracting -** As CMO gathers info about provider performance and member satisfaction, they face politically sensitive task of excluding some traditional providers from their networks
    - **Expanding the use of non-traditional providers –** CMOs will need to continue to explore alternative providers and encourage existing providers to offer new and/or more responsive services, especially in rural areas

3. **QUALITY:** Improving quality through a focus on health and social outcomes.

- Higher percentages of CMO members indicated having each of 14 outcomes met that constitute the 3 major domains of choice and self-determination, community integration and health and safety.
- Claims-based measures including residential use, nursing facility use, ER use, decubitis ulcers, and death no difference between individuals in other waivers vs. Family Care.
- Face several issues:
    - **Transitioning quality assurance/improvement to a contracted organization –** DHFS contracted with MetaStar to serve as external quality review organization (EQRO) assuming many activities DHFS staff had. Different roles may be required for some DHFS staff to keep communication and effectiveness.

- **Benchmarking the member outcome tool results –** Discourage comparison of Round I and II interviews because some process changes were implemented in 2nd round. DHFS needs to take care in presenting results and may want to consider developing mechanisms for case mix adjusting results.
- **Continuing education –** Education for DHFS, EQRO, and county staff about goals and measures. Consumers, families and providers educated on program goals and managing expectations.

4. **COST EFFECTIVE:** Creating a cost-effective system for the future.

- The difference in the increase in long-term care spending prior to CMO and early CMO implementation, were not significant.
- New CMO enrollees had spending generally 60% or less of the existing enrollees.
- Face several issues:
  - **Measuring cost-effectiveness over the long term –** DHFS and Legislature will want to continue to measure program's costs and outcomes.
  - **Instituting a functionally-based payment system –** DHFS continues to incorporate info from the functional screens into its payment methodology. DHFS and its actuaries continue to break new ground in the payment for long-term care services.

Outcome Analyses Results -

- **Progress toward meeting goals:**
  - Substantially met goal of increasing choice, access and improving quality through a focus on social outcomes
  - Yet to determine improved quality related to individual's health using claims-based measures. (due to time period of analyses and need for more time to fulfill goal)
  - Existing enrollees did not experience a decline in service levels during the 1st year
  - Too early to draw conclusions regarding program's ability to create a cost-effective system in the future
  - **Page 110 has summary of key outcomes and cost analyses (attached)**

Expanding Family Care

- Political considerations:
  - Counties not implementing Family Care have begun to question the relatively high level of state funding flowing to the current Family Care counties while they face reductions in services.
  - There is currently no discussion about pilot counties reverting back to the pre-Family Care system
  - Notable that CMO staff unanimously expressed a preference for Family Care over the old system.
  - DHFS has begun to plan for the possibility of additional CMO counties
- Major issues for DHFS:
  - Scope – Range from one more county to the whole state (another 67 counties). Issues of timing and technical assistance are important if expanded to multiple counties.
  - Configuration – Could continue to be county-based, or like MI, minimum number of covered lives require more of a regional approach for counties with smaller populations. DHFS wishes to contract exclusively with county governments and has submitted a proposal to CMS for waiver renewal process.
  - Timing – Gradual phase-in and staggered roll-out to additional CMO counties.
  - Technical assistance – Provide technical assistance so that local governments can learn how to install and implement the operational, clinical, and fiscal mechanisms necessary to become managed care organizations. DHFS has begun to consider the infrastructure elements that it may require of counties prior to implementing Family Care. Having the necessary information technology in place should accelerate the implementation process. DHFS has drafted a readiness assessment to aid in evaluating any future Family Care CMOs.

Keys to expansion:

- Commitment - State and county staff demonstrated high personal investment and pride in the program. Are committed to its success and commitment motivates continuous learning process and spirit of cooperation.
- Cooperation – Willing to work through problems and cooperate to build the program. Many groups cooperating:
    - Work groups
    - Governing bodies: LTC councils and work groups
    - State (DHFS and DWD) and County (RCs, CMOs, & ESUs)
    - Advocacy group efforts
- Trust –
    - State trust the competency of county staff to implement the program.
    - County trust state staff would support them and work with them.
    - Members trust continue to receive high quality, appropriate services.

II. OVERVIEW OF THE EVALUATION

This is the last report in The Lewin Group's evaluation of Family Care. This evaluation involved three distinct parts: 1) an **implementation process** evaluation, which focused on documenting how the Family Care Program was implemented in the five full model pilot counties; 2) an **outcome analysis** that assesses the system and individual level outcomes of Family Care; and 3) a **cost-effectiveness study** that serves the interests of the State and may provide an initial basis for the Center for Medicare and Medicaid Services' (CMS) independent review requirements.

Lewin Evaluation Reports
Implementation Evaluation Process Update Report I -November 2000
Implementation Evaluation Process Update Report II - August 2001
Implementation Evaluation Process Update Report III - December 2002
Draft Outcomes and Cost-Effectiveness Evaluation Report – May 2003
Final Report: Combined Implementation Process, Outcomes and Cost-Effectiveness Evaluation Report

This report incorporates revisions to the *Draft Outcome and Cost-Effectiveness Evaluation Report* and also provides a summary of the implementation of Family Care through May 2003, as well as major conclusions and future considerations for the program. The information in this report provides some preliminary indications of the results of the Family Care program. It is important to note that the data available for the pre/post comparison for the outcome analysis generally reflect only the first year of the program's implementation, and, as a result, does not capture the ultimate impact of the program. In addition, our prior implementation reports indicated that the CMOs were focused on start-up issues and were not yet able to fully realize the potential advantages of the new care management structures and other aspects of the program during this period. Impacts of the program would not be expected to be realized until three to four years following start-up, and the data for an analysis of this timeframe would be available four to five years after start-up, or 2004-05. In addition, ultimate impacts, particularly on nursing home use, may not be realized for some time to come. This report also updates the baseline fidelity measure (see ***Appendix C***), a measure of program progress outlined in the previous report, with information as of May 2003.

A. Phase I

The primary activity during Phase I of the evaluation was to monitor and assess the process of implementation of the Family Care Program in the five counties that implemented both components of the Family Care model – Resource Centers (RCs) and Care Management Organizations (CMOs). The process evaluation of implementation examined program organization, service delivery, context, and other key data elements to assess the effectiveness of implementation and identify lessons that can assist in replicating the program in other parts of Wisconsin, as well as in other states. The process evaluation also provides contextual basis for the outcome and cost-effectiveness analyses.

Exhibit XIII-2
Summary Results of Key Outcomes and Cost Analyses Conducted

Indicator		Result
Access		
Information		
RC Outreach Activities	+	Numerous & varied efforts by counties
Resource Center Contacts	+	Met contract standard by county except Marathon and Kenosha for DD
Benefits		
Wait Lists	+	CMO counties no wait lists; rest of state increasing
CMO Enrollment	+	Enrollment continues to Increase
Choice of Providers	+	Number of contracted providers increased
Service Use by Type	+	Use of alternative residential, transportation and vocational services increased among existing enrollees
Quality of Life/Care		
Choice and Self-Determination		
Treated fairly	+	CMO favorable compared to waiver
Privacy	+	CMO favorable compared to waiver
Personal dignity & respect	+	CMO favorable compared to waiver
Choose services	+	CMO favorable compared to waiver
Choose daily routine	+	CMO favorable compared to waiver
Achieve their employment objectives	+	CMO favorable compared to waiver
Satisfied with services	+	CMO favorable compared to waiver
Community Integration		
Choose where and with whom they live	+	CMO favorable compared to waiver
Participate in the life of the community	+	CMO favorable compared to waiver
Informal support networks connection	+	CMO favorable compared to waiver
Residential care use	o	No difference compared to rest of state
Nursing home use	o	No difference compared to rest of state
Health and Safety		
Free from abuse and neglect	+	CMO favorable compared to waiver
Best possible health	+	CMO favorable compared to waiver
Safety	+	CMO favorable compared to waiver
Continuity and security	+	CMO favorable compared to waiver
Decubitis ulcer	o	No difference compared to rest of state
Hospital use	o	No difference compared to rest of state
Emergency Room use	o	No difference compared to rest of state
Death	o	No difference compared to rest of state
Spending		
LTC Medicaid & state spending	o	Mixed dependent upon comparison area
Spending on new enrollees	o	Spending for new enrollees less than existing
Nursing Facility versus Community	o	Mixed dependent upon assumptions
Additional Spending on Net New Users	o	Mixed dependent upon assumptions

+ Indicates Family Care had a positive outcome for the indicator.

o Indicates Family Care had neither a positive nor a negative outcome

- Indicates Family Care had a negative outcome for the indicator.

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

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July 15, 2003

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

As required by 1999 Wisconsin Act 9, the Legislative Audit Bureau contracted with The Lewin Group, Inc., in 1999 to conduct an evaluation of the Family Care pilot program. This report is the final document in a series of reports prepared under the terms of the contract.

Family Care is a restructuring of Wisconsin's long-term care system for the elderly, the physically disabled, and the developmentally disabled. The first three Lewin reports focused on state and county-level implementation of the program, including the operation of Resource Centers in nine counties and Care Management Organizations in five of the counties with Resource Centers. The draft version of this final report, which examines the early outcomes and cost-effectiveness of the program, was released May 1, 2003. This final version also includes Lewin's final implementation update.

As we noted when releasing the May 2003 draft, the Lewin Group did not complete this report within the time frame required by our contract. However, the report was reviewed in draft and final form by this office and the Department of Health and Family Services. This final report reflects a number of revisions Lewin made for clarity and to correct inconsistencies in the draft report but includes only one substantive change, involving a nursing home utilization comparison.

Lewin concludes that the program has substantially met the goals of increasing choice and access and improving quality through a focus on social outcomes, but that through June 2001, it had yet to demonstrate improved health quality for its participants. Lewin further states that it is too early to draw conclusions regarding the program's long-term cost-effectiveness.

A summary of the report's key findings is enclosed. A copy of the entire report is also available on our Web site: www.legis.state.wi.us/lab.

I hope you find this information useful. Please contact me if you have any questions.

Sincerely,

Janice Mueller

Janice Mueller
State Auditor

JM/KW/bm

Enclosures

cc: Senator Robert Cowles
Senator Alberta Darling
Senator Gary George
Senator Jeffrey Plale
Representative Samantha Kerkman
Representative Dean Kaufert
Representative David Cullen
Representative Mark Pocan

FAMILY CARE PILOT PROGRAM

Family Care was created in 1999 Wisconsin Act 9 to eliminate a perceived bias toward institutional care and to streamline a fragmented funding system for long-term care services. It is administered by the Department of Health and Family Services and is currently operating as a pilot program in nine counties.

The Family Care model creates two new community organizations:

- Resource Centers, which provide elderly and physically and developmentally disabled residents in all nine counties with "one-stop shopping" for information and assistance; and

- Care Management Organizations (CMOs), which help to arrange and manage services in five counties for those determined eligible under the program.

The program also uses managed care principles, including capitated payments, in an effort to help control costs.

The fiscal year (FY) 2002-03 budget for Family Care totals $155.9 million, including $142.4 million for the costs of the CMOs, $8.3 million for the Resource Centers, and $5.2 million for other costs. The program is funded with a mix of federal funds and general purpose revenue (GPR). In FY 2002-03, approximately $71.9 million in GPR was appropriated for Family Care.

Services covered by the Family Care capitated payment include residential services, personal care, home health, physical therapy services, adult day care, and supported employment services. Hospital care, physician care, prescription drugs, and several other services are not provided as part of the Family Care benefit or reflected in the Family Care budget but are received on a fee-for-service basis under Medicaid. The monthly capitated payment amounts vary by county. In 2003, they ranged from $1,721 in Milwaukee County to $2,491 in Portage County. Family Care enrollment in December 2002 was 6,966.

The enclosed report from the Lewin Group is lengthy and detailed. We have summarized some of its major findings to assist the reader in interpreting the results of Lewin's evaluation.

Access to Services and Information

One way to measure information and outreach services by Resource Centers is in terms of contacts per 1,000 in county population. From 2001 to 2002, average monthly contacts increased for all nine counties with Resource Centers except Portage, which changed the manner in which it counted some contacts in conformance with a request by the Department. Lewin notes that contact goals for the elderly and physically disabled, as established through contracts with the Department, were met in all counties, and only Marathon and Kenosha counties failed to meet monthly contact goals for the developmentally disabled target population.

One of the program's principal goals was elimination of waiting lists for community-based services. Waiting lists were eliminated in all five CMO counties by the end of 2002, and all

CMO counties reached entitlement status by that date. Consequently, in these counties all persons found financially and functionally eligible must be offered access to benefits under the Family Care program. In contrast, the report notes that in the rest of the state, waiting lists for waiver services have continued to grow.

As noted, enrollment in Family Care's five CMOs reached 6,966 in December 2002. From December 2001 to December 2002, enrollment grew by 48 percent. By county, enrollment growth ranged from a low of 17 percent in Fond du Lac to a high of 74 percent in Milwaukee.

Lewin notes that outside Milwaukee County, enrollment growth was greatest for younger, physically disabled individuals in the two-year period from December 2000 to December 2002. Milwaukee County's Family Care program is restricted to the elderly, which affects program demographics statewide. Lewin notes that 76 percent of CMO enrollees statewide were elderly in December 2002, but the percentage of elderly CMO participants would fall to 47 percent if Milwaukee were excluded.

The report notes that the size of the program's provider network has generally increased over time, and many different provider types are used. The CMOs write contracts with service providers and also purchase some services without formal contracts. From May 2001 to May 2003, Lewin reported increases in the number of providers under contract in three of the five CMO counties: a 16 percent increase in La Crosse, a 34 percent increase in Fond du Lac, and a 73 percent increase in Portage. As of May 2003, Lewin found that all CMOs had established procedures to identify service needs among program participants.

Infrastructure Development

Information technology system development has been very important in implementation of Family Care. However, while an electronic "functional screen" developed by the Department of Health and Family Services is uniformly used to determine the functional status and eligibility of individuals, a number of systems have been put in place for other aspects of Family Care administration. For example, the report notes that Resource Centers use different systems to record information on referrals, and the five CMO counties use four different software systems for this purpose. The report also notes the existence of various manual and automated systems to record assessments, case notes, service plans, prior authorization of services, billing, and claims processing.

Lewin also reports that CMOs face staffing challenges because of both Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements and a shortage of registered nurses, who must be part of the interdisciplinary care management team for each program participant.

Quality of Life and Quality of Care

The Department has developed an interview tool to assess participants' perceptions of the program and its effects on their quality of life. The Department recently completed a third round of interviews with care managers, randomly selected Family Care participants, and participants in

other community-based waiver programs. Family Care participants reported more positive outcomes than the others surveyed in three broad areas:

- choice and self-determination, including fairness, privacy, choice in one's daily routine, and satisfaction with services;
- community integration, including choosing where and with whom to live, participating in the life of the community, and remaining connected to informal support networks; and
- health and safety, including freedom from abuse and neglect, attainment of the best possible health, and continuity and security in one's life.

Lewin compared the incidence of four traditional indicators of quality of care for CMO enrollees with the incidence of those indicators in the remainder of the state during the first six months of 2001. The report notes slightly lower levels of hospital and emergency room use, diagnosis of decubitis ulcers, and death for Family Care recipients, but no statistically significant differences.

Expenditures

Under a capitated payment system, the Department pays the CMOs a fixed amount per participant per month to provide the CMO-covered services. The CMOs actually spend more or less per participant based on assessed need. To determine how individuals who had received waiver services prior to enrolling in a CMO fared under the new system, Lewin compared actual spending levels for services delivered in the initial four CMO counties during two six-month periods—before the pilot program, or from October 1999 through March 2000, and again during the pilot program, from January through June 2001. Three areas were compared:

- the Family Care CMO counties;
- a matched "comparison" county for each Family Care CMO county; and
- the remainder of the state.

Lewin found the greatest cost increase in the Family Care CMO counties, where average monthly expenditures increased 25.2 percent, from $2,001 to $2,505 per person. In the remainder of the state, expenditures increased 10.9 percent, from $2,160 to $2,395 per person.

The services for which average monthly expenditures were highest statewide were personal care, residential services, and prescription drugs. In the CMO counties, expenditures for drugs increased at a slower rate: the increase was 10.6 percent, compared to 16.9 percent statewide. However, for inpatient care, physician services, and dental services, the increase in spending was considerably higher in the Family Care CMO counties. For all acute care services, average monthly expenditures increased 25.2 percent in the CMO counties, compared to 12.1 percent in the remainder of the state.

Lewin also measured the cost of Family Care by comparing average pre-Family Care expenditures to capitated payments made to the CMOs. In addition, Lewin examined expenditure changes

among target populations. These analyses were conducted on a county-by-county basis, as well as at the state level. Lewin found:

- Statewide, expenditures for the elderly increased 21 percent; however, in the CMO counties, expenditures for this group increased 29 percent,

- Statewide, expenditures for the physically disabled decreased 13 percent; however, in the CMO counties, expenditures for this group increased 15 percent,

- Statewide, expenditures for the developmentally disabled increased 14 percent; however, in the CMO counties, expenditures for this group increased 24 percent.

The county-by-county analysis yielded other significant results. For example, expenditures for the elderly in the La Crosse CMO increased 61 percent, while expenditures in the comparison county, Manitowoc, increased 28 percent. In contrast, expenditures for the elderly in the Fond du Lac CMO increased 24 percent, while expenditures in the comparison county, Waupaca, increased 47 percent.

Comparison of Community and Nursing Facility Costs

Comparing Family Care expenditures for care in the community to costs associated with care provided in nursing facilities was an important goal of this evaluation, and the report compares spending for long-term care services in the community to nursing facility spending at three levels of care: intermediate; skilled nursing; and intensive skilled nursing. Lewin noted that more data on service costs per individual are available for Family Care participants than for individuals in nursing facilities, and the data on individuals' functional status are collected using a different methodology for Family Care than for nursing facilities. Lewin addressed these issues by developing comparable functional measures and using various proxy measures to make cost comparisons.

Lewin found that expenditures were lower for community care services under Family Care than for nursing home care. When functional status was considered, average spending for long-term care services in the community was 74.3 percent of nursing home spending. However, if level of care was considered, the difference diminished as the level of care increased. At the intermediate level of care, average community costs were 49.8 percent of nursing home costs: $1,048 per person per month in the community, compared to $2,104 in a nursing home. At the skilled nursing level, average community costs were 65.3 percent of nursing home costs: $1,658 per person per month in the community, compared to $2,538 in a nursing home. Finally, at the intensive skilled nursing level of care, average community costs per month were 95 percent of the average nursing home costs: $2,827 per person per month in the community, compared to $2,976 in a nursing home.

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State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

JUL 15 2003

July 15, 2003

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

I am writing to offer the Department of Health and Family Services' response to the report released today by the Legislative Audit Bureau concerning the Family Care program. The report, *Wisconsin Family Care Final Evaluation Report*, was prepared by The Lewin Group and represents the first complete independent evaluation of the effects of the Family Care program. Family Care is a critical component of Wisconsin's efforts to control costs and ensures quality in long-term care for the elderly and adults with physical or developmental disabilities.

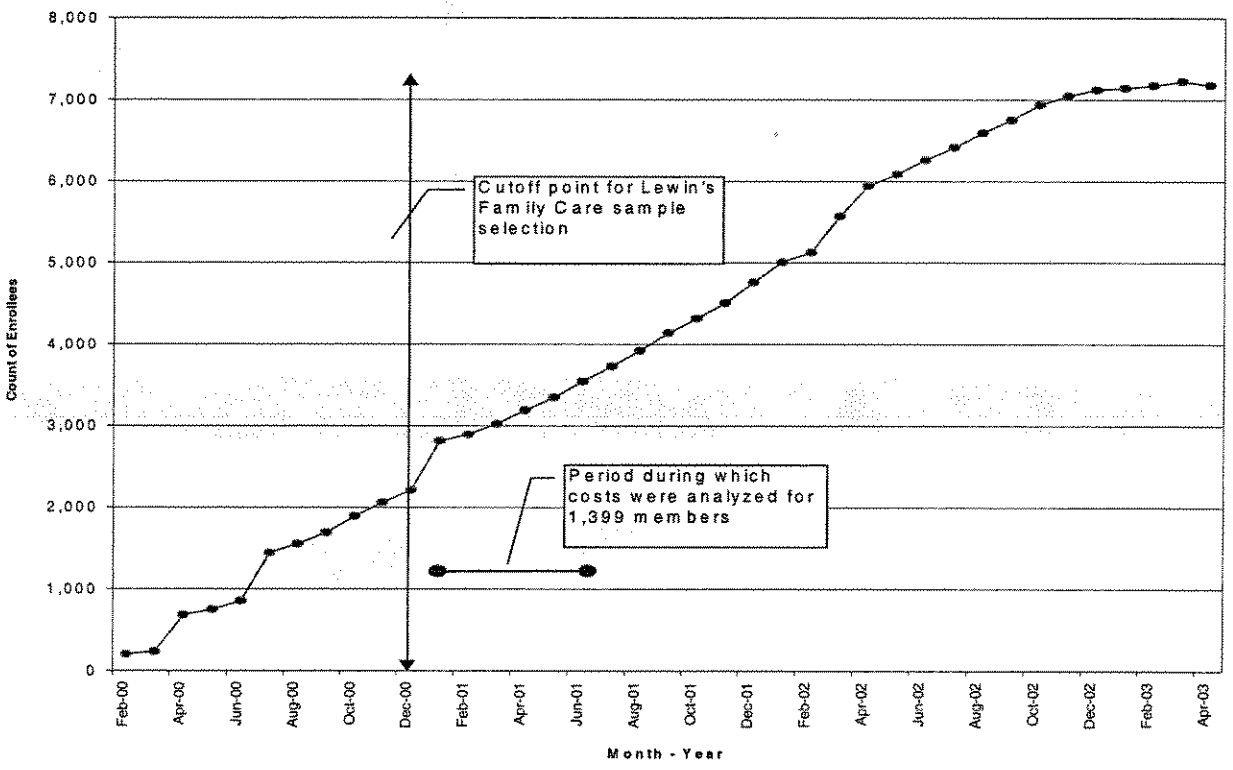
We recognize the challenge The Lewin Group faced in striving to identify meaningful program results in the early stages of implementing such a complex program. The Lewin Group exercised appropriate care to avoid inappropriate extension of any findings from those early stages to the present or to the future. For example, in its conclusions on page 109, the Lewin Group notes that "the spending data available...for this report reflected only the first year of the program's implementation and as a result failed to capture the ultimate impact of the program."

Nevertheless, The Lewin Group found, even in its early stages, that Family Care has been successful in achieving many goals. The Lewin Group concluded:

- Family Care has substantially met the goals of increasing choice and access and improving quality through a focus on social outcomes;
- Family Care has successfully eliminated the waiting lists in the Family Care counties;
- Family Care has improved access to long-term care information for the target populations, in part because outreach activities of the Resource Centers "have moved beyond the traditional approaches;"
- Virtually all of the Resource Centers have met or exceeded Department standards for contacts per capita for all target groups; and
- Consumer choice, and consumer satisfaction with choices available, have increased under Family Care, largely as the result of Care Management Organizations (CMOs) taking steps

such as increasing the number of contracted services and increasing the range of service made available in the package of services.

On the important question of whether Family Care has been a cost-effective approach to providing quality long-term care services, The Lewin Group could not be conclusive because the analysis it performed was "too early to draw conclusions regarding the program's ability to create a cost-effective system for the future." The study's cost-effectiveness analysis was limited to costs incurred in the first six months of 2001 and to only those members who had enrolled by the end of 2000 -- two and a half years ago. Below is a graphic illustration of the study period within the experience of the Family Care program.



The Lewin Group reports some encouraging signs:

- Average CMO spending for new enrollees -- those who had not been served in the waiver programs before joining Family Care -- was 58 percent of the average amount that CMOs spent on enrollees who 'rolled over' from the existing waiver programs into Family Care;

- The increase in per-person CMO spending during the 2001 study period was greater than that in the balance of the state, but was comparable to spending increases in four 'matched' counties operating traditional waiver programs; and

- Family Care is less expensive than care in nursing facilities, when costs are compared for each level of care. For example, for enrollees at the skilled nursing level of care, community-based care was 65.3% of nursing-facility care for similar individuals.

As noted on page 109, The Lewin Group concludes that the study's findings are largely mixed, and results depend on the data being compared and on assumptions made.

Furthermore, per-person spending increases reported for individuals included in the Lewin study did not occur in subsequent years or for the whole Family Care membership. The Lewin Group notes on page 95 that "since 2001, none of the CMO monthly capitation rates have increased more than three percent annually, and Portage County saw a 5 percent decline in rates in 2003." Capitation rates represent the actual per-person cost of Family Care to the State's Medicaid budget. These rates -- including the first-year rates -- were set based on the CMO members' previous years' costs, as verified by an independent actuary, plus a small inflation adjustment. Given these limited rate increases since 2001, if costs had increased at a double-digit pace as report for the six-month period studied, the individual CMOs would have lost money, and the CMOs would be experienced serious financial troubles. In fact, operating within these capitated rates, all five CMOs have had revenue in excess of costs.

Care management organizations are a new type of business for Wisconsin's counties, and managed long-term care is a new product. As with any new business delivering a new product, the CMOs could not be expected to reach their full potential for cost-effectiveness promptly after their creation. CMOs have developed many mechanisms to control costs and achieve cost-effectiveness. It is important to emphasize that Family Care was designed to achieve cost-effectiveness in two stages. Only the first stage -- high-level changes in the Medicaid long-term care delivery system -- had been largely completed by June 2001 at the end of Lewin's study period. During this stage, CMOs had been created and given authority to manage a wider range of long-term care services. The Family Care program had established a funding arrangement of flat capitated payments for each member that places the CMO at risk for financial losses if the CMO does not deliver services economically, rather than the State Medicaid program.

The longer, second stage of systems change occurs as the local organizations respond to the new incentives by adopting new business practices for the delivery of cost-effective managed long-term care. This second stage was just getting underway in June 2001 and is not yet fully completed. While there is still room for improvement, we believe the cost-effectiveness of the Family Care CMOs has improved since the close of the Lewin study period. The CMOs have been responding to the new incentives and business environment by changing many business practices. Some of the many changes include:

- Family Care care management teams include nurses who monitor members' health, coordinate services with the members' medical providers, and support the members' caregivers to prevent or delay functional decline requiring more costly care.

- Family Care care management teams use a decision-making tool that guides care-planning decisions to consider both cost and effectiveness.

- CMO fiscal and client-service staff work together with the care management teams in making cost-effective decisions.

- CMOs have increased incentives and ability to negotiate rates and service quality standards with the providers from whom they purchase services for their members. CMOs have created a more competitive local market for long-term care services and increased accountability for providers.

- The CMOs are developing improved internal management reports, more flexible personnel practices, better ways to identify and correct unauthorized purchases, improved collection from third-party payers, and other techniques to manage risk and costs.

Finally, we recognize legislative interest remains high in determining Family Care's success in achieving cost-effectiveness goals. Because it had to focus on the early years of program implementation, the Lewin Group study simply could not be conclusive on this point. However, the Department will be able to provide the Legislature and the general public with more current information and analysis of the results of the Family Care program later this year. We have contracted with APS Healthcare, Inc., to perform an independent assessment of Family Care's cost-effectiveness, as required by the federal Centers for Medicare and Medicaid Administration. This analysis, which will be released in September 2003, relies on cost data through 2002 and is making extensive use of comparison methods that adjust for differences in the level of care needs among individuals, so that the costs of serving Family Care members can be compared to groups of people who are matched in age, disability level, and other factors.

In conclusion, we appreciate The Lewin Group's extensive analytical efforts and thoughtful conclusions about the early stages of Family Cares' implementation and results. We also appreciate the continued legislative interest in, and support for, the Family Care program. Wisconsin needs to find a way to reform long-term care so that the growing needs of the target populations are met in a cost-effective manner. Forthcoming analyses should contribute to determining the extent to which Family Care has made progress in achieving this goal.

Sincerely,

Kenneth Munson
Deputy Secretary

State of Wisconsin | LEGISLATIVE AUDIT BUREAU

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Audit Report on Assisted Living Family Care in FDLCO is the watchdog. Mnp Q's change practices Local oversight.

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

In its authorization of the Family Care pilot program in 1999 Wisconsin Act 9, the Legislature also directed the Legislative Audit Bureau to contract with an organization other than an agency of the State to evaluate the pilot program. Under the terms of a contract with the Audit Bureau, The Lewin Group, Inc., has completed its third report on implementation of the Family Care pilot program. The first two implementation reports were released in November 2000 and November 2001. In early 2003, The Lewin Group will also provide a report on the program's outcomes and cost-effectiveness. A final implementation report is expected in June 2003.

Lewin to

Family Care is operating as a pilot program, under the terms of federal waivers, in nine counties. Jackson, Kenosha, Marathon, and Trempealeau counties operate Resource Centers, which provide information and assistance concerning services and program operations to both consumers and providers of long-term care services. Fond du Lac, La Crosse, Milwaukee, Portage, and Richland counties operate both Resource Centers and Care Management Organizations (CMOs), which coordinate care and manage capitated payments for those determined eligible for the Family Care benefit. Eligibility is limited to the elderly and adults with physical and developmental disabilities whose financial and functional status meet established criteria.

This third implementation report notes the progress made in implementing the Family Care model in the pilot counties, as well as issues the State and the counties will need to address as program expansion is considered. For example, to ensure unbiased information is available to consumers making decisions about long-term care services and to comply with federal requirements, a Family Care enrollment consultation function was established in 2002 in each of the five counties operating CMOs. The number of inquiries to Resource Centers continues to exceed goals established by contract, and CMOs have worked to expand the availability of service providers to better meet their members' needs. Finally, waiting lists for home and community-based waiver services have been eliminated in each of the five counties operating CMOs. Total program enrollment has increased from 5,485 in March 2002 to 6,302 by July 2002, with over 97 percent of these enrollees eligible for Medical Assistance.

We appreciate the cooperation and courtesy of the Department of Health and Family Services and the many county staff, citizen members of local long-term care councils, and provider representatives who have worked with The Lewin Group throughout the evaluation process. This third implementation report is available on our Web site at www.legis.state.wi.us/la or can be obtained by contacting our office at (608) 266-2818.

Sincerely,

Janice Mueller
State Auditor

JM/KW/bm

Enclosure

FAMILY CARE PILOT PROGRAM

Family Care was created in 1999 Wisconsin Act 9 as a redesign of the State's long-term care system. The program, which is administered by the Department of Health and Family Services, is currently operating as a pilot program in nine counties. Its goals include eliminating problems related to long-term care, such as a perceived bias toward institutional care, and streamlining a fragmented array of funding streams for services. The Family Care model creates two new community organizations: Resource Centers to provide "one-stop shopping" for information and assistance for the elderly and the physically and developmentally disabled, and Care Management Organizations (CMOs) to help arrange and manage services for those determined eligible for program services. The program also uses managed care principles, including capitated payments, in an effort to help control costs.

The legislation authorizing Family Care required an independent evaluation of the program to be administered by the Legislative Audit Bureau. In 1999, the Lewin Group was awarded a contract for this evaluation. The Lewin Group has submitted its third report on program implementation, and we have summarized its findings. A report from the Lewin Group on the program's early outcomes and cost-effectiveness is expected in early 2003.

Infrastructure Development

The Lewin Group report notes that enrollment in the Family Care program increased from 2,875 in March 2001 to 5,485 in March 2002, or by 90.8 percent, and is expected to increase throughout 2002 in all five counties with a CMO. Lewin reports that staffing levels in the pilot counties also increased, from 344.9 full-time equivalent (FTE) positions in March 2001 to 425.3 FTE positions in March 2002, or by 23.3 percent. Additional staff include CMO case management and fiscal staff, and Resource Center information and assistance (I & A) workers.

Information technology systems continue to evolve to support Resource Center and CMO functions at the county level. Lewin's November 2001 implementation report detailed the approach taken by each county to meet its information technology system needs. In this report, Lewin describes counties' progress with building information technology systems, noting variations among the counties. For example, La Crosse County is in the planning stages of automating claims processing; Portage and Fond du Lac counties are planning to integrate case notes, prior authorization, and some billing and claims processing; and Richland County has plans to integrate its systems within the next two years.

At the state level, the Department introduced a Web-based system for completing functional eligibility assessments in October 2001. Although this system creates the potential for improved coordination among Resource Center, Care Management Organization, and other staff involved in the pilot program, Lewin reports that confidentiality concerns among the counties have limited the degree of information sharing.

Governance

Implementation of an enrollment consultant function marks a significant infrastructure change that is intended to address governance concerns. The consultant is to provide unbiased

information to participants about their long-term care choices. In January 2002, the Department contracted with the Southeastern Wisconsin Area Agency on Aging to provide 3.0 FTE staff to implement the consultant function in the five CMO counties. The Department reports that funding for these positions was reallocated from the Resource Center budgets. Each county has developed a unique way to incorporate the consultant into the enrollment process. Lewin indicates that it is too early to comment on the effectiveness of the consultant on Family Care, but notes some preliminary concerns. For example, some county staff reported that participants were confused by the number of individuals temporarily involved in their care before a long-term care manager was assigned. There is also a concern that different processes in each county will be difficult to manage if Family Care is expanded statewide in the future.

Lewin also notes some concern with whether the annual recertification of participants' functional and financial eligibility by the CMOs creates incentives for the CMOs to retain only low-cost participants. The Department notes that CMOs are required to monitor the results of the recertification process, thereby guarding against manipulation of the system, and that its own staff reviews automated reports that identify questionable recertification results.

Finally, Lewin reports a number of concerns related to the role of participants in Family Care governance. For example, some advocates are concerned that the statutory definition of consumer representation used to appoint individuals to local long-term care councils and to the state long-term care council is overly broad and does not ensure effective representation of participants' interests. Lewin reported in November 2001 that the counties had met their contractual obligations to include participants on Resource Center and CMO governing boards and notes in this report that the Department has received $32,000 from a federal grant to improve, through the use of training materials, the capacity of program participants to serve on these local boards.

Access to Services

Lewin reports that the transition from the Community Options Program (COP) and other community-based services to Family Care has been completed. Further, waiting lists for program services have been eliminated.

Excluding Milwaukee County, where Family Care is limited to the elderly, 46 percent of CMO enrollees as of March 2002 were elderly, 34 percent were developmentally disabled, and 20 percent were physically disabled. Including Milwaukee County, 74 percent of CMO enrollees were elderly. Family Care is not limited to Medicaid-eligible individuals; rather, it is to be available as an entitlement to individuals who are functionally and financially eligible once the CMO has been operational for two years in their county of residence. In practice, however, 97 percent of enrollees are Medicaid-eligible. Lewin notes that between October 2001 and August 2002, Family Care was not available to non-Medicaid-eligible individuals in Fond du Lac, La Crosse, Portage, and Milwaukee counties because available funding was limited. In August 2002, the Department reinstated the ability of Family Care counties to enroll certain non-Medicaid-eligible individuals.

Choice is an important principle of Family Care, and participants reside primarily in the community; only 5 percent of Family Care participants reside in nursing homes. Since the start of 2001, 123 Family Care participants have been relocated from nursing homes to alternative

community settings. Lewin also reports that 348 individuals enrolled on June 30, 2001, had disenrolled by June 30, 2002, and that two-thirds of these disenrollments were the result of deaths. At a later date, Lewin hopes to quantify the number of individuals who disenroll while residing in nursing homes. Nursing home providers have reported that some individuals have been disenrolled from Family Care when it has been their preference to reside in a nursing home.

Contracts between the Department and the nine Resource Centers contain goals for contact with the three target populations. While most goals have been exceeded and reported contacts continue to increase, two of the nine pilot counties - Kenosha and Marathon - did not meet the contact goals for the developmentally disabled population.

Care Management, Consumer Direction, and Quality

Care management in Family Care involves forming and operating multi-disciplinary care management teams, honoring participant preferences for care, ensuring advocacy for participants' preferences, ensuring high-quality services, and monitoring caseloads. Lewin reports that the counties are continuing to adapt to the managed care model and that a private foundation grant of $98,600, matched by Medicaid funds, has enabled the development of an orientation manual to assist county staff in these new tasks. Since the 2001 report, participants have been added as members of each care planning team; a social worker and a registered nurse are also required members of the team.

Lewin reports that caseloads for social workers and registered nurses varied across the counties. For social workers, caseloads ranged from 30 to 50 for elderly or physically disabled participants and from 30 to 45 for developmentally disabled participants. Lewin reports that caseloads for registered nurses remain high; in May 2002, they ranged from 55 in Richland County to 120 in Milwaukee County. No county met its goal for caseload size for registered nurses.

Family Care requires consideration of cost-effectiveness of service delivery, participant preferences, and quality. The Resource Allocation Decision method includes a clinical tool, developed by the Department, that balances participant preference and cost in making long-term care decisions. Lewin reports significant training in the use of this method in the past year, although some advocates reported complaints related to service reductions near the time that counties began using the method consistently. Care planning has also changed in the past year as all CMOs, with the exception of Richland County, are offering a self-directed care option. Lewin reports that the Department is working with the counties, with additional federal grant funds, to reconcile the challenges inherent in having participants manage their own care in a "managed care" program model.

Another area of change in the past year has been advocacy. Internal advocacy positions have been developed in the CMOs, but an external, independent advocate program was eliminated in October 2001. Lewin notes that elimination of the independent advocate may reduce the influence of the advocates in shaping the future of Family Care.

Participant outcome interviews are being used in each county to help improve quality of care. The Department has conducted two rounds of interviews, including 847 Family Care participants and their care managers. These outcome interviews will be continued. Lewin advises the

Department to consider adjusting the resulting reports to reflect the participants' care needs and the services they received, noting also that changes in the Department's administration of the first two rounds of surveys prevented a comparison of the results from those rounds. Lewin also notes the Department has entered a contract with an external, independent organization to monitor quality.

Cost-Effectiveness and Outcomes

Lewin reports that it will use two comparison groups in its upcoming analysis of the cost-effectiveness and outcomes of Family Care: counties that have long-term care systems similar to those of the CMO counties, and the remainder of the state. Challenges noted by Lewin in conducting the cost-effectiveness analysis include capturing all costs and quantifying benefits derived through the program. Lewin recommends to both the Legislature and the Department that costs and outcomes continue to be collected and analyzed, and it cautions that data will be reliable only if they are accurately reported by the counties and CMOs.

Lewin notes several challenges in identifying the full costs of Family Care. Costs are incurred at several levels, including participant payments, county support, state funding, and federal Medicare and Medicaid expenditures. Furthermore, capitated rates for the CMOs do not include county start-up costs, the Department's staffing costs, or Medicare and Medicaid expenditures for prescription drugs, physician or dental visits, and several other services. For nursing homes, there is no variation in rates, so a point of comparison for individual Family Care participants is not available. Benefit identification is similarly challenging, as the functional information collected for all participants is not precise.

Future Considerations

Lewin concludes that commitment, cooperation, and trust among state and county staff have been pivotal to Family Care and will be necessary if the program expands in the future. Lewin identifies several issues that will need to be addressed in the future, including how necessary technical assistance will be provided; whether economies of scale will necessitate a regional approach in less-densely populated areas; and whether there are options for partnerships with providers or other organizations to meet federal competition requirements.

Lewin also notes steps the Department has taken to implement new practices in non-Family Care counties, based on lessons learned in the pilot counties. For example, the Web-based functional screen is being used in non-Family Care counties and will make comparative, individual-level data available. The Department has also drafted a readiness assessment to use in determining the adequacy of information technology for the Family Care program.

APS Healthcare Report – DHFS

CMO and Resource Center Counties: Fond du Lac, La Crosse, Portage, Richland and Milwaukee
Resource Center only Counties: Jackson, Kenosha, Marathon and Trempealeau
(give info on services but do not offer Family Care eligibility testing or enrollment)

- APS Healthcare prepared the report for DHFS on the waiver that was granted by Centers for Medicare and Medicaid (CMS) to WI to operate Family Care from January 1, 2002 to December 31, 2003.
- Center for Medicare and Medicaid Services (CMS – where received waivers from) requires an Independent Assessment of the Family Care program be conducted and the findings submitted as part of the Department's waiver renewal requests. (pg. 7)
- September 2002 DHFS contracted with APS Healthcare with the goal of the Independent Assessment is to describe the impact the Family Care program has had on long-term care services in Wisconsin in terms of access to services, quality of services, and cost effectiveness.
- September 2003 report sent with renewal.
- CMS requires all waivers to have an independent assessment of access, quality and cost-effectiveness.
- 1999 WI Act 9 authorized DHFS to operate Family Care Program. Has 2 waivers from Center for Medicare and Medicaid Services (CMS) (pg. 7)
    - 1915(b) waivers
        - one for individuals age 60 and over in Milwaukee County
        - one for adults in other 4 pilot counties
        - allows DHFS to limit the provision of long-term care services in those counties to individuals who enroll in a CMO using a Resource Center ("central broker")
        - Approved January 1, 2002 for two years
    - 1915(c) waivers
        - one for individuals with developmental disabilities
        - one for individuals with physical disabilities
        - allows DHFS to provide home and community based services, in lieu of institutional placement, for individuals with long-term care needs that would qualify for Medicaid funding in a nursing home.
        - Approved June 1, 2001 for three years
    - Through waivers DHFS is able to pay a pre-paid capitation amount to CMOs who are responsible for providing services in the Family Care benefit are needed by the members.
- CMO implementation of Family Care was completed during CY 2000, thus primary focus of this assessment is CY 2002. (pg. 7)

- Family Care Goals
    - Provide individuals better choices about their living arrangements and services they receive; improve access to services; improve quality of care including an emphasis on both health and social outcomes; and establish a system that will be cost-effective into the future.
    - Reduce complexity of system in order to improve access to services
    - Combined, coordinated system of long-term supports, rather than a system made up of discrete separate elements
    - Individuals are entitled to both community-based supports and institutional care, so that they may find the balance that best meets their needs over time (pg. 9)

- Evaluation may be limited or constrained by start-up issues with any new initiative.

- APS analyzed data collected directly by the DHFS, the Family Care programs External Quality Review Organization (EQRO), the Family Care Care Management Organizations (CMOs) and independently gathered info.

- Aspects and activities of Family Care program are successfully contributing to access, quality and cost-effectiveness and what areas are in need of improvement.

INTRODUCTION

1. ACCESS TO CARE
   A. Screening – WI Long Term Care Functional Screen is an accurate, reliable and validated instrument for assessing eligibility and assess level of care needs.
   B. Entry Into Program – "Enrollment Consultants" (3rd party) ensure members or their representatives fully understand aspects and eligibility with the program or any other long-term care services.
   C. Elimination of Waiting Lists – Eliminated wait lists in the CMO counties by the end of CY 2002. Waiting lists in CMO counties were eliminated while wait lists for non-CMO counties continued to increase and cause waits that could be months or years.
   D. Access Monitoring
      – Access monitoring activities need to be strengthened. DHFS has not routinely monitored the 30-day enrollment requirement. Recommend DHFS develop routine reports to monitor access county-by-county basis. (pg. 2)
      - CMO's appear to meet requirements for health services and performance standards. Limited documentation made it difficult to fully assess. EQRO evaluated service and access through care plan reviews and CMO's sufficiently meet requirements.
   E. Services within the Program – may have increased number of providers participating. Info gathered through site visits and mtgs overall providers are joining the network, retained and meet traditional and unique service needs.
   F. Patterns of Service – (detailed in cost-effectiveness section)
      - No change in emergency room frequency of use – no significant reduction in visits
      - Seems to have decreased the frequency of visits to physicians – pre vs. post analysis indicated significant reduction of visits. Although less likely to see a physician, those who did tended to be in the program longer and it is
      - Hospital lengths of stay decreased – no change in hospital admissions, but length of stay significantly decrease following enrollment
   G. Exit from program -
      April 2003 Resource Centers implemented a new process to record a single, primary reason for disenrollment.
      CY 2000 – 2002 disenrollment was high - over 14% (including deaths). But, if deaths were excluded the rates were cut nearly in half
      DHFS must continue to develop strategies to better track and understand reasons for disenrollments. Suggested DHFS utilize historical disenrollment data to identify and address disenrollment trends (red flags) that deviate from normal trends DHFS conduct routine surveys for individuals who both voluntarily disenroll and who lose eligibility to better assess patterns. (pg. 3)

2. Quality of Service
   A. Overall quality strengths
      1. All 5 CMOs demonstrate "member centered" – give members opportunity to have active role in decision-making regarding long-term care and health services to live independently as possible.

2. Care managers are creative and flexible for trying to get most appropriate level of service.

B. Quality monitoring
   1. 4 of 5 CMOs able to resolve all outstanding issues within 3 reviews of their Member Centered Assessment and Plan Reviews (MCAP).
   2. Grievance and appeal data does not reflect full amount of complaints made. DHFS analyzed only complaints filed at regional offices; they plan to look at complaints in CMO log books and filed with DOA Fair Hearings.
   3. CMOs have great levels of flexibility and autonomy but have problems with record keeping and data utilization.
      They can be effective and creative but DHFS lack of specificity on reporting and record keeping has resulted in CMOs operating differently in records. Two examples are info for Family Care Enrollment Consultant and record keeping contractually required performance measures. (pg. 4)

C. Member Outcomes
   1. In the member outcome interview survey members report high levels of "self determination and choice" and "health and safety" outcomes and supports. Lower levels are reported in "Community Integration" but expect lag given a fundamental principle of program to provide ways to reintegrate institionalized individuals back into the community.
   2. More time spent in program greater presence of outcomes and supports being present.

D. Members Health and Functioning
   1. Potential to reduce costs by improving health care and health outcomes – members saw significant decrease in institutional settings and significant reduction in functional status impairment.

3. Cost-Effectiveness

A. Payment Methodology – capitation and rate setting process has been continually improving since inception to more accurately reflect the population covered and the services provided under the program.

B. Individual costs

- In the 4 non Milwaukee County CMO counties, the total long term care costs increased less than the statewide comparison group. If Milwaukee CMO is included, the slower growth in costs is not apparent.

-From pre to post enrollment, members experienced increases in spending and utilization rates for Home Health Care visits – increases significant relative to statewide comparison group with Milwaukee CMO included or not.

- Inpatient hospital and dr. office visit costs went down for members but increased for the comparison group during study period.

-Prescription drug costs increased more for members than comparison group over study period. When looking at all 5 CMOs prescription drug costs increased $34 PMPM more than comparison. The 4 non-Milwaukee CMOs drugs decreased $31 relative to comparison group.

-Geographic differences account for amount of change observed in spending and utilization. Milwaukee CMO illustrated very different findings from other CMOs that tended to show more consistently when compared to one another.

C. Source of Cost Savings

- Members in 4 non Milwaukee CMO saw significant decreases for Personal Care and Residential

care services compared to comparison group (collective decrease of $175 PMPM for personal care and $98 PMPM for residential care services). The Milwaukee CMO saw a significant increase of $90 PMPM on residential care and no significant change for personal care costs.

-Members saw post-enrollment costs and utilization reductions in ICF-MR days. APS determined that costs ($62 PMPM) and utilization rates (.28 days PMPM) declined for this service from pre to post enrollment periods compared to comparison group.
-again mentioned, family care has the potential to effect cost savings through improved member health care and health related outcomes. Members saw significant reductions in institutional settings and significant reductions in functional status impairment.

Family Care Program Overview

- program success rely on "buy in" of providers serving individuals in 5 CMO counties
- Resource Centers
  - primary point of entry for accessing long-term care services in 9 counties
  - Provide information, advice, access to full range of resources, performing functional and financial screening that is required to determine eligibility for certain services in Family Care.
- Care Management Organization (CMO)
  - Purpose of managing the Family Care benefit at the county level
  - State and federal funding from a variety of services are combined into a single capitated payment to the CMO.
  - CMO responsible for providing all needed long-term care services covered by the Family Care benefit.
  - Primary and acute services, including physician and hospital services are not included in Family Care package and remain available as a Medicaid fee-for-service benefit.
  - CMO contracts with service providers to form its Provider Network for services.
  - Allows member to arrange, manage and monitor services in Family Care benefit package directly or with the assistance of another person chosen by the member.
  - Participants work with CMO to choose from the whole range of long-term care options, including both the type of care and setting (individual's home, community residence, institution) and to coordinate health care services.
  - Arrangement focuses on needs of the member, rather than be limited to traditional service systems.
  - Cover approximately 29% of all individuals statewide who would be eligible for Family Care
  - Older adults, persons with DD and PD are served in 4 of 5 counties, Milwaukee currently only serves older adults
  - August 1, 2003 7,474 individuals cumulatively enrolled in Family Care from all 5 counties
  - Over 50% of WI's Family Care members reside in Milwaukee County
- Enrollment Consultants
  - DHFS contracted with SE Area Agency on Aging to carry out this service
  - Ensures potential members fully understand the implications of participating in a managed care program and provides these individuals with information about all available options for which they are eligible, Family Care or otherwise.

A. Eligibility Criteria

- CMO serve 3 primary target groups who have a long-term condition expected to last for more than 90 days
- 3 target groups:
  - Frail Older Adults (65 years+/60+ Milwaukee)
  - Adults w/Physical Disabilities (17 years/9 months+)
  - Adults w/Developmental Disabilities (17 years/9 months+)
- Financial Eligibility:

- Anyone who qualifies for Medicaid meets the financial eligibility criteria for Family Care. Individuals who are not financially eligible for Medicaid may still qualify based on their cost of care needs.
- Most, but not all, individuals who are eligible for Family Care will be eligible for Medicaid.

- Functional Eligibility:
  - Pg. 11-12 lists conditions individuals must meet including activities of daily living (ADLs)

B. Eligibility Determination Process

- 3 step process:
  - Resource Center trained staff completes Long-Term Care Functional Screen to assess need for service and functional eligibility. Resource Center provide advice about options including Family Care
  - If interested in Family Care person will get help contacting Economic Support Unit. ES makes final eligibility determination for Family Care and Medicaid.
  - Once functional and financial eligibility determined Resource Center has the Enrollment Consultant call the person by phone or person and consult. If person pursues Family Care membership, Resource Center completes enrollment process and notifies CMO of enrollment date.

C. Quality Assurance – Quality Improvement

DHFS established following member personal outcomes for measuring quality:

- Self-determination and choice outcomes
- Community Integration Outcomes
- Health and Safety Outcomes

Outcomes are measured through member and case manager in-person interviews:

- 3 rounds of interviews have been completed to date. The 3rd round of 491 members was completed May 2003, 4th round began July 2003.
- CY 2002 quality indicators included measuring the turnover of care management staff and immunization rates for influenza and pneumonia. These indicators provide information as to how the CMO is doing in achieving specific member outcomes such as continuity of care and best possible health.
- CMO's must conduct one Performance Improvement Projects (PIPs) annually and be on one program participant outcome. CMO must then develop specific, quantifiable outcome indicators to measure the progress of their performance in the context of this project. Further, they are required to demonstrate improvement by the end of the following year.
- In 2002, 436 care plans were reviewed, including plans of 101 new members, 185 continuing members and 150 identified as high-risk members.
- On-site reviews are conducted by DHFS staff prior to an initial contract with a CMO and as a condition of annual contract renewal which focuses on the CMO's quality assurance/quality improvement program.
- 2002 5 quality site visits took place and CMOs have been implementing the Department's recommendations for improvement.
- Ongoing quality assurance - Department staff and consultants provide technical assistance to both CMOs and Resource Centers on an as-needed basis.

FAMILY CARE MEMBER CHARACTERISTICS

A. Initial Long-Term Care Functional Screens Completed by Target Group

- Not all individuals who are screened are found to meet Family Care financial and functional eligibility criteria.

B. Total CMO Enrollment by Target Group

- Implementation dates by county are on pg. 18
    1. Resource Centers screened and CMOs enrolled those participating in a long-term care waiver program.
    2. Enrolled those on waiting lists for long-term care waiver services
    3. Individuals seeking publicly funded home and community based long-term care for the first time
- During CY 2002 all 5 CMOs completed their waiver conversions and enrolled everyone on their waiting lists into Family Care.
- Initially the majority of the individuals enrolled in Family Care outside of Milwaukee County were individuals with developmental disabilities. Proportion of elderly members has significantly increased over time as the Milwaukee CMO became operational.

C. Most Commonly Occurring Diagnoses

- page 20 has a chart – hypertension is the highest 51%

D. Demographics

- Just over 2/3 in July 2002 were women (70.2%) with a mean age of 74 years.
- Males had a mean age of 64
- Milwaukee had a much higher percentage of its members who were dually eligible for Medicaid and Medicare in the six months prior to their enrollment (92 percent) compared to 74 percent in the non-Milwaukee CMO counties.
- Physical disabilities enrollment rose slightly between 2000 and 2001 and substantial gain in 2002 (29.7, 31.2 and 39.1 percents, respectively)
- Elderly members had steady state of enrollment growth during this three-year period (21.2, 35.7 and 43.0 percents)
- Developmentally Disabled members experienced rather sharp declines over this same timeframe (52.1, 31.8, and 16.1 percent).
- Milwaukee CMO, enrolled members in July 2000, encountered a steady rate of increase in its enrollment through 2002.
- Non-Milwaukee CMOs (3 of the 4 began operations before Milwaukee) experienced a sharp drop among the Family Care population enrollment from 2000 to 2001

Access to Care:

- Accomplished one of its primary goals with elimination of the waiting lists in all CMO counties by the end of CY 2002.
- Resource Centers required to have a Family Care access plan
    - LTC functional screen for eligibility
    - Financial options counseling
    - LTC options counseling
    - Refer to appropriate provider if urgent services are needed
- CMO (in terms of access)
    - Enrollment kept open to all who meet eligibility requirements
    - Provide the services an eligible member qualifies for
    - Coordinate services with other services
    - Coverage 24 hours, 7 days a week
    - CMO employee designated as member advocate
    - Interpreter service must be provided
- CMO (in terms of service providers)
    - Allow free choice of providers for service that relate to intimate personal needs or when a provider frequently comes into a member's home
    - Maintain contractual agreements with network of providers and must meet state requirements
    - Pay family members under certain conditions
    - Maintain cultural competence promoting

- State Monitoring of CMO Access Standards
  - CMO required to perform needs assessment for its provider network
  - DHFS can ensure full range of covered services will be available to members
  - DHFS shares findings from review with the CMO
  - DHFS conducts site visits annually to evaluate the functioning of the CMO
  - DHFS utilizes regular CMO monitoring reports to share status of access and capacity elements of the program
- Access Monitoring
  - Enrollment in Family Care can take no longer than 30 days, from time consumer first expresses a desire to join to date when enrollment is confirmed.
  - State-level staff have highlighted a major challenge to monitoring program access and compliance within a 30 day enrollment requirement.
  - State-level staff do not have access to CARES (client assistance re-employment and economic support) – the only source of info for determining the length of the enrollment process at an individual or aggregate level.
  - **Recommended that DHFS develop routine CARES reports to monitor access to Family Care at a county level. These reports could be generated monthly to identify the minimum, maximum and average time it takes for an individual to be enrolled in Family Care by county. The report should also identify the number of cases pending for enrollment that have been open for more than 30 days so that DHFS can track these cases and provide technical assistance as needed to maximize compliance. (pg. 27)**
- Prevention/early intervention
  - Visits to primary care physicians: In summary, those who did not have a visit to a primary care physician in 2002 tended to be enrolled in Family Care approximately 6 months less time, were about 5 years older, and had slightly higher ADL and IADL counts with a larger percentage meeting comprehensive eligibility requirements.
  - EQRO conducted a literature review to aid CMOs in their prevention and early intervention projects to undertake.
  - 3 primary categories of prevention – programs should cover all 3:
    - primary – prevent the occurrence of disease and promote health
    - secondary – disease management
    - tertiary – promoting as much independent function as possible while preventing worsening of the condition or disease
- Long term care functional screen (pg. 30)
  - Pre-admissions counseling provided by RCs and assess functional eligibility for Family Care participants on an on-going basis
  - CY 2002: 7,043 individuals assessed
    - 70.9% frail elderly members
    - 11.5% developmentally disabled members
    - 9.5% physically disabled members
- Enrollment consultants Value (pg. 31)
  - Charged with protecting the interests of the applicant, cannot be someone who works for the county that operates the CMO
  - DHFS contracts with SE WI Area Agency on Aging (3 FTE staff)
  - Enters process after receiving referral notification from RC or ESU after eligibility has been determined for an individual.
  - Contact is made within 3 days by phone or face-to-face
  - Provides applicant – compares and contrasts the various choices:
    - Outlining aspects of different programs and services
    - Identifying spectrum of services
    - Detailing consumer rights and responsibilities
    - Specifying entirety of publicly funded long-term care program options