Department response to
Family Care Independent Assessment Report

APS Healthcare, Inc., December 2003

The Department of Health and Family Services is pleased to accept the report of APS Healthcare, Inc., which has served as the independent assessor (IA) for Wisconsin's Family Care program since July 2002. This report, required by the U.S. Centers for Medicare and Medicaid Services (CMS), describes Family Care experience and achievements in 2002 and early 2003, the first and second years of the current waiver authorization and the third and fourth years of the program's operation.

In brief, this report concludes that Family Care is fulfilling its objectives with regard to improving access and assuring quality in all five counties, and that Family Care is restraining long-term care costs and other Medicaid costs in four of the five counties.

The report makes thoughtful and constructive suggestions for additional activities that both the Department and the local CMOs could be doing to ensure and further improve the program's results. The Department is currently engaged with the Milwaukee County Department on Aging, where cost restraint has not yet been achieved, to identify areas for improvement and to develop solutions that will bring results in that county more into line with results elsewhere in the state.

Family Care Program: Background and Goals

The Family Care program was authorized by legislation in 1999, for the purposes of improving access to community long-term care services for eligible individuals, assuring quality of community long-term care, and restraining the Medical Assistance costs of caring for individuals receiving long-term care. The first care management organization (CMO) enrolled its first member in February 2000; Family Care currently provides a comprehensive and flexible package of long-term care services to Wisconsin residents in five counties: Fond du Lac, La Crosse, Milwaukee, Portage, and Richland. Enrollment as of November 30, 2003 is shown on the following table.

Family Care Enrollment, by CMO and Target Group
November 2003

	Individuals with developmental disabilities	Frail elders	Individuals with physical disabilities	Total
Fond du Lac	314	468	130	903
La Crosse	434	570	473	1,463
Milwaukee	*	4,690	*	4,690
Portage	202	339	135	671
Richland	93	125	68	286
Total	1,043	6,192	806	8,041

* The Milwaukee CMO serves only frail elders.

ACCESS

The IA report found the most dramatic and consequential achievement related to access to long-term care services has been the elimination of the waiting lists for community long-term care among eligible residents in the five counties served by the Family Care CMOs. At the end of 1998, the year before the Family Care program was authorized, 3,136 frail elders and adults with disabilities were waiting in these five counties to receive the services they needed. These waiting lists were eliminated by the end of 2002.

The IA report also concludes that individuals' eligibility for the Family Care program is assessed accurately before enrollment, and that the enrollment consultant, an independent counselor who meets with potential enrollees before they join Family Care, provides effective assurance that potential enrollees understand their choices before enrollment in a CMO.

Access to services after members are enrolled in the program is also important. The independent assessor relied upon care-plan reviews performed by Family Care's External Quality Review Organization (EQRO) to conclude that the CMOs were meeting program requirements for providing access to needed services for their members. In addition, the IA report notes that providers of the services purchased through Family Care "are joining the network, are being retained, and are meeting both the traditional and the more unique needs of Family Care members."

The Department accepts, and has begun to act upon, reported findings that better monitoring is needed for enrollment processing time, the number of local providers, and reasons for voluntary disenrollments.

QUALITY

The IA report correctly explains that quality in Family Care centers around the member—involving him or her in identifying the outcomes to be pursued, planning for care, and assessing whether the desired outcomes are in place. Care plans are assessed based on the extent to which they have identified and incorporated the individual's desired outcomes; the IA report concludes, "care managers were creative and flexible in terms of working for the most appropriate level of services for members."

The IA report documents some effects of this high-quality care management for the members' results. For example, APS Healthcare found, upon analysis of member-outcome results data collected by Family Care's EQRO, that the longer an individual remains in Family Care, the more likely he or she was to have achieved desired outcomes, and to be receiving appropriate support for those outcomes.

Other interesting and positive findings resulted from an analysis of changes in individuals' functional status impairment, which includes abilities to perform activities such as bathing, dressing, or fixing meals. APS Healthcare found beneficial effects for the Family Care members' functional status compared to that of their counterparts in other long-term care programs. In

addition, APS found evidence that Family Care members spent less time in nursing home and in hospitals.

The Department accepts, and has begun to act upon, reported findings that better tracking and analysis is needed of grievance and appeals, record-keeping and data utilization, and use of member-outcome assessment results.

COST

The IA report affirms that the Family Care rate-setting methodology meets legal requirements, provides sound and appropriate rates for the populations served, and facilitates Family Care goals.

The Department believes that this rate-setting methodology provides the needed foundation for a cost-effective program, because rates must be set appropriately to provide each CMO with the ability to operate a solvent, sustainable organization, while providing incentive for cost control. The rates must be appropriately adjusted for the needs of each CMO's unique membership, while continuing to provide incentive to keep members as healthy as possible and to encourage economy and efficiency. However, sound rate-setting will not, by itself, produce cost restraint. The cost-effectiveness of the Family Care program ultimately depends upon the CMOs' ability to respond to these incentives by providing economical and effective well-managed long-term care.

The challenges of assessing the effect of a complex set of system changes on the costs of long-term care to the Medicaid program are evident in the IA report; however, the report reaches several significant conclusions, which appear consistent with the Department's own assessment of the Family Care program's operations.

After investing substantial effort in creating statistically valid and risk-adjusted comparison groups for Family Care members who enrolled during 2002, APS Healthcare performed several analyses of both groups' long-term care Medicaid costs in the periods before and after the Family Care members' enrollment. Because Family Care may also affect Medicaid costs for services outside the benefit package, such as hospitalization and physician visits, the analyses also examined selected primary and acute costs for both groups.

Both inside and outside Milwaukee County, for both the Family Care and non-Family Care groups, costs increased during the study periods. However, a traditional regression analysis found that the Family Care members' overall long-term care costs increased faster than did those of the comparison group during the study period. Among primary and acute care services, costs for only hospital inpatient care improved for the Family Care members in comparison to those for their non-Family counterparts.

To explore these findings more deeply, APS Healthcare used a methodology that is more sensitive to variation across local units, called hierarchical linear modeling, or HLM, to examine the effects of Family Care on a local scale. This second set of analyses found that Family Care

appears to operate as two distinct programs—one in Milwaukee, and one in the other four counties—rather than a single program operating in five counties.

In four of the five Family Care counties, but not in Milwaukee, APS Healthcare found that Family Care members' overall long-term care costs increased at a significantly slower rate. This increased averaged $113 per member per month less than the increase for the non-Family Care comparison group. Among individual long-term care services, costs for personal care and residential facility care were significantly restrained in comparison to the non-Family Care group. The only service for which costs increased faster for the Family Care members than for their non-Family Care counterparts was home health care, which may not be an unexpected or undesirable result within the context of relatively lower overall costs.

Among primary and acute services, and in these four counties, Family Care members' costs for physician office visits and prescription drugs were restrained, compared to those for non-Family Care individuals, while no primary and acute services costs increased any faster than those for non-Family Care members.

However, costs for Family Care members in Milwaukee County showed no similar savings. Neither overall long-term care costs nor any single long-term care service showed any cost savings relative to the non-Family Care comparison group. Residential care facility expenditures for the Milwaukee County Family Care members increased more rapidly than did those for their non-Family Care counterparts. Because Milwaukee serves more Family Care members than the other four CMOs combined, the cost experience of the Milwaukee members determines the results when costs for the Family Care program are studied as a whole.

The APS Healthcare analyses took population differences into account, so that differences in the target-group composition of the Milwaukee Family Care membership do not explain the absence of cost restraint in Milwaukee. Nevertheless, the Department and the Milwaukee CMO are already aware of some factors, not measured by the data used in the APS Healthcare analyses, that are likely among the factors preventing cost restraint in Milwaukee's Family Care program. The Department is continuing to work with the Milwaukee CMO. Efforts to assess and to improve fiscal management and enrollment processing in that county will need to show results in the coming year.

CONCLUSION

The Department will carefully consider APS Healthcare's suggestions for improvement in the Family Care programs, and will continue to address those areas that we are already working on in collaboration with the local Family Care programs.

While improving the cost-effectiveness of the Milwaukee CMO is a priority, the Department believes that it is also possible to continue to improve the Family Care program in the four counties that have already achieved beneficial results in restraining long-term care costs. Although these CMOs have been making steady and noticeable progress in responding to the incentives provided by the capitated Family Care rate, neither these counties nor the Department are ready to say that all possible mechanisms for cost restraint are in place and operating well. In

addition, as the IA report notes, measurable beneficial results for the Family Care members' functional status in comparison to that of their non-Family Care counterparts bode well for additional, future cost savings.

Beyond these five counties, the Department is working with the Wisconsin Long-Term Care Reform Council to identify ways to improve access to long-term care services, assure quality, and restrain long-term care costs statewide. The cost-restraint achievements from the Fond du Lac, La Crosse, Portage, and Richland CMOs are reassuring for the future of long-term care reform in Wisconsin, because they are more similar to the remainder of the state's counties than is Milwaukee. The findings of APS Healthcare give us confidence that Family Care is providing us with lessons and experience that we can use in making the statewide long-term care system more responsive to consumers' needs, and more affordable for the State.