

# Wisconsin Department of Health and Family Services

## Second Independent Assessment of Family Care

Report prepared by APS Healthcare, Inc.  
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The Department of Health and Family Services is pleased to release the report of the second Independent Assessment of Family Care, an innovative program of managed long-term care. Family Care began operation in the first of five counties in February, 2000. This report describes the program's effects on access, quality, and cost-effectiveness in 2003 and 2004, its fourth and fifth years of operation. At the end of December 2004, the Family Care program was serving 9,131 enrolled members; for services provided during 2004, the local Care Management Organizations (CMOs) received MA payments totaling \$170.9 million.

The findings of this report are consistent with the two earlier evaluations of the program, a legislatively mandated report on the start-up period (the 'Lewin Report,' released in July 2003) and the first Independent Assessment (September 2003) that described the program's third year of operations. Positive results that were beginning to emerge in the earlier studies are becoming more evident as the local CMOs continue to adopt the management practices of managed care.

The Second Independent Assessment study, performed by APS Healthcare, Inc. under contract to DHFS, found that the CMOs continue to improve the quality of long-term care services for their members. Waiting lists for services have been eliminated for over three years and earlier problems with timely processing of enrollments have been addressed. Achievement of member's individual outcomes remains good, and each CMO has continued to improve cost-effectiveness through improving fiscal management and introducing efficiencies and other cost-saving measures.

Analyses compared Family Care members' health status, health care costs and long-term care costs to those of carefully matched comparison groups of similar individuals receiving fee-for-service Medicaid services in the remainder of the state. The results revealed favorable effects of Family Care on both cost and quality. Family Care produced better results for members' health and levels of functioning, more visits to primary-care physicians, and less use of nursing facilities. While results for individual services are mixed (Family Care increases spending for some and decreases spending for others), Family Care restrained growth in overall long-term care costs and in total Medicaid spending for individuals enrolled in the program.

**Features of the Family Care Program** The Medicaid-funded Family Care program provides long-term care services to eligible adults who have physical or developmental disabilities or frailties of aging. A wide array of long-term care services (see next page) is provided by Family Care, including both nursing facility care and in-home services. Primary and acute health care services are not included among Family Care services, although a registered nurse is on each member's interdisciplinary care management team, or IDT.

Family Care Services include:

- Care management
- Home chores
- Personal care
- Home health care
- Nursing facility care
- Other residential care
- Transportation
- Daily living skills training
- Supported employment
- Equipment and supplies
- Home-delivered meals
- Home modifications
- Other services

When an individual is enrolled in Family Care, the IDT works with the member to identify his or her desired results and create a service plan to achieve those results cost-effectively. The Family Care CMO provides, purchases, or arranges the needed long-term care services, and nurses coordinate these services with the member's primary health care provider.

The CMO receives payment from the state Medicaid program in the form of a flat monthly per-member, or 'capitated,' payment. The amount of these payments is determined through a rate-setting formula based primarily on the cost experience associated with the levels of disability among the particular group of

members served by the CMO. If the CMO delivers care to their members at an average per-person cost that is less than their capitated rate, they retain and reinvest earnings. If the average per-person cost of care provided to their members exceeds their capitated rate, they lose money until they can re-balance costs and revenues.

The capitated rate transfers financial risk from the State, which cannot determine cost-effectiveness of each purchase decision on the basis of the members' individual circumstances, to the CMO, which can. This feature is among the primary differences between Family Care and the traditional home and community-based waiver programs, in which counties are reimbursed for the cost of services and have no financial risk if purchased services are not cost-effective.

**Effects on Quality and Access** Assessing effectiveness of a long-term care program at an aggregate level is difficult for several reasons, not the least of which is that the desired results are an individual experience. Aggregate measures indicating high quality do not serve to comfort the one individual who may be poorly served, or to excuse instances of ineffective care. Comparing quality across programs is also challenging because no definitive indicator of quality is consistently measured across all programs. Nevertheless, findings from the Independent Assessment provide strong evidence that Family Care has succeeded in improving results for its members.

With regard to participating individuals' quality of life, Family Care assesses members' achievement of their personal outcome for each of 14 aspects of quality of life, as identified by consumers, providers, advocates and state staff at the inception of Family Care. The outcomes include living where and with whom one chooses, achieving employment objectives, being respected, being free from abuse and neglect, and others. Family Care's member outcome results cannot be compared to those of the comparison groups, because outcomes are not similarly measured in any of the fee-for-service programs. However, the percentage of Family Care members achieving their desired outcomes has increased over the five years in which it has been measured.

With regard to the health status of participating individuals, Family Care's favorable effects on its members' health can be inferred from findings relating to physician-office visits for primary care and for non-primary care. The Independent Assessment found that Family Care members visit their primary care physician more regularly than their comparison group counterparts, across all counties and target groups. For example, Family Care members of the CMOs outside Milwaukee visited a physician's office 20.6 times on average during the two-year study period, while their matched comparison group had an average of only 14.7 visits. It is likely that this additional attention to primary health care is related to the work of the Family Care nurse care managers, and that it is among the causes of the clear reductions in institutionalization, illness burden and functional impairment that were found in a statistical analysis of Family Care's favorable cost results. The cost-effectiveness analysis also shows that Family Care has a significant effect on hospital inpatient costs, reducing costs over time for all target populations except DD members in the non-Milwaukee counties.

Further evidence of improved health among Family Care is that while Family Care members had more frequent physician office visits for *primary care*, expenditures for *non-primary care* office visits decreased among all Family Care groups except Milwaukee County members with waiver experience before Family Care. It appears that the more-frequent primary care physician visits provided opportunities to increase prevention and early intervention health care services that in turn reduced the need for more acute and costly services among members of Family Care.

The Independent Assessment also found continued improvement and efficiencies in access to long-term care services and supports in the Family Care counties. Provider networks have increased, functional assessments have improved, enrollment has been streamlined and disenrollment tracking is becoming more detailed.

**Analysis of costs** The independent assessment separately examined Family Care's effects on:

- Total Medicaid spending,
- Total long-term care costs (a subset of total Medicaid spending), and
- Costs and utilization for selected individual services.

To meet federal requirements regarding the focus of the independent assessment, the analysis looked separately at Milwaukee experience and at the experience of the other four CMOs considered as a single aggregate unit. This approach is also helpful in that it allows separate focus on the experience (that of the Family Care program outside Milwaukee County) that is most relevant to plans for long-term care reform in the remainder of the state. Additional analyses separately examined results for the members with and without Medicaid participation before enrollment, and for the three target groups (other than Milwaukee, in which enrollment of non-elderly individuals with physical or developmental disabilities was too small to examine with these statistical methods.)

**Effects on Total Medicaid Spending** Average individual monthly Medicaid spending in 2003-2004 for all services—including all types of medical and long-term care—was less for Family Care members in the non-Milwaukee CMOs and for the frail elders served by the Milwaukee CMO than for their matched comparison groups. Specifically, over the two-year study period, average individual monthly Medicaid costs for Family Care members outside Milwaukee were \$452 lower than costs for their comparison group, and costs for members of the Milwaukee CMO were \$55 lower than those for their comparison group.

In addition, a separate analysis using a different technique (a ‘path analysis’) compared costs for the two groups in a way that revealed the sources of the cost savings. The path analysis discovered that Family Care produces savings for total Medicaid costs in two ways:

- Family Care reduces costs *directly* by purchasing or providing services more economically, and
- Family Care reduces costs *indirectly* by favorably affecting Family Care members’ health and abilities to function so that they have less need for services.

**Effects on long-term care costs** Long-term care costs were defined as those that are included in the Family Care benefit package. The analysis compared average individual monthly costs of Family Care members with those of a matched comparison group:

- at the beginning of the study period (‘baseline’), when some effect of Family Care was already evident because many members had been enrolled for a time before the study period,
- over the course of the study period (rate of change), and
- at the end of the study period.

Average individual monthly long-term care costs for Family Care members outside Milwaukee were lower than those of the matched comparison group, both at baseline (\$250 less) and at the end of the study period (\$722 less). For the frail elders served in Milwaukee, average individual monthly long-term care costs were \$1 less than those for the comparison group at the baseline, and \$565 less at the end of the study period. For most of the sub-groups for which costs were separately analyzed, similar results were found; for the remaining subgroup (individuals in the non-Milwaukee CMO with developmental disabilities), the difference was not statistically significant.

**Sources of the Family Care savings** Analysis of expenditures and utilization for individual services revealed some sources of the Family Care savings. Family Care members were found to be relying upon a different mix of services than the matched comparison group. The Family Care CMOs purchased (or prompted their members to purchase, in the case of primary and acute care) more of some lower-cost services and less of other, higher-cost services, with the result that the cost of the total package was lower for the Family Care members.

For example, average individual monthly costs at the end of the study period for the Milwaukee County frail elders’ care in community-based residential facilities (CBRFs)

was \$462 more than that spent for CBRF care for the comparison group. On the other hand, average individual monthly costs for nursing facility care of frail elders served by the Milwaukee CMO were \$1,363 less than those for frail elders in the matched comparison group at the end of the study period.

Similarly, among members of the four non-Milwaukee CMOs, average individual monthly spending for supportive home care at the end of the study period was \$313 more than that for members of the matched comparison group. On the other hand, average monthly Family Care spending for home health care for this group was \$460 less per person, and spending on personal care was \$296 less. This is a direct result of the flexibility in funding provided by the Family Care benefit package. In the waiver programs, where the services are funded from different sources or programs, local agencies must frequently provide a higher-unit-cost service (such as home health or personal care) for some tasks that could be provided through lower-cost services (such as supportive home care) to preserve limited waiver funding and maximize regular Medicaid funding.

Differences between the amount, types, and cost of medical care between the Family Care groups and the comparison groups also indicate that purchases of preventative care and less costly services were replacing purchases of more costly services. For example, frail elder non-Milwaukee Family Care members' average individual monthly costs were \$4 more for prescription drugs and \$22 more for outpatient hospital care than those for their matched comparison group. On the other hand, their average individual costs for inpatient hospital care were \$65 less per month. Similarly, for frail elders served by the Milwaukee CMO, average monthly individual costs for physician office visits were \$11 higher at the end of the study period than those for their matched comparison group, while their average monthly individual costs for inpatient hospital care were \$18 less.

**Selecting cost-effective services** The incentives that Family Care's financial structure has provided to the CMOs have caused them to adopt care management practices and fiscal management practices that differ from those they employed when they operated as fee-for-service waiver programs. An understanding of these differences can help to explain why effects of the Family Care program are still emerging in the program's fifth year of operations.

Care management practices under the fee-for-service waiver programs were shaped by the need to match individuals' needs with services and with funding sources. Before Family Care, they relied on many different funding sources, and at times available funding dictated care plans more directly than did the needs of the consumer. For example, waiver care managers are instructed to maximize reliance on Medicaid 'card services'—services outside the restricted set of waiver services. On occasion, this causes waiver care managers to selected higher-cost services over more economical services.

Care managers within Family Care, on the other hand, are instructed to rely exclusively on the 'Resource Allocation Decision-making' (RAD) method, which directs them to consider the consumer's personally-desired goals, all the possible services that could be

effective in supporting those goals, and to select the service that is most economical for the CMO. While the RAD method seems straightforward, it requires care managers to adopt new perspectives on their work and to access and use cost information in a way for which their pre-Family Care experience did not prepare them. Family Care directors report that consistent, rather than intermittent, attention to costs by both managers and staff of the CMOs is one of the most pronounced differences between their pre-Family Care operations and their current practices.

The Independent Assessment report describes additional care-management practices that have been adopted by CMOs in response to the incentive to control costs, including:

- development and adoption of service-coordination protocols;
- emphasis on preventive care and interventions;
- routine review of ongoing services, particularly those provided on a per-diem basis, to monitor effectiveness and economy; and
- methods to achieve better intra-team communication to improve efficiency and utility of case documentation.

Fiscal management practices employed by these counties before Family Care concentrated on properly documenting expenditures and properly submitting them to the correct funding source. County fiscal managers tended to be uninvolved in long-term care program issues and knew little about the delivery of long-term care or possible economies that could be achieved without damaging quality. For waiver program managers, procurement and contract-negotiation activities were only two of a large number of other responsibilities. When they operated traditional waiver programs, the most direct method of controlling costs was restricting enrollment; eligible individuals could be placed on waiting lists until funds are available.

As Family Care CMOs, however, they do not have the option of placing people on waiting lists; they are required to enroll eligible individuals when they seek enrollment, and thus must find other ways to control costs. CMO administrators point out that the Family Care reimbursement structure has allowed and prompted them to devote more organizational resources to the specific purpose of managing costs, and that these resources have enabled them to identify and implement cost-control practices. Among the newly adopted cost-control practices described in the Independent Assessment are:

- more aggressive negotiation of rates with contracted providers;
- controlling costs for durable medical equipment by aggressively seeking and negotiating lower prices and establishing loan/share arrangements;
- controlling costs for disposable medical supplies by purchasing in bulk and delivering directly to residences;
- employing claim specialists to work specifically on coordination of benefits to maximize reimbursement from other payors, such as Medicare and private insurance; and
- thoroughly reviewing care plans to ensure that amounts and timeframes are clearly specified, and reviewing bills to ensure payment for only authorized services.

**Estimating potential future savings** The results of the IA analysis can be used to estimate the costs associated with expanding Family Care to the remainder of the state. In preparing this estimate, it is the effects on total Medicaid spending cited above that are most important. That is, from the State's fiscal perspective alone, it makes little difference whether one specific service area, or a more general grouping of services, costs more or less. It is the aggregate costs associated with *fully serving* a person that are crucial; this allows for more efficient investments to be made across the primary/acute care and long-term care domains (as was observed in Family Care), as well as within long-term care.

The total savings calculation includes applying the savings above to current and/or potential, future enrollment levels. Total Family Care enrollment at the beginning of September 2005 was 9,396, of whom 5,626 resided in Milwaukee County. It is therefore reasonable to estimate *monthly savings* for the current enrollment levels to be roughly \$1.9 million, based on the savings estimates provided above. In the future, should the program expand, the non-Milwaukee experience will be more reflective of what might happen. This implies that for every 1,000 persons enrolled in an expanded Family Care program, an additional \$452,000 Medicaid dollars would be saved on a monthly basis.

Approximately 10,000 persons are now on the State's waiting list for long-term care services. Some of the savings described above would be required to serve these persons, who currently have little or no access to the services they need. The net cost of expanding Family Care will therefore involve balancing the monthly savings produced by this innovative managed care model with the incremental, new costs generated by serving additional persons who are eligible for the program.