Long-Term Care in Motion: 2008 Annual Report of Wisconsin's Managed Long-Term Care Programs

FAMILY CARE Long-Term Care

FAMILY CARE Partnership

Table of Contents

Executive Summary....4

History....6

Figure 1: Managed Long-Term Care Service Areas, 2008....5
Long-Term Care Options in Wisconsin....6
The Long-Term Care Reform Initiative....7
Figure 2: Explanation of Benefit Packages of the Three Programs....8

2008 Highlights....9

Table 1: Number of Waiver and Waitlist Enrollees during 2008 Expansion....9
Figure 3: Projected Managed Long-Term Care Implementation, 2009....12

Section 1: Member Profile....14

Figure 4: Total Active Members by Target Group....14
Table 2: Members Active on December 31, 2008, by Target Group....15
Table 3: Members Active on December 31, 2008, by Age Group....15
Figure 5: Members by Age Group....15
Member Profile: Current Living Arrangements....16
Figure 6: Living Arrangement for all Members Active on December 31, 2008....16
Member Profile: Health Status....17
Figure 7: Multiple Health Diagnoses among Members Active on December 31, 2008....17
Member Story: Don's Story from Care Wisconsin....18
Table 4: Most Common Health Diagnoses for Members on December 31, 2008....19
Member Profile: Employment Status....20
Figure 8: Employment Status of Members Active on December 31, 2008....20

Section 2: Services Provided....21

Table 5: Number of Members who Received Care Management Services during 2008 by MCO 21
Figure 9: Members who Received Care Management by Target Group during 2008....22
Member Story: Mary's Story from Western Wisconsin Cares....23
Table 6a: Top services Provided to Family Care Members during 2008....24
Table 6b: Top services Provided to Family Care Partnership Members during 2008....25
Living Situations....26
Table 7: Use of Purchased Residential Services during 2008....26
Table 8: Nursing Home Stays of 90 days or Longer for Members with Low Care Needs....26
Coordination of Health Services and Long-Term Care....27
Use of Informal Supports....28
Table 9: Use of Informal Supports with Members who Have at Least One ADL during 2008....28
Table 10: Use of Informal Supports with Members who Have at Least one IADL during 2008....29
Self-Direction of Services within Family Care Programs....30
Member Story: Dr. Lubar's Story from Community Care, Inc....31

Section 3: Results....32

Member Story: Alex's Story from Community Care, Inc. 33
Indicators Related to Health Status 34
Table 11: Preventable ER visits 34
Table 12: Preventable Hospital Admissions 34
Table 13: Proportion of Members with Current Immunizations 35
Figure 10: Percent of Family Care Partnership Members Who Had Dental Services during 2008 35
Member Story: Todd's Story from Creative Care Options of Fond du Lac 36
Indicators Related to Functional Status 37
Table 14: One-Year Changes in Need for Assistance with Activities of Daily Living by Target Group and Program 37
Table 15: One-Year changes in Need for Assistance with Instrumental Activities of Daily Living by Target Group and Program 37
Member Story: Narda's Story from Care Wisconsin First 38
Desired Living Arrangements 39
Table 16: Percent of Members by Current and Preferred Living Situation on December 31, 2008 39
Changes in Members' Employment Status 40
Table 17: Changes for Employed Status of Family Care Program Members during 2008 40
Members' Satisfaction 41
Disenrollment for Reasons Other than Death or Loss of Eligibility 42
Table 18: Members who Left the Program during 2008 42

Appendix 1— Footnotes, Information on Data Used in Report, and Sources of Additional Information 43

Appendix 2 —Focus on the Frail Elder Target Group 45

Appendix 3—Focus on the Developmental Disabilities Target Group 52

Appendix 4—Focus on the Physical Disabilities Target Group 59

Appendix 5—Additional Data on Members with Mental Health/Substance Abuse Issues 67

List of Current Family Care, Partnership and PACE Managed Care Organizations 74-75

Executive Summary

Welcome to the 2008 annual report on managed long-term care in Wisconsin. The managed long-term care programs – Family Care, Family Care Partnership and the Program of All Inclusive Care for Elderly (PACE) – provide care management, Medicaid-funded in-home and residential long-term care services and some additional Medicaid-funded health care services to adults with physical or developmental disabilities and to frail elders. The Family Care Partnership and the PACE programs also provide Medicare-funded acute and primary health care and long-term care services to their members.

This report will provide you with information and analysis on how these programs are providing long-term care options and services to Wisconsin's frail elders and individuals with developmental and physical disabilities. You will also find member success stories and quotations from the member satisfaction survey.

For many years, Wisconsin has offered innovative programs that give at-risk citizens choices about how they receive services and where they live when they need long-term care. Through these programs, the majority of frail elderly and adults with developmental and/or physical disabilities have chosen to stay in their own homes or other community-based settings, rather than entering nursing homes prematurely or at all. Family Care and Family Care Partnership were two programs that were developed in Wisconsin to provide consumers with choice and access while allowing the consumer to maintain independence. Family Care is being expanded to serve the entire state, and Family Care Partnership will exist where there is a managed care organization certified to provide that program. PACE is a Medicaid state plan service that exists in several states; in Wisconsin there are PACE sites in Milwaukee and Waukesha Counties. There are no plans to expand PACE outside the southeast Wisconsin area.

A comparison of the information in this annual report, for 2008, with the previous year's report shows many differences—in the number of people served, the proportion in each target group, the types of health conditions they live with, and most other characteristics of the programs. The main reason for most of these changes is the rapid expansion of the programs during 2008.

In 2008, 18 additional counties offered managed long-term care programs and enrolled more than 7,000 new members. Expansion was not just about making the program bigger; it has changed the program, specifically who we serve and the organizations involved in the program. In previous years, over 70% of the members were frail elders. With the expansion in 2008, the number of people with developmental disabilities more than doubled.

2008 brought an unprecedented event that is also reflected in this report: the termination of one managed care organization (MCO), which served members in Dane County, and the transfer of its members to another MCO, Care Wisconsin First. Each member received an offer of options counseling before the closing, and the overwhelming majority chose to stay with managed long term care. The transfer of members went smoothly in large part due to the exceptional cooperation among the employees of the closing program, along with the staff from Care Wisconsin First and Department.

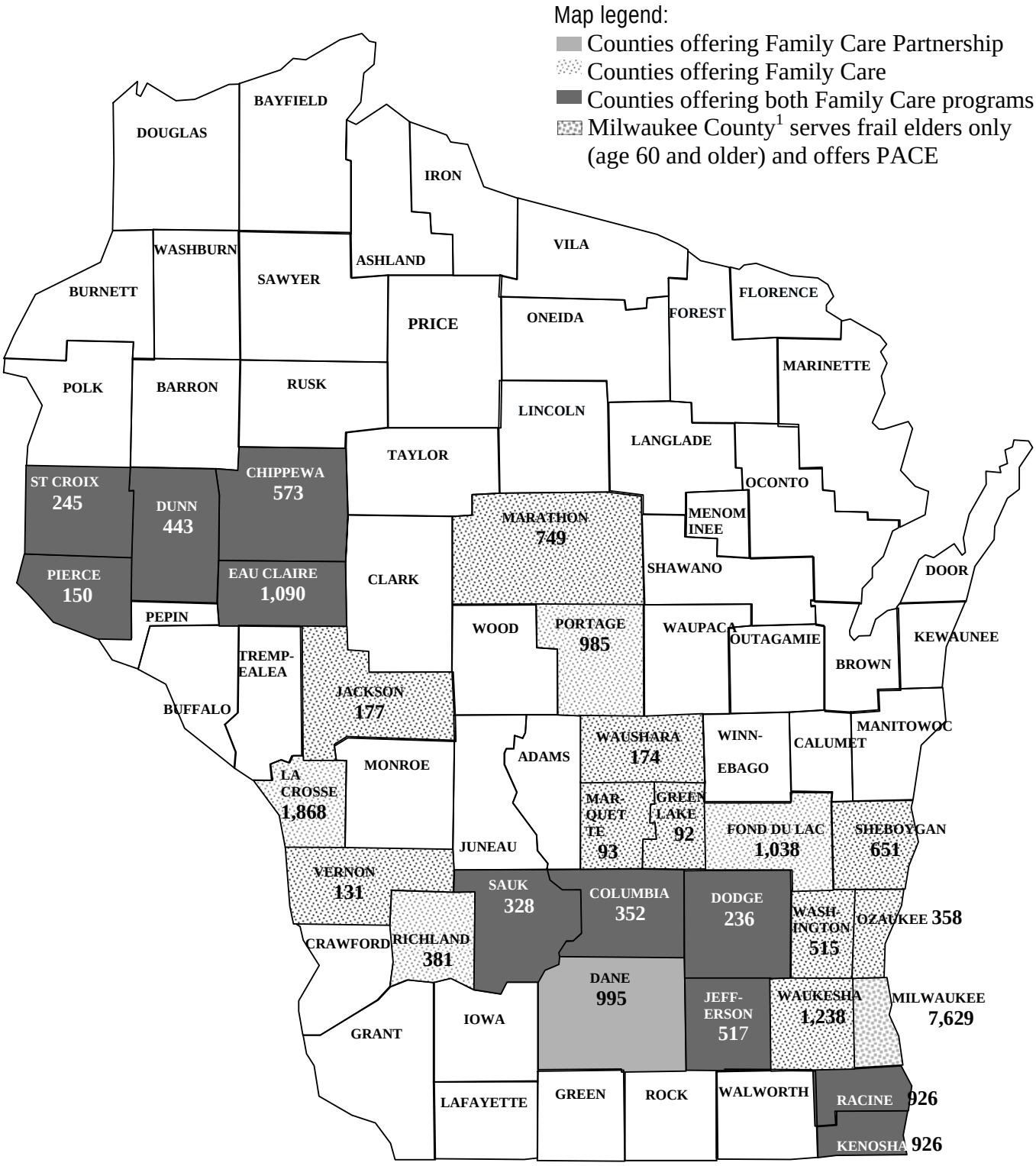
Managed care organizations themselves also changed in 2008. Some single county MCOs evolved into long-term care districts serving several counties, and non-profit managed care organizations also greatly expanded their role and services areas in the delivery of managed long-term care.

2008 was a year of growth and challenge on many levels. Many people who were on waitlists in expansion areas were able to receive long term care services where they live and the State is on a march to expand the entitlement to community-based long term care over the next few years. Rapid expansion also brought challenges as long term care programs moved from county-based operations to MCOs, MCO organizations expanded rapidly and grappled with providing high quality and cost-effective care to new target groups and a greatly expanded enrollment, providers experienced the change from operating in a fee-

for-service to a managed care model, and state program management began transitioning staff and operations from the home and community-based waivers to managed long term care. All parts of the system will need to work hard and collaboratively to continue to improve choice, access, quality and cost-effectiveness and to eliminate waitlists for publicly funded long term care services. We welcome your feedback and comments.

Figure 1: Managed Long-Term Care Service Areas, 2008

including enrollment numbers as of 12/31/08 for all programs available in county



History

Long-Term Care Options in Wisconsin

For many years, the State of Wisconsin has offered innovative programs to give frail elders and adults with developmental or physical disabilities choices about how they receive services and where they live when they need long-term care. Most people participating in these programs have chosen to stay in their own homes or other community-based settings, rather than entering nursing homes prematurely or at all.

The current community-based long term care system, which began in the early 1980s, included the Community Options Program (COP), the Community Integration Program (CIP) and the Brain Injury Waiver Program, operated by county long-term support and community program agencies. A fixed and limited amount of money was appropriated each year to fund these programs, so care in community settings was rationed and many people were place on waitlists, some for five or more years. Eventually, these waiting lists grew and in 2006, more than 11,000 people were on waiting lists for long term care in their own homes or other non-nursing home settings.

In the mid 1990s, the State began exploring other innovative ways to stretch scarce resources in order to provide long-term care to more eligible Wisconsin residents in need of services. This resulted in the development of the Family Care Partnership Program (previously called the Wisconsin Partnership Program) – an integrated managed care model where the State partnered and contracted with private, non-profit community organizations to offer acute and primary health and long-term care management for the frail elderly and adults with physical disabilities. The service and benefit package covered all Medicaid, Medicare, and Home and Community-Based Waiver services. Partnership programs opened in five pilot counties, starting in 1995, serving elders and adults with physical disabilities.

Still, by the early 1990s, Wisconsin was spending 50% more than the national average for each Medicaid-eligible elderly person. Access, choice and quality in the home and community-based services were not consistent from county to county, for both elders and adults with disabilities. Entitlement to nursing facility care and long waiting lists for community care kept many eligible people in nursing facilities or living independently while receiving inadequate or no care.

When individuals did obtain services, the choice of services was often dictated by a fragmented and confusing system of public programs. More than 40 public programs provided funding for long-term care, each with a different set of eligibility criteria and covered services.

To improve access and information, the Long-Term Care Redesign Task Force in 1998 proposed the creation of Aging and Disability Resources Centers (ADRCs) to inform individuals seeking long-term care about their options and to help them get enrolled in those programs they chose.

The Task Force also proposed the Family Care Program, and in 2000 the State entered into managed care contracts with five pilot counties to offer long-term care management for a package of services that included the long-term care portion of Medicaid State Plan (card) services and the Medicaid Home and Community-Based Waiver services that were part of the COP and CIP programs. An independent evaluation of the Family Care program, published in late 2005, found that Family Care, a managed care approach with an interdisciplinary team, helped people stay independent longer in their communities and also achieved significant cost savings compared to the fee-for-service Medicaid program.

In spite of documented success, eligible people were entitled to community-based long-term care in only the five Family Care pilot counties. Eligible people who lived in the five Partnership pilot counties had access to this program, but it was not an entitlement and enrollment was controlled by the state budget.

Residents in 67 of Wisconsin's 72 counties had access to the county-based COP. CIP and Traumatic Brain Injury waiver programs, with accompanying waitlists.

With the encouragement of consumers, advocates, counties, providers and other supporters, Governor Jim Doyle and the Wisconsin Legislature decided it was time to take the next step in launching Statewide Long-Term Care Reform. The purpose of reform was to use the savings from the more integrated managed long term care program to make services available for all eligible people who needed it and to provide that care where the person lives.

Wisconsin's Long-Term Care Reform includes both Family Care and Family Care Partnership and the Include, Respect, I Self-Direct (IRIS) waiver programs. In IRIS, people self-direct their long-term care services. As indicated previously, the PACE program also exists in two counties in southeastern Wisconsin.

The Long-Term Care Reform Initiative

Family Care expansion is built on long-held Wisconsin values of the wise stewardship of limited public resources and the social responsibility for making these public programs available to all eligible citizens of Wisconsin.

The State's vision is to eliminate waiting lists and offer all eligible residents in every county and tribe the choice among traditional nursing-home care, Family Care (including Partnership and PACE wherever possible) and IRIS. To serve everyone with long-term care needs, the Family Care program must call on everyone involved – consumers, families, providers, advocates, managed care organizations, public policymakers – to be wise stewards of our resources**. If we provide the right services, in the right amount, and at the right time, we will be able to serve every eligible person who needs long-term care services.**

The goals of the Family Care initiative are:

CHOICE – Give people better choices about the services and supports available to meet their needs.

ACCESS – Improve access to services.

QUALITY – Improve quality through a focus on health and social outcomes.

COST-EFFECTIVENESS – Create a system where the planning for resources and options to meet an individual's outcomes also considers the comparative costs of those options and resources.

The State chose a managed care approach as a framework for this long-term care initiative, because it offered:

- A broader pooling of funds from the county long term support funding and Medicaid;
- More flexibility at the local level in the use of those funds to purchase services wisely;
- A system to more uniformly work with providers under contract with managed care organizations to ensure quality stewardship; and collaboration in helping members achieve their outcomes.

Figure 2: Explanation of Benefit Packages of the Three Programs

Family Care Partnership & PACE (Program of All Inclusive Care for the Elderly)
(The difference between PACE & Partnership is that Partnership has a drug co-pay & PACE does not.)

Family Care		Medicaid Card Services - Acute/ Primary	Medicare Card Services
Home and Community-Based Waiver Services	Medicaid Card Services - LTC services		
Adaptive Aids (general and vehicle) Adult Day Care Care/Case Management (including Assessment and Case Planning) Communication Aids/Interpreter Services Community Support Program Consumer Education and Training Counseling and Therapeutic Resources Daily Living Skills Training Day Services/Treatment Home Modifications Housing Counseling Meals: home delivered Personal Emergency Response System Services Prevocational Services Relocation Services Residential Services: Certified Residential Care Apartment Complex (RCAC) Community-Based Residential Facility (CBRF) Adult Family Home Respite Care (for care givers and members in non-institutional and institutional settings) Supported Employment Supportive Home Care Vocational Futures Planning	Alcohol and Other Drug Abuse Day Treatment Services (in all settings) Durable Medical Equipment, except for hearing aids and prosthetics (in all settings) Home Health Medical Supplies Mental Health Day Treatment Services (in all settings) Mental Health Services, except those provided by a physician or on an inpatient basis Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease) Nursing Services (including respiratory care, intermittent and private duty nursing) and Nursing Services Occupational Therapy (in all settings except for inpatient hospital) Personal Care Physical Therapy (in all settings except for inpatient hospital) Specialized Medical Supplies Speech and Language Pathology Services (in all settings except for inpatient hospital) Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier) and non-Medicaid covered.	Physician services Laboratory and x-ray services Inpatient hospital Outpatient hospital services EPSDT (under 21) Family planning services and supplies Federally-qualified health center services Rural health clinic services Nurse midwife services Certified nurse practitioner services Medical care or remedial care furnished by licensed practitioners under state law Prescribed drugs Diagnostic, screening, preventive and rehabilitation services Clinic services Primary care case management services Dental services, dentures Physical therapy and related services Prosthetic devices, eyeglasses TB –related services Other specific medical and remedial care Inpatient mental health Chiropractic services Podiatry services Outpatient mental health Outpatient substance abuse Outpatient surgery Ambulance services Emergency care Urgent care Diagnostic services Outpatient prescription drugs Hearing services Vision services	Medicare Part A (Hospital) Medicare Part B (Medical) Medicare Part D (Prescription Drugs) Ambulance services Ambulatory surgical centers Anesthesia Blood Bone mass measurement Durable medical equipment, supplies and prosthetics Cardiac rehab Chiropractic services Diabetes supplies Diagnostic tests, x-rays and lab services Physician services Emergency and urgent care services Home health care in certain situations Hospice care Inpatient hospital care Inpatient mental health care Outpatient mental health care Outpatient hospital services, including outpatient surgery Limited skilled nursing facility care Physical/speech/occupational therapy Podiatry services Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D Partnership has a small drug co-pay, PACE has no co-pay Certain preventive tests Certain dental, hearing and vision services Respite care Substance abuse treatment (outpatient)

Family Care Team coordinates covered services with primary and acute health care and other services not covered by Family Care.

PLEASE NOTE: This benefit grid is for illustrative purposes. It provides a comprehensive but not a complete listing of all benefits provided under these programs

2008 Highlights

This year was a turning point for long-term care in Wisconsin, as the managed long-term care programs expanded to areas covering more than half of the state's adult population.

Expansion of Managed Long-Term Care

On January 1, 2008 the managed long-term care programs served 15,666 members in 11 counties. By December 31, the programs became an available option in 27 counties. Family Care was available in 26, Partnership in 12 and PACE in one. Along the way, managed long-term care became an available option for 5,539 waiver participants and—more importantly—498 individuals who had been on waiting lists for home and community-based long-term care in the expansion counties. When Family Care enters a county, individuals who are being served by the fee-for-service waiver programs are offered enrollment over a period of time not to exceed six months, although in Milwaukee County the timeline will be 12 months. People on the waitlist are enrolled during a transition period. At the end of the transition period, the managed long-term care program is an entitlement program in that county, so eligible people can receive services immediately, without going on a waitlist.

Table 1: Number of Waiver and Waitlist Enrollees during 2008 Expansion

County	MCO	Month	# of Waiver	# of Waitlist
Ozaukee	CCI	March	295	45
Sheboygan	CCI	February	572	65
Washington	CCI	April	205	31
	Care Wisconsin	April	265	16
Chippewa	CHP	May	142	6
Dunn	CHP	June	89	3
Columbia	Care Wisconsin	March	248	86
Waushara	Care Wisconsin	June	156	18
Marquette	Care Wisconsin	July	71	12
Waukesha	Care Wisconsin	July	691	71
	CCI	July	408	43
Pierce	CHP	July	133	2
Green Lake	Care Wisconsin	August	78	10
Dodge	Care Wisconsin	August	224	15
Jefferson	Care Wisconsin	September	400	29
St. Croix	CHP	September	193	4
Sauk	SFCA	September	302	14
	Care Wisconsin	September		
Vernon	WWC	November	126	1
Marathon	CCCW	November	692	25
Eau Claire	CHP	November	74	2
Jackson	WWC	December	175	
Total			5539	498

Formation of Long-Term Care Districts

During 2008, three single-county managed care organizations, each affiliated with one county's government, transitioned to multi-county operations.

- Growing up around the Richland County Family Care pilot, the Southwest Family Care Alliance (SFCA) came into being in July as an eight-county long-term care district. By the end of the year SFCA was providing care to members in Richland and Sauk Counties.
- Growing up around the La Crosse County Family Care pilot, Western Wisconsin Cares (WWC) was created in October as an eight-county long-term care district. By the end of the year, WWC was serving members in both La Crosse, Vernon, and Jackson Counties.
- Growing up around the Portage County Family Care pilot, Community Care of Central Wisconsin (CCCW) was created in July as a three-county long-term care district. By the end of the year, CCCW was serving members in Portage and Marathon Counties.

Closure of the Health Plan for Community Living

Family Care encountered and successfully weathered one unprecedented challenge during 2008. The failure of a contracted managed-care organization has always been recognized as a possibility in managed care. In anticipation of this possibility, various safeguards are built into the contracting and monitoring systems to provide early warning of an organization's impending inability to fulfill its contractual obligations, so that the problems can be resolved or the contract terminated before the organization's problems affect the care provided to the members.

In February 2008, the financial condition of the Health Plan for Community Living, a Dane County-based Partnership program operated by Community Living Alliance (CLA) deteriorated to the point where the Department could no longer continue the contract. CLA was informed that its contract to provide Family Care Partnership services would not be continued after April 30. At that time, the program was serving 370 members.

Throughout March and April, CLA's members were contacted to explain the coming change and were provided with a choice between receiving their future services from the CIP II waiver program or from the Family Care Partnership program offered in Dane County by Care Wisconsin First. Staff of the Department, Care Wisconsin First, and CLA worked diligently and cooperatively to ensure the members experienced a smooth and safe transition to their new service provider. Of the 366 individuals who were CLA members at the time that program ceased operations on April 30, all chose to remain enrolled in the Partnership program. On May 1, these members were successfully transferred to Care Wisconsin First, along with many of their care managers and service providers. This successfully completed the first termination of a managed long-term care contract in the nation's history.

Pay-for-Performance Initiative – Dementia Screening

Pay-for-Performance initiatives reward managed care organizations for meeting specific quality standards. These initiatives provide higher funding for providers that perform well and lower funding for providers that perform poorly, in contrast to traditional fee-for-service contracting arrangements that reimburse providers for the number of service units provided. Pay-for-Performance initiatives are selected by the Department with input from the managed care organizations and the external quality review organization.

The objective of the 2008 Pay-for-Performance Initiative addressed two key Family Care program goals. These are (1) improving the overall quality of the long-term care system by focusing on achieving people's health and social outcomes; and (2) enhancing the cost-effectiveness of the State's long-term care system for the future.

The 2008 Pay-for-Performance Initiative provided incentives for each MCO to screen every member over the age of 65 for early signs of cognitive impairments or dementia, to refer those for whom the screen indicated possible problems for more in-depth assessment of their cognitive abilities, and to provide appropriate intervention and support for those who were found to have cognitive impairments. The Initiative focused on Family Care members in Fond du Lac, La Crosse, Milwaukee, Portage, Racine, and Richland Counties. Members who enrolled in calendar year 2008 were not included in the initiative.

The Department received data from the MCOs and will be evaluating the data and reporting on the findings during 2009. This is the second Pay-for-Performance Initiative, following the successful completion of the diabetes Pay-for-Performance Initiative.

Performance Improvement Projects

A performance improvement project (PIP) is a highly targeted, specific project carried out by each MCO that results in a sustainable improvement in areas that will have a favorable effect on members' health or satisfaction. Each MCO selects and carries out its own projects; the results are evaluated each year by an external quality review organization (EQRO) retained by the Department.

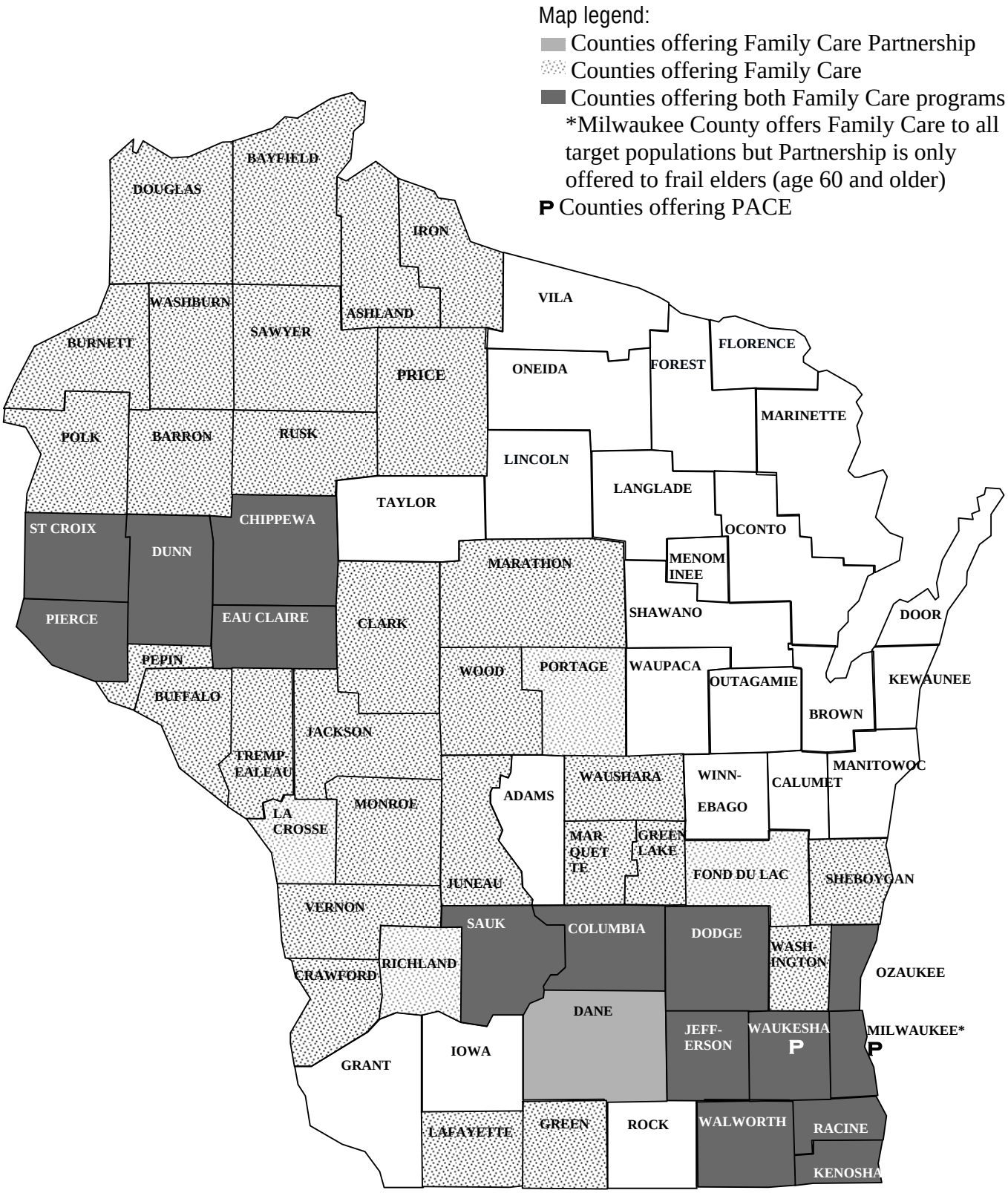
During 2008, MCOs were working on the following PIPs:

- Improving attainment of functional goals for members with persistent pain
- Improving services for members with complex home care needs or situations
- Improving scheduling of direct care workers who serve members in their homes
- Improving coordination of health care for members with diabetes (two MCOs)
- Analyzing fall-related risks and injuries to identify areas for potential intervention
- Improving mental health outcomes for members with depression

Creation of the Council on Long Term Care

Then Secretary Kevin Hayden appointed an 18-member Council on Long Term Care in March to advise the Department on Family Care implementation. The Council was asked to advise the Department on quality focusing on the Managed Care Organizations' services and ADRC services. The Council members represent the key stakeholder groups: consumers, advocates, ADRCs, MCOs, counties and providers. The council provided feedback in developing the annual report on managed long-term programs. The Council replaces the Council on Long Term Care Reform, which operated from 2003 through 2007 and advised the Department on goals and strategies for implementing statewide reforms of long term care for elderly people and adults with disabilities.

Figure 3: Projected Managed Long-Term Care Implementation, 2009



Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES)

In June 2008, through a contact with the Center for Health Care Research and Analysis (CHSRA) at the University of Wisconsin-Madison, the Department completed the development of an interview tool known as PEONIES. With this interview tool, care managers and quality reviewers can identify individual members' hopes and dreams—that is, their desired 'personal experience outcomes'—and record those outcomes in a methodical way so that they can be used for care planning and for quality assurance. Immediately after completion of the PEONIES interview, the Department contracted with the developers to validate that the interview tool does, in fact, identify and measure what it intends to identify and measure. In addition, the Department began working with the MCOs and with the External Quality Review Organization (MetaStar) to explore ways the interview tool could be used.

Employment in Managed Care

Employment for Family Care members was another initiative that made headway during 2008. In the second year of federal grant funding for this purpose, six MCOs increased their level of support for their members' employment objectives and increased the number of members who have paid employment in the community. Community Health Partnership (CHP) reported 136 additional members had paid jobs in some capacity at the end of 2008. Southwest Family Care Alliance (SFCA) reported an additional 19 members in integrated employment jobs, such as restaurants, a bowling alley, and several retail stores. All the MCOs receiving grant funds improved their ability to support members' employment in ways that included development of self-directed support options for their members' jobs; incentives for providers of employment supports, and written materials that explain work incentives and how employment affects the member's benefits. In July 2008, the Managed Care and Employment Task Force, a broad-based Task Force composed of internal and external stakeholders, issued its final report. The report includes numerous recommendations to strengthen community-based employment options in the long-term care system.

Long-Term Care Conference

The Division of Long-Term Care hosted a very successful conference for professionals in long-term care in La Crosse, Wisconsin from April 14-16. This conference was attended by over 900 people and featured excellent plenary presentations and 70 workshops. Secretary Karen Timberlake was one of the speakers at the conference.

Long-Term Care Independent Ombudsmen

In the 2007-2009 biennium the Wisconsin Legislature funded a Family Care ombudsmen program in 2007 Wisconsin Act 20, Wis. Stats. 46.281(1n)(e). Ombudsmen assist managed long-term care program members and potential members in navigating the program and in resolving problems. The Wisconsin Board on Aging and Long Term Care provides ombudsmen services for people age 60 and older enrolled in Family Care and Family Care Partnership. As a result of the request for proposal process, the Department of Health Services contracted with Disability Rights Wisconsin beginning October 1, 2008 for Ombudsmen services to current or potential enrollees age 18-59.

Section 1: Member Profile

To be a member of a managed long-term care program, a person must have a disability: a significant limitation in his or her ability to perform basic activities of daily living such as dressing, bathing, eating, toileting, mobility, ability to cook meals, manage medications or manage money. Eligibility for managed long-term care programs is limited to three 'target groups' or categories of people with disabilities: frail elders, adults with physical disabilities, and adults with developmental disabilities.[2] Not all people with disabilities are eligible for managed long-term care programs: for example, managed long-term care does not serve children under the age of 18. Although managed long-term care programs do not serve the mental illness target group, more then half of the members have a mental illness but their main diagnosis is within one of the three target groups.

Frail elders are individuals 65 and older who have serious and long-lasting physical health problems or dementia. Conditions that are common among frail elders are diabetes, disabling arthritis, congestive heart failure, cancer, Alzheimer's disease, and the effects of a stroke.

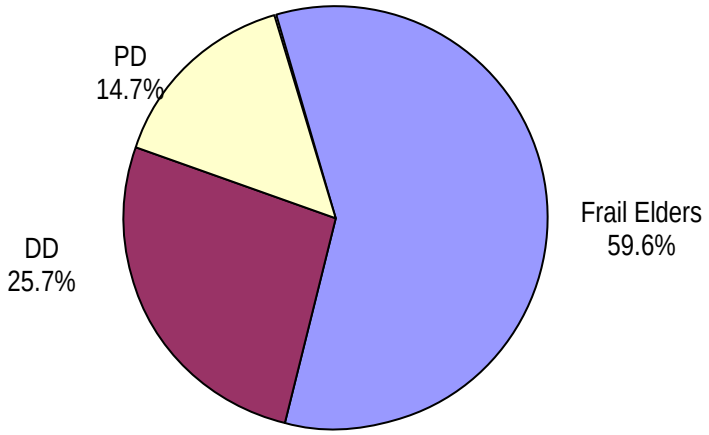
Managed long-term care program members with **physical disabilities** are adults who have a physical problem or condition that significantly limits their ability to care for themselves. Typical disabling conditions include amputations or paralysis as a result of accidents or disease, multiple sclerosis, chronic obstructive pulmonary disease and traumatic brain injuries**.**

Managed long-term care program members with **developmental disabilities** are adults who had onset of the disabling condition before the age of 22 and have severe cognitive or physical functioning that significantly limits their ability to care for themselves. Some common disabling conditions include intellectual disability, cerebral palsy and epilepsy. The person must also have substantial functional limitations in at least three of the following areas: learning, use of language, self-direction, mobility, self-care (bathing, dressing, eating, etc.) or the ability to live independently without help from anther person.

Finally, managed long-term care program members are all financially eligible for Medicaid. Individuals in Wisconsin can get information about Medicaid eligibility at their local Aging and Disability Resource Center (ADRC).

The following Tables and Figures provide a breakdown of the active managed long-term care program members by target group and age range.

Figure 4: Total Active Members by Target Group



[2]Precise requirements for functional eligibility for Family Care can be found in Wisconsin statutes s.15.197(4)(a) 2 and s.15.197(4)(a)1, and in Wisconsin Administrative Code HFS 10.13(25m).

Table 2: Members Active on December 31, 2008, by Target Group

MCO and Program	Frail Elder	Members with Developmental Disabilities	Members with Physical Disabilities
Milwaukee - Family Care	6,623	2	10
Fond du Lac - Family Care	474	386	178
Community Care of Central WI Family Care	744	695	291
Southwest Family Care Alliance - Family Care	272	267	140
Western WI Cares - Family Care	820	731	616
CCI - Family Care	1,032	1,778	601
CCI - Partnership & PACE	943	15	173
Care WI - Family Care	867	1,254	310
Care WI - Partnership	638	39	409
CHP - Family Care	139	443	70
CHP - Partnership	1004	242	558
All MCOs	13,556	5,852	3,356

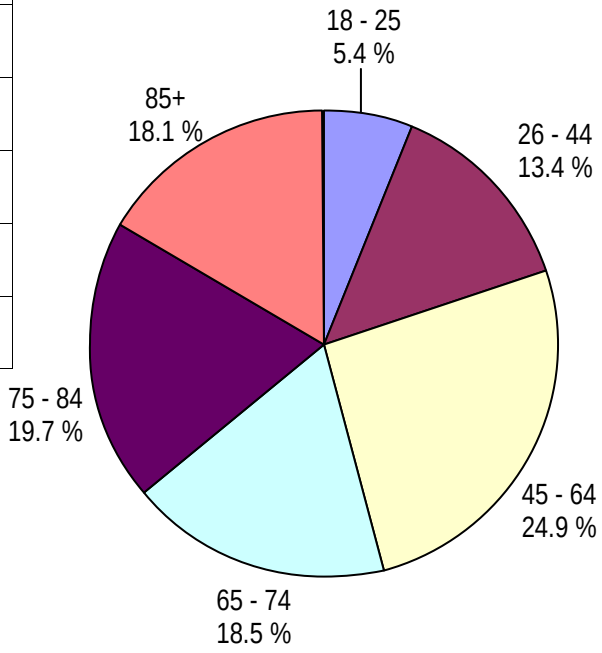
Source: Each member's most recently completed functional screen as of December 31, 2008.
Note: The Milwaukee County Family Care program, operated by the county's Department on Aging, enrolls people over the age of 60 as elders, while other MCOs enroll people over the age of 65 as elders. In all MCOs, members with developmental or physical disabilities who are within the age range considered by that MCO to be 'elder' are reported as elders in this table.

Table 3: Members Active on December 31, 2008, by Age Group

Age Range	No. of Family Care Members	No. of Partnership & PACE Members	Total
18-25	1,183	51	1,234
26-44	2,780	269	3,049
45-64	4,451	1,208	5,659
65-74	3,453	760	4,213
75-84	3,547	933	4,480
85+	3,308	801	4,109
Total	18,722	4,022	22,744

Source: DHS enrollment records.

Figure 5: Members by Age Group



Member Profile: Current Living Arrangement

The proportion of active members who were living outside residential care facilities is consistent with the philosophy that with proper supports, the majority of frail elders, people with developmental disabilities and people with physical disabilities can live in their own homes and experience an improved quality of life and life choices. The MCOs work to assist members who prefer to live in a home setting by providing the appropriate services and supports to maintain the desired living arrangement.

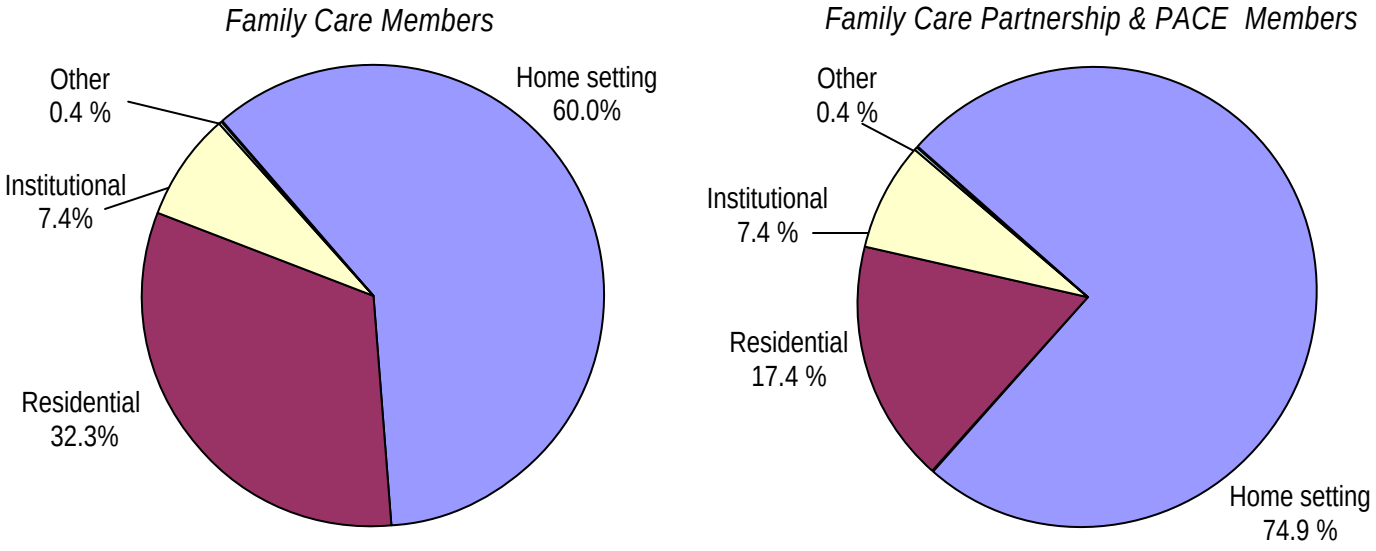
Figure 6 displays the percentages of members by living arrangement on December 31, 2008.

- A 'home setting' is the member's own home or apartment, or the home or apartment of the member's family
- 'Residential' is an adult family home, a residential-care apartment complex, or a community-based residential facility, as these facilities are defined in Wisconsin Administrative Code.
- 'Institutional' is a nursing home, an intermediate care facility for people with developmental disabilities, or a swing bed (temporary nursing home bed in a hospital).
- The 'Other' category includes settings such as temporary living arrangements, hospices, jails, or homeless shelters. Due to uncertainty regarding the nature of certain living arrangements, occasionally screeners inflate the number of people reported to be living in these 'other' arrangements.

"My care manager is the greatest. She always checks on me and makes sure I have what I need."

- Response from the 2008 Member Satisfaction Survey

Figure 6: Living Arrangement for all Members Active on December 31, 2008



Source: Each member's most recently completed functional screen.

Member Profile: Health Status

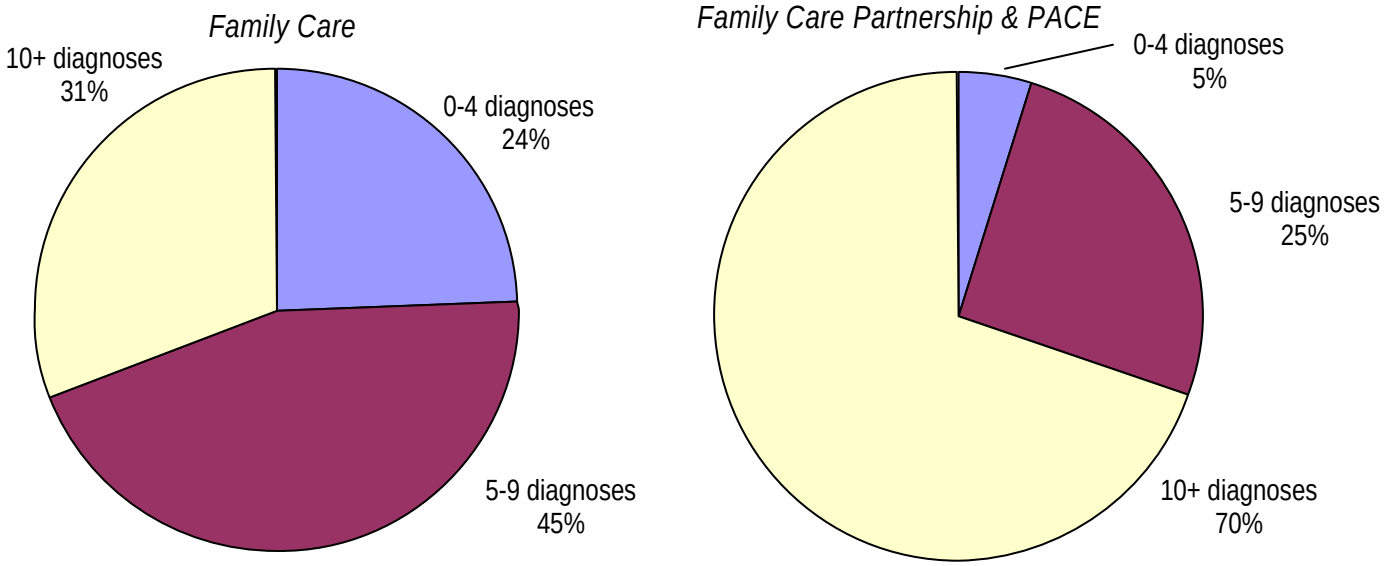
Frail elders and adults with physical or developmental disabilities present a wide variety of sometimes complex medical conditions. While every member is unique, a few common medical conditions can be found among members. The population of members with physical disabilities include, for example, younger adult men who experienced severe trauma from motor vehicle or other accidents. These members may have a spinal cord injury and paralysis, and these conditions are often accompanied by depression. Other examples of members with physical disabilities include middle-aged women with a complex mix of auto-immune, metabolic, and nervous-system disorders, frequently accompanied by depression.

An example of members with developmental disabilities, includes middle-aged and relatively physically healthy individuals with disorders such as Down's Syndrome who need continual support with the activities of daily living. Another example would include members with severe developmental disabilities who have very complex disabilities that significantly impair their physical health and require near-total care.

Finally, the frail elders among managed long-term care members include individuals of advanced age—in 2008, 39 Family Care and five FC Partnership members were 100 or older—and whose physical health needs are continuous and often complex. Other elders in Family Care are younger—still in their 60's—but impaired by varying degrees of irreversible dementia and chronic illness.

The majority of members have more than one health diagnosis as detailed in Figure 7. The number of managed long-term care program members with 10+ diagnoses decreased in 2008 while the number of members with 0-4 diagnoses increased. This change can be attributed to the change in membership during 2008 with the infusion of younger members.

Figure 7: Multiple Health Diagnoses Among Members Active on December 31, 2008.



Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 4 lists the most common diagnoses for members active in December 2008. While the diagnoses listed in the table were not necessarily the conditions that made the members eligible for a managed long-term care program, the MCOs are responsible for providing the proper services, supports and coordination to help the member manage his/her health and remain as active and healthy as possible. The most common diagnosis, affecting over half of Family Care members and almost three-fourths of the Partnership and PACE members, was hypertension. Although hypertension was also the most common health diagnosis in 2007, the percent of members who have hypertension has decreased, most likely because of the change in the membership in 2008. For more specific diagnostic breakdowns see the appendix for each target group.

Member Story: Don's Story from Care Wisconsin

In 2000, when Don moved in with his brother and guardian in West Bend, all was well for a while. However, in May 2008, his brother started working second shift, which left Don fending for himself much of the time. His brother soon realized that Don needed more assistance than he could provide. Don, his brother and Don's care manager, who had also been Don's county case manager prior to his enrollment in Family Care, worked on identifying a living situation that would meet Don's outcomes and needs.

Quietly friendly, happy, and cooperative, Don adjusted beautifully to the loosely structured, home-like atmosphere at the four-bed residential facility. He enjoys the freedom to have friends over and to choose from dancing, games, crafts, baking, or movies for a nightly activity—usually followed by a night-time tea break with his "buddy," Tracey.

He also attends an adult day center, where he enjoys many friendships among the four staff members and 20 people who go there. The day center offers music therapy, swim and bowling teams, games, puzzles, crafts, pet-a-pet days, theme weeks, field trips, senior bingo, and frequent collaboration with Lutheran Social Services for exercise programs. They also have monthly one-on-one time, during which each participant decides how their time will be spent. Don also volunteers at the center, where he sells things at the Habitat for Humanity shop, and has logged as many as 32 hours of community outings in just a six-month period.

His care team and staff at the residential facility have worked together with Don to identify important goals—one of which is for him to become more assertive. "Don is such a helpful, compliant person that we made it a goal for him to become more comfortable expressing his ideas and preferences," says his care manager.

Don has identified that he likes talking about his spirituality. Using natural supports, arrangements have been made for a volunteer to pick Don up and take him to and from his church for services each Saturday, where he is known well.

He still counts "bumming with" his brother as one of his favorite activities, and he likes visiting his nephew. But Don is also very comfortable with his new home and staff, and enjoys making plans with staff.

Initially concerned about not providing all of Don's care himself, his brother appreciates the supportive, home-like atmosphere of his new residence. He's also thankful for the long-standing, caring relationship Don has with his care manager.

Table 4: Most Common Health Diagnoses for Members on December 31, 2008
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnoses	FC	FC Partnership & PACE
Allergies	16.6%	27.7%
Alzheimer/Other Dementia	20.0%	22.5%
Anemia/Coagulation Defects	14.9%	32.6%
Angina/Coronary Artery Disease	19.1%	34.9%
Anxiety Disorder	19.8%	33.9%
Arthritis	44.0%	63.1%
Asthma	21.4%	37.2%
Blood/Lymph Disorders	13.0%	34.4%
Cancer	9.2%	13.6%
Cerebral Vascular Accident	13.4%	17.6%
Chronic Pain/Fatigue	28.5%	48.3%
Congestive Heart Failure	13.8%	22.4%
Dehydration/Fluid Imbalance	3.9%	11.2%
Depression	31.8%	53.8%
Diabetes Mellitus	27.7%	38.0%
Disorders GU System[3]	18.9%	39.0%
Heart Rate Disorders	12.2%	22.6%
Hip-Fracture	22.1%	34.0%
Hypertension	53.7%	74.1%
Hypo/HyperThyroidism	16.9%	21.5%
Kidney/Renal Failure	10.5%	26.6%
Mental Retardation	29.4%	6.4%
Nutritional Imbalances	35.9%	63.7%
Osteoporosis	14.3%	27.1%
Other Diagnoses	21.9%	50.0%
Other Digestive Disorders[4]	40.5%	70.6%
Other Heart Conditions	10.3%	20.7%
Other Mental Illness	10.0%	13.3%
Other Nerve Disorders[5]	18.9%	38.6%
Other Sensory Disorders[6]	11.5%	20.9%
Respiratory	12.9%	25.8%
Skin Diseases	7.0%	19.1%
Urinary Tract Disorder	7.3%	15.8%
Visual Impairment[7]	29.9%	45.3%

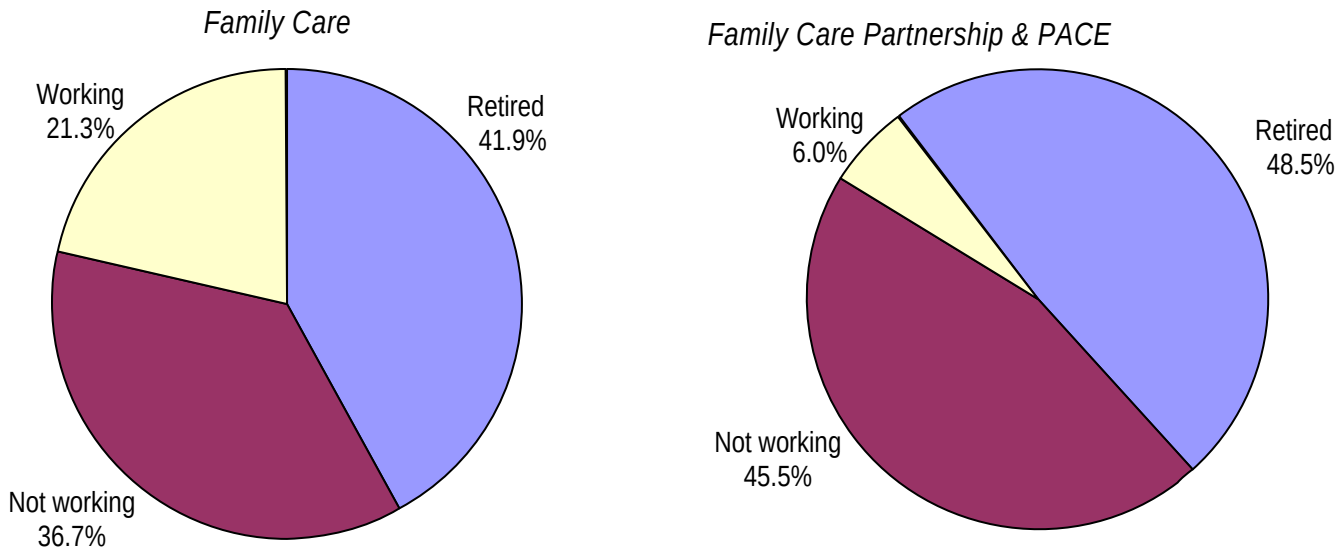
Source: Each member's most recently completed functional screen as of December 31, 2008.

Member Profile: Employment Status

When employment is an outcome desired by a member, the MCO's care team works with the member to provide the opportunity to identify and explore employment options. Care plans can include a mix of employment and non-employment activities that reflect an individual's needs and preferences. Managed long-term care programs include a comprehensive and integrated set of services, including vocational services for all populations, transportation, and personal care services in the workplace. The MCOs are responsible for developing provider capacity in all service areas and have the flexibility to structure their contracts and relationships with providers in creative ways that will help expand and support integrated employment. In previous years, employment was identified as an area of improvement for managed long-term care programs. The MCOs were able to apply for Medicaid Infrastructure Grant (MIG) funded grants to develop plans to expand the number of employment providers. The MIG grants are administered by the Pathways to Independence initiative in the DHS Office of Independence and Employment. In 2008, six of the MCOs applied for the grants to develop projects. The projects were required to address activities including decreasing barriers to employment, increasing opportunities for person-centered, integrated employment, and supporting people with disabilities in achieving their desired employment outcomes. Funding could not be used to provide direct services and the projects needed to plan for and demonstrate sustainability beyond the grant funding. The success of the plans will be measured in future years.

Figure 8 details the work status of active members on December 31, 2008 by program. The percent of members who are retired is lower then the number in 2007 reflecting the change in membership during 2008.

Figure 8: Employment Status of Members Active on December 31, 2008



Source: Each member's most recently completed functional screen as of December 31, 2008.

Section 2: Services Provided

The managed long-term care programs are designed to provide cost-effective coordination of an integrated Medicaid benefit package of health and long-term care services, which would otherwise be available separately through the Medicaid State Plan (Medicaid "card services" and the home and community-based waiver programs. This unified funding stream, administered by a single managed care organization, results in a more coordinated and cost-effective package of services and supports for the individual member. The Partnership and PACE Programs provide its members with all Medicaid State Plan services as well as Medicare services, which brings all the acute and primary health care services, such as physician visits, emergency room services and hospital services, under the coordination of the care management team. The Family Care Program coordinates its members' acute and primary health care that the members receive from Medicaid fee-for-service providers. MCOs receive a monthly per person payment, called capitation, to manage and purchase care for their members.

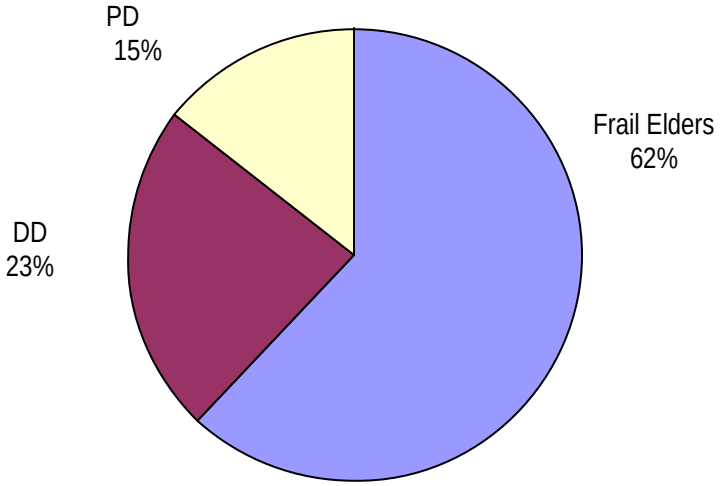
The MCOs assign a care team to each member. In Family Care, the care team includes the member, a registered nurse and a care manager assigned by the MCO, in addition to anyone else the member chooses, which could be a guardian, a family member or friend, or a professional ombudsman or advocate. Other professionals such as an occupational or physical therapist, or mental health specialist, may be involved, depending on the member's needs.

Table 5: Number of Members who Received Care Management Services during 2008 by MCO

MCO and Program	Frail Elder	Members with Developmental Disabilities	Members with Physical Disabilities
Milwaukee - Family Care	7,798	4	12
Fond du Lac - Family Care	600	400	205
Community Care of Central WI Family Care	845	706	319
Southwest Family Care Alliance - Family Care	328	274	148
Western WI Cares - Family Care	971	762	684
CCI - Family Care	1,225	1,831	673
CCI - Partnership & PACE	1,145	15	198
Care WI - Family Care	893	1,266	325
Care WI - Partnership	786	43	484
CHP - Family Care	137	444	69
CHP - Partnership	1,195	260	620
All MCOs	15,923	6,005	3,737

Source: Encounter data submitted by each MCO

Figure 9: Members who Received Care Management by Target Group during 2008



Source: Encounter data submitted by each MCO

In Partnership and PACE, the care team is the same as in Family Care, but also includes an assigned MCO nurse practitioner and the member's primary care doctor. Usually the nurse practitioner communicates with the doctor, who may or may not attend the care plan meetings.

The job of the managed long-term care programs' care team is to work with the member to:

- Identify the clinical, functional and personal experience outcomes the member needs and wants.
- Develop a member-centered plan that outlines the services and other help the member needs to achieve those outcomes.
- Make sure the services in the plan are actually provided.
- Make sure the plan continues to work in support of the member.

The first step the member's care team completes is an assessment. The assessment is an ongoing process of identifying the real-life personal outcomes that matter to the member and his/her unique strengths and needs for support. During this process the member will tell his/her care team:

- What kind of life the member wants to live,
- Whether the member wants to live at home or in a different living situation, and
- What kind of support is needed to live the member's desired life.

To complete the assessment, the care team must first know about the member's current situation, where the member lives, activities during the day and the health situation of the member. After the assessment is completed the care team will develop a member-centered plan and help the member move towards his/her personal outcomes. The plan must be clear about:

- What services and supports are needed to achieve the member's personal outcomes,
- Who is going to provide the member with each service or support, and
- When each service or support will be provided.

The member-centered plan should be both reasonable and effective. The care team works with the member to find the best provider for each service or support, including when possible informal unpaid supports from family, friends or volunteers.

The Managed Care Organizations are responsible for helping members achieve their personal outcomes and for considering cost when deciding on services and providers. The care team and member will work through a series of questions to help identify the member's personal outcomes and to match the outcomes with the effective and cost-effective services and supports. The member-centered plan should be both reasonable and effective.

Table 5 and Figure 9 detail the total number of members in 2008 by MCO and target group that received the basic service of care management by MCO. Tables 6a and 6b detail the top services provided to Family Care, Family Care Partnership and PACE members during 2008.

Member Story: Mary's Story from Western Wisconsin Cares

Meet Mary. At age 75, she ran circles around family and friends much less her age. Camping trips, grandkids' sporting events, volunteering at her church, and other activities kept her hopping. She also found great joy in collecting baby clothes, shoes, blankets and other supplies to be shipped to Honduras, where her sister and one of Mary's daughter were doing missionary work. She made several trips to Honduras to help dispense these supplies to the poor in remote mountain villages, traveling many times by mule or walking. Life was good.

Then she suffered a severe brain stem stroke. After several weeks in the hospital, she was admitted to the nursing home, where she lived three years prior to her enrollment in Family Care. Mary required a very high level of medical care with her impaired mobility/right-sided paralysis, her permanent feeding tube, and especially her tracheotomy, which needed frequent suctioning and care. She also had frequent occurrences of pneumonia and other infections, which required numerous hospitalizations while living in the nursing home.

When Mary became a Family Care member, she had three outcomes she wanted to realize.

- She wanted to live with her daughter, in their own home or apartment
- She wanted to be able to go fishing
- She wanted to be able to bake cookies in her own home or apartment

Accomplishing these outcomes required a huge collaborative effort on the part of Mary's care team and her family. The fact that Mary's daughter is a registered nurse was a huge factor in the success of the move; and although Mary's other daughters each live at least 3 hours away, they and their families made huge sacrifices to help and support the move in numerous ways. They all believed in their mom's deep faith and fierce determination, having been at her side through two cancer survivals (stomach in 1977 and colon in 2000), two major hip surgeries, and the heart-breaking losses of her husband, father and mother within a two year span.

This whole undertaking involved very precise coordination of the delivery of equipment and organizing of services. The extensive medical equipment and supplies needed to arrive at Mary's home the same day that Mary left the nursing home. Also, the skilled nursing, personal care, adult family home licensing and respite care needed to be coordinated very carefully. She left the nursing home on August 22, 2006.

All of the hard work and effort paid off big dividends. Mary has remained out of the hospital for 2 ½ years. Mary was able to actually achieve her goals and make her three desired outcomes reality, already within the first year she was at home! Mary's success story is truly inspiring.

Table 6a: Top Services Provided to Family Care Members during 2008

The following tables contain information about the services provided to the 17,785 members for whom expenditures were reported for calendar year 2008.

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	1178	6.6%	$5,889,165	1.4%
Case Management	17785	100.0%	$53,758,163	13.2%
CBRF, AFH, RCAC	6028	33.9%	$155,612,197	38.2%
Community Support	48	0.3%	$211,977	0.1%
Counseling and Therapeutic Resources	3957	22.2%	$2,668,316	0.7%
Daily Living Skills Training	961	5.4%	$5,506,859	1.4%
Day Center Services Treatment	1518	8.5%	$9,539,887	2.3%
Day Treatment -Medical	67	0.4%	$136,139	0.0%
Energy/Housing Assistance	420	2.4%	$238,957	0.1%
Equipment and Supplies	11397	64.1%	$11,367,289	2.8%
Financial Management	3418	19.2%	$1,826,415	0.4%
Home Health/Nursing	2467	13.9%	$11,553,139	2.8%
Meals	3298	18.5%	$5,161,340	1.3%
Nursing Home/ICF-MR	2524	14.2%	$51,298,955	12.6%
Other LTC Services	1140	6.4%	$496,094	0.1%
Pre-Vocational	1636	9.2%	$7,858,795	1.9%
Recreational Activities	248	1.4%	$54,974	0.0%
Respite	949	5.3%	$2,769,194	0.7%
Supported Employment	1023	5.8%	$4,217,621	1.0%
Supportive Home Care	8444	47.5%	$67,901,534	16.6%
Transportation	8694	48.9%	$9,826,951	2.4%
Total unduplicated	17,785		Total $407,893,962	

Source for Table 6a and 6b: Encounter data submitted by each MCO.

Notes:

1) The distribution of services provided by Family Care Programs from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

2) At time of production, the encounter data from Care Wisconsin and CHP were not certified and are not included in this table.

Table 6b: Top Services Provided to Family Care Partnership & PACE Members during 2008

The following tables contain information about the services provided to the 3,865 members for whom expenditures were reported for calendar year 2008.

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	981	20.7%	$7,348,685	5.0%
Case Management	4,747	100.0%	$34,298,349	23.3%
CBRF, AFH, GH	539	11.4%	$21,579,157	14.7%
Consumer Directed Supports	267	5.6%	$101,182	0.1%
Equipment & Supplies	4,124	86.9%	$1,892,814	1.3%
Home Health/Nursing	628	13.2%	$1,666,654	1.1%
Meals	1,002	21.1%	$1,279,063	0.9%
Nursing Home	1,051	22.1%	$2,183,059	1.5%
Other LTC Services	4,747	100.0%	$2,049,935	1.4%
Recreational Activities	131	2.8%	$220,341	0.1%
Respite	65	1.4%	$99,729	0.1%
Supportive Home Care	1,556	32.8%	$1,894,592	1.3%
Transportation	3,163	66.6%	$7,374,687	5.0%
Total LTC Service Costs			$91,032,013	
Acute Care Services				
Anesthesia	1,624	34.2%	$377,011	0.3%
Dental	2,016	42.5%	$1,396,974	1.0%
E&M Care (Office calls, NH, Hosp Visits)	4,521	95.2%	$6,428,692	4.4%
ER	733	15.4%	$250,407	0.2%
Inpatient Hospital	1,207	25.4%	$21,555,276	14.7%
Medications	4,630	97.5%	$14,687,707	10.0%
MH & AODA Outpatient Therapy	1,939	40.8%	$766,018	0.5%
Nutrition Intervention/Counseling	1,217	25.6%	$1,035,345	0.7%
Physician Pathology & Lab	3,958	83.4%	$302,067	0.2%
Physician Radiology	3,529	74.3%	$2,980,078	2.0%
Physician Surgery	3,481	73.3%	$2,885,354	2.0%
Physician/other medical services	4,747	100.0%	$3,117,809	2.1%
Total Acute Care Service Costs			$55,782,738	

Notes:

The distribution of services provided by Family Care Partnership from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.

Costs shown represent about 80% of the expected 2008 expenditures because of the time lag for filing claims and submitting encounter data. A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Living Situations

The managed long-term care programs support the Department's policy that with proper supports, most frail elders, people with developmental disabilities and people with physical disabilities can live in their own homes and maintain their independence as much as possible. Living at home is not possible or preferred by all managed long-term care program members but the MCOs will work with members who have identified living at home as a personal outcome. The care team and member will work to find services and supports to help the member live as independently as possible.

Table 7 details the percentage of eligible days in natural settings (their own home or apartment) versus the percentage of days members spent in residential service settings (AFH, RCAC, CBRF, ICF-MR, nursing homes, and other institutions).

On average, the Family Care members spent 66% of eligible days in natural settings during 2008. There are variations among the MCOs, which can be due to the differences in members, member preferences and availability of providers in their area.

Table 8 illustrates one way that utilization of residential services can be reviewed. Members with relatively low care needs can almost always be served in community settings, and yet a small number can be observed with relatively lengthy (90 days or longer) stays in nursing facilities. Information like this helps the Department and the MCOs study and manages utilization of such services.

For all the managed long-term care programs, the majority of the members were never admitted into a nursing home during 2008. Nursing homes are an important part of the long-term care system for short-term stays, rehabilitation services and members who have complex needs that cannot be safely provided for at home, and people who prefer to live in a nursing home. The managed long-term care programs provide wellness and prevention services and supports to reduce the need for nursing home stays or reduce the number of days of a stay.

Table 7: Use of Purchased Residential Services during 2008
Percent of Total Member-Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	66.9%
Group residences	26.1%
Nursing facilities	6.9%
Total	100.0%
Family Care Partnership & PACE	
Natural (non-purchased) residential settings	78.1%
Group residences	16.3%
Nursing facilities	5.6%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 8: Nursing Facility Stays of 90 Days or Longer for Members by Target Group with Low Care Needs

Family Care	Percent of Members in Target Group
Frail Elders	1.1%
Members with Developmental Disabilities	0.1%
Members with Physical Disabilities	0.6%
Family Care Partnership & PACE	
Frail Elders	0.03%
Members with Developmental Disabilities	0%
Members with Physical Disabilities	0.15%

Source: Encounter data submitted by each MCO and member's Functional Screen data.

Coordination of Health Services and Long-Term Care

Another service provided to members by the MCOs is coordinating primary health care with long-term care.

In Family Care Partnership and PACE MCOs provide both Medicare and Medicaid primary, acute, and long-term care for their members. A nurse practitioner or physician's assistant is on every member's care management team and provides some medical care and acts as a liaison with the primary care physician. In Family Care, which does not directly provide primary or acute medical care, nurses are assigned to each care management team and coordinate care with the members' medical care providers. Care team members may accompany the member to see their physicians. The MCO care team then assists the member in following medical recommendations and achieving the best possible health. In addition to assuring that people get the health and long-term care services in the Family Care benefit package, the care teams also help members coordinate all their health care, including, if needed, helping members get to and communicate with their physicians and helping them manage their treatments and medications.

An in-depth independent study of Family Care (not Family Care Partnership or PACE) that was conducted in 2005 compared member's health status, health care costs and long-term care costs to those of a carefully matched comparison group of similar individuals receiving fee-for-service Medicaid services in the remainder of the state. The study found that Family Care members visited their primary care physicians significantly more frequently than members of the non-Family Care comparison group. In 2008, 81.5% of the Family Care members visited their primary care physician at least once during the calendar year. The study also found lower rates of hospitalization and nursing home utilization, and suggested that the more frequent physician and team visits increased opportunities for prevention and early intervention health care services.

A good example of coordinating health care is how care teams work with the members to coordinate influenza and pneumonia vaccinations. These vaccinations are important because the members served in the managed long-term care programs are at higher risk for having medical complications from influenza and pneumonia. The Family Care Partnership and PACE benefit package includes primary and acute health care services, and the doctor on the member's care team will recommend vaccinations for appropriate members. In Family Care, the care teams assist in making sure members have access to appropriate immunizations, and track whether members have received those immunizations.

Another example is dental care. 29.1% of Family Care members had at least one dental visit during 2008. According to the Mayo Clinic[8], bad oral hygiene can increase the risk of health problems, including cardiovascular disease and diabetes. In Family Care Partnership and PACE, dental and primary care visits are included in the benefit package.

"All the workers are wonderful. Each and every one of them is special in their own way. I enjoy them all, whether it is in person or on the phone. When I decided that it was the time to do some changing with my health problems progressing, they were there for me and still are."

- Response from the 2008 Member Satisfaction Survey

Use of Informal Supports

Every managed long-term care member enters the program with a certain number of impaired activities of daily living (ADLs) or instrumental activities of daily living (IADLs). ADLs are:

- Bathing
- Dressing
- Eating
- Moving around in one's home
- Using the toilet
- Moving between surfaces, such as from a chair to a bed.

IADLs are:

- Preparing meals
- Managing and taking medications
- Managing money
- Coordinating or managing transportation
- Performing household chores and laundry
- Using the telephone

The member-centered plan identifies who will provide the member needed services and supports. Providers may include the member, family, friends and other providers of informal, or unpaid, supports. Informal supports services are an important part of a member's individual service plan and many members include the use of informal supports in their own desired outcomes.

Table 9: Use of Informal Supports with Members who Have at Least One Limited ADL during 2008

Program and Target Group	No. of Members with at Least One ADL Limitation	No. of Members with at Least One ADL Limitation and at Least One ADL Informal Support	Percent of Members With at Least One Informal Support
Family Care	17,466	5,718	32.7%
Frail Elders	11,360	3,232	28.5%
Members with Developmental Disabilities	4,197	1,608	38.3%
Members with Physical Disabilities	1,909	878	46.0%
Family Care Partnership & PACE	3,648	1,575	43.2%
Frail Elders	2,475	1,038	41.9%
Members with Developmental Disabilities	229	84	36.7%
Members with Physical Disabilities	944	453	48.0%

Source: Members Functional Screen data

Most of us have informal supports. We have a neighbor who uses his snow blower to clear our driveway or a friend who brings a hot meal over when we do not feel well. People who provide informal supports help us feel connected to the community and add a social component to our life. However, people who provide informal supports can become "burned out" if they are not supported. The managed long-term care programs' staff monitor the informal support people and watch for signs of caregiver "burn out". Program staff arrange respite care or increase the amount of personal care given by program staff to ease the burden and give support to the people who provide informal supports. As the baby boomer population ages and needs more assistance, people who provide informal supports will become even more important and integral to helping people remain in their homes.

Because the arrangement and maintenance of informal supports is an objective of the Family Care, Partnership and PACE programs, observing changes in members' reliance on informal supports over time can help to assess the success of the program in this area. Tables 9 and 10 detail the percentage of members who depend on informal supports for some of their care. The percentage of members who use at least one informal support in 2008 stayed consistent with the experience in 2007 except for the members with developmental disabilities in the Family Care Partnership and PACE program. This decrease can be explained by the increase of Partnership members with developmental disabilities. In 2007, Partnership and PACE had less then 100 members with developmental disabilities and by the end of 2008 that number had more than tripled.

Table 10: Use of Informal Supports with Members who Have at Least One Limited IADL During 2008

Program and Target Group	No. of Members with at Least One IADL Limitation	No. of Members With at Least One IADL Limitation and at Least One IADL Informal Support	Percent of Members With at Least One Informal Support
Family Care	20,364	12,735	62.5%
Frail Elders	12,502	8,453	67.6%
Members with Developmental Disabilities	5,656	2,908	51.4%
Members with Physical Disabilities	2,206	1,374	62.3%
Family Care Partnership & PACE	4,655	3,294	70.8%
Frail Elders	3,091	2,383	77.1%
Members with Developmental Disabilities	315	169	53.7%
Members with Physical Disabilities	1,249	742	59.4%

Source: Members Functional Screen data

Self-direction of Services within Family Care Programs

Individuals with disabilities (or their guardians, when they have guardians) can participate in the planning and directing of their services in a variety of ways. All Family Care members exercise 'self-determination' by participating in the development of the care plan, choice of the services, and evaluation of whether the services are successful. Beyond that, some prefer to exercise greater control, such as by participating in the training of their personal care aides.

Some members or their guardians prefer to handle even more responsibility for planning and managing their services, such as recruiting and selecting staff, handling scheduling, or even managing payroll and benefits bookkeeping and reporting. These higher levels of member control of services are called 'self-direction,' and within Family Care, the member can choose to self-direct all of his/her services, or only some services, while choosing to rely on the MCO to manage others. Though frequently used for in-home care, self-direction can also be used outside of the home for services such as transportation and personal care at the member's work place. For example, a member could choose to self-direct personal care services that help him/her to stay home or to find and keep a job, and choose to rely on the care team to manage services such as purchase and maintenance of durable medical equipment.

In the managed long-term care programs, the MCOs are required to offer their members the services of a fiscal intermediary or a co-employment agency to assist them in directing the more administrative or managerial aspects of care planning. The reporting of members who use these services is difficult. The Department's staff will be working with MCOs in 2009 on this reporting data.

In addition, 2008 saw the creation of a separate program, IRIS (Include, Respect, I Self-direct), for individuals who prefer to exercise the greatest degree of self-direction, with no involvement of an MCO. IRIS meets the federal requirement that persons have an alternative choice to a managed care program. Individuals who choose IRIS self-direct their publicly funded, community-based, long-term care supports and services. For more information on IRIS, visit http://dhs.wisconsin.gov/bdds/IRIS/

"The Family Care Programs will eliminate waiting lists for community-based long-term care programs in Wisconsin by providing the right services, in the right amount and at the right time."

Judith Frye, Director
Office of Family Care Expansion

Member Story: Dr. Lubar's Story from Community Care, Inc.

Dr. Mike Lubar of Mequon, a clinical psychologist with Jewish Family Services, is pleased with the Self-Directed Supports (SDS) Option available to him through the Family Care Program.

Dr. Lubar, who has muscular dystrophy, needs round-the-clock care. He already had an excellent care team, with some nurses who have cared for him for nine years. When Community Care's Family Care Program replaced the Ozaukee County-run program, Dr. Lubar was happy to learn he could keep his same team and make a smooth transition to the new program. He found that with the SDS Option, he has even more ability to control who cared for him.

The SDS Option allows Dr. Lubar the ability to make his own decisions about the support he needs to live, allowing him to take responsibility of his own care. He appreciates the flexibility in deciding who will care for him. He found several excellent caregivers he wanted to include in his team who were not RNs or LPNs that would not have been qualified without the SDS option. "It's a win-win situation for all of us," he says. "It makes it possible for me to find someone to cover all my hours."

Having muscular dystrophy has meant that Dr. Lubar's muscles have weakened throughout his life. He began using a wheelchair as a fourth grader and has been ventilator-dependent for 14 years. "Physically, I can't do anything from the neck down," he explains.

Yet Dr. Lubar finished his doctorate degree after he was already ventilator-dependent. He maintains an active clinical practice, meeting with clients and doing the necessary recordkeeping associated with his practice. "My practice is a big part of my life. I like being productive and doing meaningful work," he explains.

Section 3: Results

Managed long-term care programs--like every worthy endeavor--exists to create desired results, also known as 'outcomes.'

The 'member-centered' methods and techniques that are built into the managed long-term care programs are designed to keep the focus of all activities on the outcomes that are desired by the member. The outcomes supported by Family Care are of three types: clinical, functional, and personal experience:

Clinical outcomes involve the member's physical, mental, or behavioral health. Usually measured by professionals such as doctors, nurses, or therapists, they include outcomes such as having diabetes under control, recovering from depression, or avoiding preventable medical crises that require emergency-room or inpatient care. In this report, Tables 11 and 12 describe the frequency of certain preventable medical events; Table 13 describes the proportion of members who are protected from flu and pneumonia through immunizations.

Functional outcomes involve the normal activities that members can or do perform. Functional outcomes include simple activities such as the ability to eat, fix a meal, or take a bath, and more complex activities such as living in the community rather than in an institution or getting and keeping a paid job. In this report, Tables 14 and 15 contain information about documented increases or decreases in members' abilities to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs); Table 16 reports on the types of residences in which members are living during the past year; and Table 17 reports on changes in their employment status over the past year.

Personal experience outcomes involve the member's overall quality of life. Long-term care affects consumers' daily life more continuously and for longer periods than primary and acute health care. As a result, the clinical and functional outcomes are generally sufficient to measure the quality of most medical care, but long-term care outcomes need specifically to address broader quality-of-life indicators.

For example, a person's freedom to socialize is limited when he or she is in the hospital, but because hospital stays are generally short, we do not tend to consider that seriously detrimental to quality of life. If, however, someone is served in an institutional setting away from their family and friends on an ongoing basis, his/her inability to engage in the life of the family and community could be a significant quality-of-life issue that should be addressed.

Personal experience outcomes is the term the managed long-term care programs use to refer to quality-of-life outcomes, because each member's personal experience of his or her daily life is the only possible measure of these outcomes. Before creating each member's member-centered plan, care managers explore each member's hopes and dreams, and help the member to express these in terms of personal-experience outcomes that will be supported by Family Care services. Personal-experience outcomes cover three general areas:

Choice

Personal-experience outcomes related to choice include the freedom and authority to choose where and with whom one lives; to make choices regarding the supports and services that one uses; and to make decisions about one's daily routine, such as what clothes to wear and when to go to bed.

Life activities

Personal experience outcomes related to life activities include having relationships with family and friends; being treated fairly and in ways that make one feel respected; engaging in activities that give meaning or significance to life, such as employment; being involved in one's community to the extent that one desires; having stability in important living conditions; and having a desired amount of privacy.

Health and safety

Personal experience outcomes related to health and safety include feeling comfortable with one's level of health; and experiencing a feeling of safety, particularly from abuse or neglect.

Measurement of personal experience outcomes is difficult, because it requires program administrators to objectively assess the subjective experience of the program's members. However, long-term care researchers throughout the U.S. have been working toward reliable measures of personal experience outcomes for more than a decade. Building on that work, the Department contracted with the University of Wisconsin-Madison in 2007 to develop an interview tool with sufficient reliability to support measurement of personal-experience outcomes. This interview tool, known as PEONIES, is expected to be ready for use in creating performance-measure quality data in 2010.

Member Story: Alex's Story from Community Care, Inc.

Meet Alex, a who had been a Waukesha County home and community based waiver program participant. Alex was unable to be placed in the community due to lack of an appropriate adult family home to provide for his care and safety. Alex is a 23-year-old male diagnosed with Autism and behavioral problems. His care manager became instrumental in the care and re-integration of this young man into the community by slowly becoming familiar with Alex and his unique situation. Residing at the Winnebago Mental Health Institution (WMHI), he was being cared for his autism and needed one-on-one supervision for self abusive behavior and abusive behavior to others. Alex needs assistance with ADLS: bathing, grooming, dressing, toileting and IADLS: meals preparation, housekeeping, shopping, laundry and transportation. In addition, Alex needs a quiet, calming environment and supervision to redirect his behaviors.

His care manager was determined to find a place for Alex in his community. She developed a care plan in collaboration with numerous professionals, including a member of the Community Care behavioral health team, and Alex's legal guardian. Alex's care manager continued to advocate for Alex after he had setbacks with a gastrointestinal bleed that required a hospital stay. During his stay in the hospital and even with all new staff and in a new environment, Alex did not engage in any inappropriate or aggressive behavior.

His care manager worked with a provider to develop a property that would meet Alex's needs in the community. Alex visited the adult family home (AFH) to help with the transition and moved in January 2009.

Alex is currently enjoying his new home in the community. Alex continues with one-on-one care but has more opportunities to go shopping and walking outdoors. Alex continues to thrive in his new environment. The AFH staff is beginning to slowly transition Alex into their adult day care/ vocational program.

Alex now lives in the community and is cared for by staff specifically trained to meet his needs. Alex's family is so grateful that their son is safe and cared for with the services needed to keep him healthy and whole.

Indicators Related to Health Status

Ambulatory care sensitive conditions (ACSCs) are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. These conditions provide insight into the quality of the health care system outside the hospital setting. Some common ACSCs include asthma, bacterial pneumonia, urinary tract infection and long- and short-term complications from diabetes. The list of ACSC's was developed by the federal Department of Health and Human Services' Agency for Healthcare Research & Quality and is used nationwide as an indicator of quality of healthcare.

The tables below detail the percentage of members by target group that either went to an emergency room or were admitted into a hospital due to a preventable health issue. An example of a preventable event is when a person with diabetes is admitted into the hospital for an unexpected toe amputation. If a person with diabetes receives regular care and preventive education and maintains good blood sugar control, adverse events from diabetes can be minimized or avoided.

Table 11: Preventable Emergency Room (ER) Visits

Family Care	Percent of Members in Target Group with Preventable ER Visit
Frail Elders	6.2%
Members with Developmental Disabilities	2.5%
Members with Physical Disabilities	8.1%
Family Care Partnership & PACE	
Frail Elders	2.3%
Members with Developmental Disabilities	0.6%
Members with Physical Disabilities	4.2%

Source: Encounter data.
The Medicare admissions are included only in the FC Partnership numbers.

Table 12: Preventable Hospital Admissions

Family Care	Percent of Members in Target Group with Preventable Hospital Admission
Frail Elders	5.2%
Members with Developmental Disabilities	0.6%
Members with Physical Disabilities	3.3%
Family Care Partnership & PACE	
Frail Elders	7.0%
Members with Developmental Disabilities	0.6%
Members with Physical Disabilities	5.3%

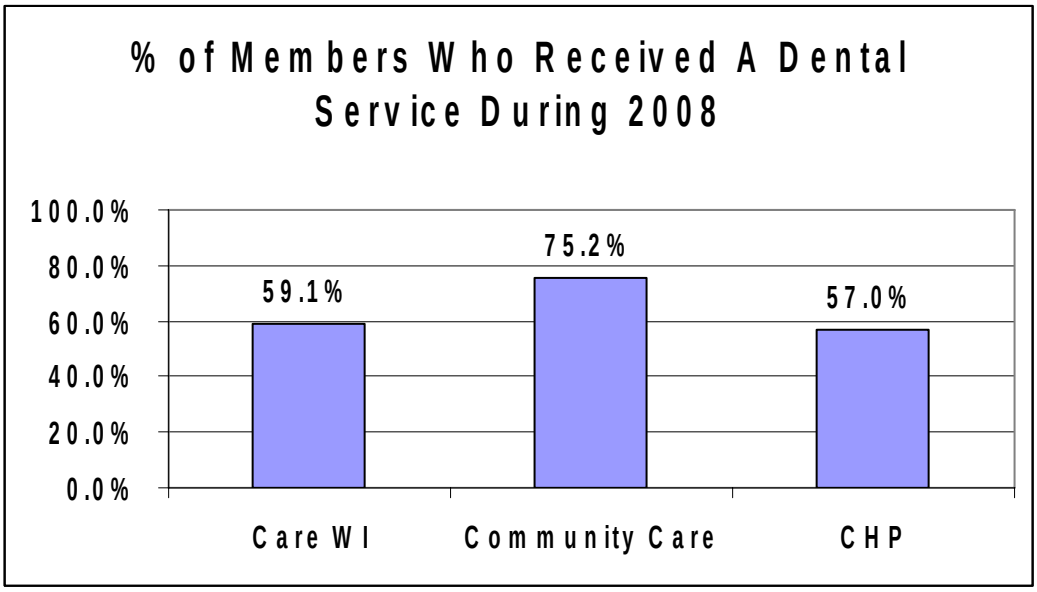
Source: MMIS claims data for Family Care.

Table 13: Immunizations – Influenza and Pneumonia Vaccinations for Active Members on December 31, 2008

MCO and Program	Influenza Immunization	Pneumonia Immunization
Milwaukee - Family Care	85.2%	83.0%
Fond du Lac - Family Care	77.4%	30.6%
Community Care of Central WI Family Care	70.4%	33.2%
Southwest Family Care Alliance - Family Care	40.6%	56.1%
Western WI Cares - Family Care	59.1%	55.8%
CCI - Family Care	51.3%	27.0%
CCI - Partnership & PACE	90.0%	93.0%
Care WI - Family Care	*Not available at time of production*	
Care WI - Partnership	76.3%	10.5%
CHP - Family Care	*Not available at time of production*	
CHP - Partnership	76.9%	59.6%

Source: Partnership and PACE event data submitted by MCOs. Family Care event data submitted by External Quality Review Organization (MetaStar).

Figure 10: Percent of Family Care Partnership & PACE Members Who Received Dental Services during 2008



Source: Event data submitted by MCOs.

Member Story: Todd's Story from Creative Care Options

The two most important things in Todd Moely's life are his independence and his Green Bay Packer season tickets. His home and power wheelchair are adorned with Packer insignias. For those of us who know him, his Packer advocacy and his advocacy in speaking on behalf of people who have disabilities share equal stage.

Todd Moely lives independently in a house he rents from his father. Todd receives support from Creative Care Options in Fond du Lac County and from his family. He has worked at the local Target store for over sixteen years and serves on the safety team. A graduate of Fond du Lac Goodrich High School and the University of Wisconsin at Whitewater, he has used his speech and communication training to represent himself and others who have physical disabilities on a number of public boards and committees. Todd Moely has been a member of the local Long-Term Care Council (formerly the COP Planning Committee) for 17 years, serving since 1991. He has been the elected chairperson of the Council for the past three years. This Council has given input and feedback to the pilot effort to plan and begin Creative Care Options in 2000 as a Medicaid Managed Long-Term Care Organization. The Council continues to monitor all long-term care programs for children and adults in the county.

As a member of the Creative Care Options Governing Board since 2000, Todd has provided input and leadership for the state's first long-term managed care organization. He currently serves as the vice-chairperson of the Board. He represents members of Creative Care Options on the board and shares information with the Board on the impact of policies and processes of the organization on the day-to-day life of members. His perspective and advocacy has been appreciated by the Board as it works to continually improve Creative Care Options as a managed care organization. Todd has earned the respect of Governing Board members and staff.

As Creative Care Options planned to offer Self-Directed Supports (SDS) in 2000, Todd Moely served on the local SDS Advisory Committee. The SDS Advisory Committee hammered out the values and basics of the local program through two years of meetings. Three Board-adopted policies were developed which guide the SDS option for Creative Care Options yet today. His input and understanding were invaluable to establish the policies and processes for the local SDS option.

Todd recently received the Michael J. Falconer Distinguished Service Award from the Governor's Committee for People with Disabilities. The Falconer award recognizes an individual with a history of extensive involvement in advocacy activities, improving services or expanding access to the community for people with disabilities. His nominating papers noted, "his understanding, his feedback, his questions, and his interest to help local and state organizations to better serve and support people who have physical disabilities. He has been active at work and in his community to make improvements."

Source for Tables 14 and 15: Functional screens submitted for each member during 2008, compared with functional screens from one year earlier.

Indicators Related to Functional Status

Every Family Care member enters the program with a certain number of impaired activities of daily living (ADLs) or instrumental activities of daily living (IADLs).

The MCOs' services are intended to reduce or delay any unavoidable deterioration in each member's functional abilities and to, whenever possible, help members to recover or improve their abilities. Tables 14 and 15 document the increases or decreases in members' abilities to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) during 2008. Comparing the results to 2007, the percentage of members who see no change in ADLs or IADLs is very similar.

Table 14: One-Year Changes in Need for Assistance with Activities of Daily Living by Target Group and Program
ADLs (Eating, bathing, toileting, dressing, transferring and mobility)

Program and Target Group	Percent of Members with Fewer ADLs Limitations	Percent of Members with No Change in ADLs Limitations	Percent of Members with More ADLs Limitations
Family Care	13.0%	63.6%	23.4%
Frail Elders	14.4%	57.3%	28.3%
Members with Developmental Disabilities	10.2%	74.5%	15.2%
Members with Physical Disabilities	13.4%	66.4%	20.2%
Family Care Partnership &PACE	16.3%	58.5%	25.2%
Frail Elders	13.7%	59.6%	26.7%
Members with Developmental Disabilities	16.5%	61.9%	21.6%
Members with Physical Disabilities	23.8%	54.6%	21.6%

Table 15: One-Year Changes in Need for Assistance with Instrumental Activities of Daily Living by Target Group and Program.
IADLs (Meals, medications and money)

Program and Target Group	Percent of Members with Fewer IADLs Limitations	Percent of Members with No change in IADLs Limitations	Percent of Members with More IADLs Limitations
Family Care	5.9%	85.6%	8.4%
Frail Elders	6.3%	84.2%	9.5%
Members with Developmental Disabilities	3.5%	90.9%	5.6%
Members with Physical Disabilities	11.0%	78.0%	11.0%
Family Care Partnership & PACE	10.3%	78.5%	11.2%
Frail Elders	7.9%	82.0%	10.0%
Members with Developmental Disabilities	6.2%	79.4%	14.4%
Members with Physical Disabilities	17.5%	68.4%	14.0%

Member Story: Narda's Story from Care Wisconsin First

Even with a painful arthritic hip from a childhood injury and a weight of 500 pounds, 62-year-old Narda stayed busy with her family. Through a medical weight loss program, Narda lost nearly 200 pounds so that she could undergo gastric bypass surgery. Post-surgery strokes and falls left her bed-bound with a broken femur, dependent on help for all activities of daily living. Narda enrolled in Care Wisconsin's Partnership program a month after the strokes, with the lofty goal of regaining her independence.

From the beginning, Narda's story is one of relationships. Her care team extended and shadowed the physical therapy visits she'd been receiving to ensure a smooth transition to the Partnership physical therapy visits. The Care Wisconsin First Partnership team nurse at the time, reflects, "Our team conducted an initial assessment and got all players involved and communicating—including physical therapy, occupational therapy, and homecare."

The installation of an overhead trapeze helped Narda build up her strength; the team reduced her daily home visits from six to just two visits after only six weeks. Six months later, Narda was able to stop all home care. Her care team used her case with first-year University of Wisconsin physical therapy students to show how much improvement can be made in an individual's home with the correct staff, equipment, and member-driven priority-setting.

The care team worked with Narda to determine her priorities, then formed and communicated a plan to help her reach her desired outcomes. Her first major goal was to use the commode on her own—and with great determination and hard work, she accomplished this surprisingly quickly. Planning for socialization was also important since "Narda is a social butterfly," says her social worker on her care team. They put a ramp and para wheelchair in place for her at her daughter's new home before the move so she would be mobile.

Narda required hip replacement surgery before she could bear weight on her hip. A post- surgery infection set her back so far that when it finally cleared, her physical therapy had to begin again, nearly from scratch. The same interdisciplinary team worked with a determined Narda to help her follow her grandson's instructions to "hurry up and get walking" so she could teach him how to dance and she did.

In fact, Narda now lives in her own apartment, buys groceries, cooks, sews, crochets, draws, and spends time with her family. She takes the Care Wisconsin First van to the day center three days a week, where she shares her homemade cooking and plays spades and dominoes with her friends.

Narda is enthusiastic about her team at Care Wisconsin First: "This is the best place to be if you have problems with your health, because there are so many people to help you." Her brother recently enrolled with Care Wisconsin First, and will soon begin taking the van to the day center with her. Narda says she'll introduce him to everyone there, but emphasizes that if he wants to be independent, "he'll have to make some friends of his own too."

Desired Living Arrangements

A primary goal of the managed long-term care programs is giving people meaningful choices about where they want to live. As stated earlier, the current public policy is that most people can remain living in their homes if provided with the proper services and supports. The membership of the managed long-term care programs reflect the trend that most people prefer to live in their home. Table 16 shows the current and preferred living arrangements of active members in the managed long-term care programs.

The table includes data on where the member is currently living and the member's preferred living setting. The shaded boxes designate the percentage of members who are currently living in their preferred living setting for each residential choice. Overall, 82.4% of the Family Care members and 84.1% of the FC Partnership members are living in their preferred living arrangement.

Table 16: Number of Members by Current and Preferred Living Situation on December 31, 2008

Family Care	Preferred Residence				Total number of members in living setting
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	10,814	138	6	272	11,230
Currently lives in Group Setting	708	4,147	11	1,179	6,045
Currently lives in Nursing facility	405	221	465	286	1,377
Currently lives in Other setting	49	12	2	7	70
Total number of members who would prefer setting	11,976	4,518	484	1,744	18,722

Family Care Partnership & PACE	Preferred Residence				Total number of members in living setting
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	2,930	13	0	68	3,011
Currently lives in Group Setting	136	362	1	200	699
Currently lives in Nursing facility	109	18	92	77	296
Currently lives in Other setting	11	3	1	1	16
Total number of members who would prefer setting	3,186	396	94	346	4,022

Source: Each member's most recently completed functional screen, as of December 31, 2008.

Changes in Members' Employment Status

The Managed Care Organization's care teams provide services to help members achieve their employment objectives. Services such as daily living skills training, day treatment, pre-vocational services and supported employment are included in the Family Care benefit package. Other Family Care services such as transportation and personal care also help people meet their employment goals.

Supporting employment goals among frail elders and adults with physical and developmental disabilities is a challenge to long-term care programs, and there is room for improvement in the employment rates among Family Care members. Historically, in Wisconsin and across the nation participation in employment. and particularly integrated employment, among working age adults with disabilities has been limited. 2008 marked the second year that Pathways to Independence initiative in the DHS Office of Independence and Employment made grant funds available to all MCOs serving working-aged adults with disabilities in Wisconsin. The grant was funded by the Centers for Medicare and Medicaid Services via a Medicaid Infrastructure Grant (MIG). Six MCOs requested funding to develop projects to decrease barriers to employment, increase opportunities for person-centered, integrated employment, and support people with disabilities in achieving their desired employment outcomes.

Table 17: Changes for Employment Status of Family Care Program Members during 2008

Year-later Employment Status of Retired Members on Earlier Screen	Family Care Total (N=3603)	FC Partnership & PACE Total (N=1109)
No Change: Still Retired and Satisfied	99.6%	99.5%
Now Have Employment and Satisfied	0.2%	0.2%
Not Satisfied: Still Retired but Desiring Employment	0.2%	0.3%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care Total (N=318)	FC Partnership & PACE Total (N=110)
Now Have a Job, Satisfied	12.6%	2.7%
No Longer Desire Employment, Satisfied	21.7%	21.8%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	65.7%	75.5%
Total	100.0%	100.0%

Year-later Employment Status of Members who were Employed and Satisfied With Job on Earlier Screen	Family Care Total (N=1633)	FC Partnership & PACE Total (N=71)
No Change: Still Employed in Desired Job	90.6%	74.6%
Now Retired or Unemployed but Satisfied	3.3%	19.7%
Now Out of a Job or Desiring a Different One	6.1%	5.6%
Total	100.0%	100.0%

Source: Functional screen created for each member during 2008, compared with functional screens from one year earlier.
Note: Employment information collected from the screener may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Members' Satisfaction

Although it is not an 'outcome' in the same sense as the clinical or functional well-being of the members, members' satisfaction with the program is an important indicator of the programs' success. Member satisfaction can be observed in at least two measures: satisfaction surveys and the rate at which members choose to leave the program.

Satisfaction Surveys

The eight Family Care, Partnership and PACE managed care organizations (MCOs) distributed 8,265 member satisfaction surveys and 3,063 were returned for a completion rate of 37.1%. The ten core questions were developed by a stakeholder workgroup, including MCOs and DHS staff.

Overall, the level of satisfaction with the programs is very positive. In responses to open-ended questions, members commented about how the programs have helped them remain in their home and how they worry less about getting needed health care.

At least 92% or more of the members responded that they were "always" or "most of the time" satisfied with each of the following statements:

- The work that my care manager and nurse (or team) does for me;
- My nurse or team listens to my concerns;
- My nurse or team talks to me so I can understand;
- I get help from my nurse or team when I need it;
- I am happy with the services I receive;
- I feel comfortable asking questions.

Strong but lower levels of satisfaction were reported for two additional statements:

- 81.0% of the members responded that they can "always" or "most of the time" select the people who help me with their personal care;
- 84.4% of the members responded that they "always" and "most of the time" participate in planning and making decisions about the services they will receive.

The MCOs summarized the findings and added varying amounts of text to explain the findings and how the information would be used. Several of the MCOs described making changes to improve their member's satisfaction with the program. The individual MCOs' surveys and detailed summary of the 2008 Member Satisfaction Survey will be available on the MCO's and DHS website. The DHS website is http://dhs.wisconsin.gov/ltcare/index.htm.

"Partnership is a wonderful place. I have been a member since 1997. My team is very good and is ready to help me."

- Response from the 2008 Member Satisfaction Survey

Disenrollment for Reasons Other than Death or Loss of Eligibility

Voluntary disenrollment from a managed care organization is another way to measure member satisfaction. There are a variety of reasons for a member to leave the program, such as, loss of eligibility, move out of state, or the individual chose another program to receive their services from. Overall there is a small percentage of eligible members who choose to leave a managed long-term care program.

Table 18: Members who chose to leave the program during calendar year 2008
Left the program means members who left the program and did not come back within a 3-month time period.

MCO and Program	Members Served in Calendar Yr. 2008	No. of Members who chose to leave program	% of Members who chose to leave program
Milwaukee - Family Care	7,840	305	3.9%
Fond du Lac - Family Care	1,206	54	4.5%
Community Care of Central WI Family Care	1,874	47	2.5%
Southwest Family Care Alliance - Family Care	754	29	3.8%
Western WI Cares - Family Care	2,422	102	4.2%
CCI - Family Care	3,743	143	3.8%
CCI - Partnership & PACE	1,362	72	5.3%
Care WI - Family Care	2,492	36	1.4%
Care WI - Partnership	1,317	75	5.7%
CHP - Family Care	651	10	1.5%
CHP - Partnership	2,085	88	4.2%
All MCOs	25,746	961	3.7%

Source: MMIS eligibility data.

"I don't know how I would cope with my situation without the assistance of Family Care. Great services and care…."

- Response from the 2008 Member Satisfaction Survey

Appendix 1

Footnotes:

[1] Milwaukee County serves frail elders, only (age 60 or older)

[2]Precise requirements for functional eligibility for Family Care can be found in Wisconsin statutes s.15.197(4)(a) 2 and s.15.197(4)(a)1, and in Wisconsin Administrative Code HFS 10.13(25m).

[3]Disorders GU System: Artificial Bladder, Bladder Incontinence, Cystocele, Enlarged Bladder, Enlarged Prostate, Hematuria, Kidney Stones, Kidney Transplant, Prostatitis

[4]Other Digestive disorders: examples of common diagnoses include dysphagia (difficulty swallowing), gallstones, gastroesophageal reflux (GERD), gastroenteritis, GI bleed, hernia, hemorrhoids, irritable bowel syndrome (IBS), soft palate deformity, pancreatitis, ulcers.

[5]Other Nerve disorders: examples of common diagnoses include anoxic brain syndrome (lack of oxygen at birth), apraxia (disorder of movement planning), bacterial meningitis, brain aneurysm, brain tumor, cerebellar ataxia, cerebral aneurysm, encephalitis, fetal alcohol syndrome, hydrocephalus.

[6]Other Sensory disorders: examples include chronic vertigo, hearing deficit (partial), otitis, vertigo

[7]Visual impairment: examples of common diagnoses include cataracts, diabetic Retinopathy, glaucoma, lens implant, macular degeneration, retinal keratosis.

[8] *Oral health: A window to your overall health*, February 7, 2009, http://www.mayoclinic.com/health/dental/DE00001

Information on the data:

The following pages provide a description of the program's current members. The data that were used to produce the information that is included in this section came from the Department's administrative data systems, primarily the Medicaid Management Information System (MMIS). Two other major sources for information presented here is the Long-Term Care Functional Screen and the Encounter Reporting System, which provides a wide range of data on member demographics, functional needs and health status.

Most of the data used here resides on several universes in the MEDS data warehouse. These universes are databases, or logical configurations of Oracle tables that were designed to meet specific research needs and purposes.

In comparing several tables, readers may note that the total number of cases varies amount tables, even sometimes when it seems as if the 'N' should be the same. This variation results from several factors:

- Missing data. Most tables presented in this report are the products of matching and analyzing multiple administrative data sources. When certain data are missing from any of the data sources used in such analysis, any attempt to offer different views of even a similar phenomenon will frequently result in a somewhat different population size (N), or in a different count of the characteristics being analyzed.
- Reporting lag and database updates. Late reporting (lag) effects data completeness at any given point in time. Since the analyses presented here were performed over several months, some discrepancies in the number of cases and the data associated with them can occur. The same holds true for the updating of the administrative databases in the MEDS data warehouse. Since these databases are updated on different schedules, certain discrepancies are possible as well.
- Data instability. The correction and adjustment of various data on the administrative database is com-

mon and can result in certain data fluctuations over time. The eligibility data, which are the primary source for identifying Family Care members and is the starting point to form any analysis, is a primary example of data instabilities. On different days the eligibility databases can yield different numbers of eligible members for the same focal date.

List of Acronyms/Abbreviations:

ADL – Activities of Daily Living

ADRC – Aging and Disability Resource Center

BOALTC – Board on Aging and Long Term Care

DHS – Department of Health Services

EQRO – External Quality Review Organization

IADL – Instrumental Activities of Daily Living

Managed Long-Term Care Programs – refers to Family Care, Family Care Partnership and PACE

MCO – Managed Care Organization

MIG – Medicaid Infrastructure Grant

Sources of Additional Information

- For additional information specific to a MCO, contact the MCO. Contact information is listed on pages 74-75.
- External Quality Review Reports by State Fiscal year are located on the MetaStar website: http://www.metastar.com/web/

Comments and suggestions regarding the content of this report can be submitted to Karen McKim, Quality/Research Team Manager (Karen.McKim@dhs.wisconsin.gov).

Acknowledgement

Thank you to all of the members and Managed Care Organizations that submitted the stories and/or satisfaction quotations. These stories provide the readers with a real look at who and how managed long-term care is helping. We wish we could have used all of the member stories and quotes.

Appendix 2—Focus on the Frail Elder Target Group

Table 19: Frail Elder Membership by MCO on December 31, 2008

MCO and Program	Frail Elder	Percent of Total MCO Membership
Milwaukee - Family Care	6,623	99.6%
Fond du Lac - Family Care	474	45.3%
Community Care of Central WI Family Care	744	42.2%
Southwest Family Care Alliance - Family Care	272	41.7%
Western WI Cares - Family Care	860	37.6%
CCI - Family Care	1,032	30.3%
CCI - Partnership & PACE	943	82.4%
Care WI - Family Care	867	34.2%
Care WI - Partnership	638	57.0%
CHP - Family Care	139	21.1%
CHP - Partnership	1004	53.7%
All MCOs	13,556	59.6%

Source: Each member's most recently completed functional screen as of December 31, 2008.
Note: *The Milwaukee County Family Care program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 20: Current and Preferred Living Situation for Frail Elder Members
All Members Active on December 31, 2008.
The shaded boxes designate the percent of member who are currently living in their preferred living setting for each residence choice.

Family Care Current Residence	Preferred Residence Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	Total number of members in living setting
Currently lives in Home Setting	6,182	73	6	75	6,336
Currently lives in Group Setting	386	2,254	9	686	3,335
Currently lives in Nursing facility	345	184	442	256	1,227
Currently lives in Other setting	40	6	2	4	52
Total number of members who would prefer setting	6,954	2,519	459	1,025	10,950

Family Care Partnership & PACE Current Residence	Preferred Residence Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	Total number of members in living setting
Currently lives in Home Setting	1,750	7	0	54	1,811
Currently lives in Group Setting	95	252	1	166	514
Currently lives in Nursing facility	85	14	85	73	257
Currently lives in Other setting	3	0	0	0	3
Total number of members who would prefer setting	1,933	273	86	293	2,585

Source: Each member's most recently completed functional screen, as of December 31, 2008.

Table 21: Most Common Health Diagnoses Among Frail Elder Members on December 31, 2008
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnosis	FC	FC Partnership & PACE
Allergies	16.4%	31.1%
Alzheimer's/Other Dementia	31.6%	31.8%
Anemia/Coagulation Defects	21.6%	37.3%
Angina/Coronary Artery Disease	29.8%	42.8%
Anxiety Disorder	20.3%	31.9%
Arthritis	65.3%	74.2%
Asthma	27.4%	36.1%
Blood/Lymph Disorders	18.9%	41.5%
Cancer	13.9%	16.6%
Cerebral Vascular Accident	19.9%	20.4%
Chronic Pain/Fatigue	37.7%	46.5%
Congestive Heart Failure	21.3%	27.8%
Dehydration/Fluid Imbalance	5.5%	12.6%
Depression	35.9%	50.5%
Diabetes Mellitus	37.0%	37.9%
Heart Rate Disorders	18.3%	29.2%
Hip-Fracture	28.7%	38.3%
Hypertension	76.7%	83.1%
Hypo/HyperThyroidism	19.8%	24.3%
Nutritional Imbalances	48.5%	69.8%
Osteoporosis	20.5%	33.8%
Other Diagnoses	23.9%	48.7%
Other Digestive Disorders[4]	50.6%	76.6%
Other Disorders GU System[3]	25.8%	44.5%
Other Heart Conditions	13.0%	23.7%
Other Nerve Disorders[5]	22.6%	39.1%
Other Sensory Disorders[6]	14.8%	26.3%
Renal Failure/Kidney Disease	15.2%	33.0%
Respiratory	15.5%	24.6%
Skin Diseases	7.0%	20.9%
Urinary Tract Infection	9.8%	17.4%
Visual Impairment[7]	42.7%	58.5%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 22: Multiple Diagnoses Among Frail Elder Members on December 31, 2008

MCO and Program	Family Care	FC Partnership & PACE
0-4 Diagnoses	8.5%	2.1%
5-9 Diagnoses	46.5%	19.6%
10+ Diagnoses	44.9%	78.3%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 23: Employment Status Among Frail Elder Members on December 31, 2008

Family Care	No. of Frail Elder Members	Percent of Frail Elder Members
Retired	7,601	69.9%
Working	280	2.6%
Not Working	2,997	27.6%
Total	10,878	100.0%
Family Care Partnership & PACE		
Retired	1,846	72.2%
Working	33	1.3%
Not Working	679	26.5%
Total	2,558	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 24a: Top Services Provided to Frail Elder Family Care Members during 2008

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	942	8.0%	$5,067,913	1.9%
Case/Care Management	11,767	100.0%	$37,231,524	14.2%
CBRF, AFH, RCAC	3,982	33.8%	$89,766,244	34.3%
Community Support Program	22	0.2%	$95,129	0.0%
Counseling and Therapeutic Resources	2,838	24.1%	$1,601,250	0.6%
Daily Living Skills Training	149	1.3%	$1,130,117	0.4%
Day Center Services	245	2.1%	$1,983,633	0.8%
Day Treatment Medical	25	0.2%	$80,771	0.0%
Energy/Housing	368	3.1%	$188,961	0.1%
Equipment and Supplies	8,499	72.2%	$7,668,196	2.9%
Financial Management services	1,789	15.2%	$1,307,151	0.5%
Home Health/Nursing	1,526	13.0%	$8,539,857	3.3%
Meals	2,802	23.8%	$4,744,585	1.8%
Nursing Home/ICF-MR	2,181	18.5%	$46,733,816	17.9%
Other LTC Services	818	7.0%	$367,865	0.1%
Pre-Vocational Training	125	1.1%	$412,231	0.2%
Recreational Activities	56	0.5%	$14,025	0.0%
Respite	270	2.3%	$666,148	0.3%
Supported Employment	111	0.9%	$900,180	0.3%
Supportive Home Care	6,204	52.7%	$47,986,336	18.3%
Transportation	5,860	49.8%	$5,184,575	2.0%
Total Unduplicated	11,767		$261,670,508	

Source: Encounter data submitted by each MCO

Notes:

1) The distribution of services provided by Family Care Programs from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.
2) At the time of publication the encounter data from Care Wisconsin and CHP were not certified and are not included in this table.

Table 24b: Top Services Provided to Frail Elder Family Care Partnership & PACE Members during 2008

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	747	23.9%	$5,934,365	6.2%
Case Management	3,127	100.0%	$22,601,598	23.8%
CBRF, AFH, GH	337	10.8%	$8,344,197	8.8%
Consumer Directed Supports	188	6.0%	$64,947	0.1%
Equipment & Supplies	2,634	84.2%	$1,004,448	1.1%
Home Health/Nursing	382	12.2%	$918,473	1.0%
Meals	683	21.8%	$872,850	0.9%
Nursing Home	458	14.6%	$8,967,429	9.4%
Other LTC Services	3,127	100.0%	$1,024,495	1.1%
Recreational Activities	60	1.9%	$167,335	0.2%
Respite	22	0.7%	$37,207	0.0%
Supportive Home Care	1,011	32.3%	$1,449,291	1.5%
Transportation	2,105	67.3%	$4,909,386	5.2%
Total LTC Service Costs			$56,296,021	
Acute Care Services				
Anesthesia	1,217	38.9%	$288,173	3.8%
Dental	1,329	42.5%	$846,250	0.9%
E&M Care (Office calls, NH, Hosp Visits)	2,976	95.2%	$4,509,222	4.7%
ER	388	12.4%	$130,968	0.1%
Inpatient Hospital	825	26.4%	$13,901,512	14.6%
Medications	3,084	98.6%	$12,007,939	12.6%
MH & AODA Outpatient Therapy	890	28.5%	$148,275	0.2%
Nutrition Intervention/Counseling	974	31.1%	$807,359	0.8%
Physician Pathology & Lab	2,727	87.2%	$203,280	0.2%
Physician Radiology	2,326	74.4%	$1,979,616	2.1%
Physician Surgery	2,359	75.4%	$1,941,563	2.0%
Physician/other medical services	3,127	100.0%	$2,037,619	2.1%
Total Acute Care Service Costs			$38,801,776	
Total Acute & LTC Service Costs			$95,097,797	

Notes:
A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 25: Use of Purchased Residential Services for Frail Elders during 2008
Percent of total member-days spent in residential settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	63.4%
Group residences	26.8%
Nursing facilities	9.7%
Total	100.0%
Family Care Partnership & PACE	
Natural (non-purchased) residential settings	73.7%
Group residences	18.2%
Nursing facilities	8.1%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 26: Changes in Employment Status during 2008 *(Refers to Table 17 in main report)*

Year-later Employment Status of Retired Members on Earlier Screen	Family Care FE (N=3500)	FC Partnership & PACE FE (N=1075)
No Change: Still Retired and Satisfied	99.7%	99.4%
Now Have Employment and Satisfied	0.1%	0.2%
Not Satisfied: Still Retired but Desiring Employment	0.2%	0.4%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care FE (N=32)	FC Partnership & PACE FE (N=14)
Now Have a Job, Satisfied	3.1%	0.0%
No Longer Desire Employment, Satisfied	25.0%	14.3%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	71.9%	85.7%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care FE (N=146)	FC Partnership & PACE FE (N=15)
No Change: Still Employed in Desired Job	87.0%	66.7%
Now Retired or Unemployed but Satisfied	11.6%	33.3%
Now Out of a Job or Desiring a Different One	1.4%	0.0%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2008, compared with functional screens from one year earlier.
Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 3—Focus on the Developmental Disabilities Target Group

Table 27: Members with Developmental Disabilities by MCO on December 31, 2008

MCO and Program	Members with Developmental Disabilities	Percent of Total MCO Membership
Milwaukee - Family Care	2	0.1%
Fond du Lac - Family Care	386	37.5%
Community Care of Central WI Family Care	695	42.5%
Southwest Family Care Alliance - Family Care	267	36.9%
Western WI Cares - Family Care	731	32.6%
CCI - Family Care	1,778	52.0%
CCI - Partnership & PACE	15	1.4%
Care WI - Family Care	1,254	53.0%
Care WI - Partnership	39	4.4%
CHP - Family Care	443	68.8%
CHP - Partnership	242	14.6%
All MCOs	5,852	25.7%

Source: Each member's most recently completed functional screen as of December 31, 2008.
Note: *The Milwaukee County Family Care Program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 28: Current and Preferred Living Situation for Members with Developmental Disabilities
All Members Active on December 31, 2008.
The shaded boxes designate the percent of member who are currently living in their preferred living setting for each residence choice.

Family Care Current Residence	Preferred Residence				Total number of members in living setting
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	2,901	57	0	189	3,147
Currently lives in Group Setting	235	1,651	1	454	2,341
Currently lives in Nursing facility	15	16	6	22	59
Currently lives in Other setting	3	4	0	2	9
Total number of members who would prefer setting	3,154	1,728	7	667	5,556

Family Care Partnership & PACE Current Residence	Preferred Residence				Total number of members in living setting
	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	166	4	0	7	177
Currently lives in Group Setting	19	70	0	20	109
Currently lives in Nursing facility	1	3	2	1	7
Currently lives in Other setting	2	1	0	0	3
Total number of members who would prefer setting	188	78	2	28	296

Source: Each member's most recently completed functional screen, as of December 31, 2008.

Table 29: Most Common Health Diagnoses Among Members with Developmental Disabilities on December 31, 2008

Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members

List is alphabetical.

Common Health Diagnosis	FC	FC Partnership & PACE
Allergies	16.6%	18.9%
Anxiety Disorder	17.3%	31.1%
Arthritis	7.3%	18.2%
Asthma	7.5%	16.6%
Behavioral Diagnoses	11.8%	13.2%
Blood/Lymph Disorders	2.1%	6.4%
Cerebral Palsy	14.9%	17.6%
Chronic Pain/Fatigue	6.1%	19.3%
Depression	15.5%	39.9%
Diabetes Mellitus	7.7%	17.6%
Hip-Fracture	10.6%	20.3%
Hypertension	12.4%	33.1%
Hypo/HyperThyroidism	12.2%	15.2%
Mental Retardation	84.0%	67.6%
Nutritional Imbalances	12.0%	33.8%
Osteoporosis	4.0%	12.8%
Other Brain Disorders	6.1%	14.5%
Other Diagnoses	14.1%	35.8%
Other Digestive Disorders[4]	20.8%	42.2%
Other Disorders GU System[3]	5.7%	17.6%
Other Infectious Diseases	1.7%	6.1%
Other Mental Illness	15.1%	27.0%
Other Nerve Disorders[5]	8.3%	26.7%
Other Sensory Disorders[6]	7.3%	7.1%
Otherwise Meets State/Fed DD	12.1%	23.3%
Respiratory	6.4%	14.5%
Seizure Disorder After age 22	2.7%	7.8%
Seizure Disorder Onset age 22	26.0%	28.4%
Skin Diseases	7.4%	14.5%
Visual Impairment[7]	10.6%	13.2%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 30: Multiple Diagnoses Among Members with Developmental Disabilities on December 31, 2008

MCO and Program	Family Care	FC Partnership
0-4 Diagnoses	56.8%	25.7%
5-9 Diagnoses	38.3%	44.3%
10+ Diagnoses	4.9%	30.1%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 31: Employment Status Among Members with Developmental Disabilities on December 31, 2008

Family Care	No. of Members with Developmental Disabilities	Percent of Members with Developmental Disabilities
Retired	70	1.3%
Working	3,440	61.8%
Not Working	2,058	37.0%
Total	5,568	100.0%
Family Care Partnership & PACE		
Retired	14	4.7%
Working	130	43.5%
Not Working	155	51.8%
Total	299	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 32a: Top Services Provided to Family Care Members with Developmental Disabilities during 2008

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	180	4.5%	$670,323	0.6%
Case/Care Management	3,977	100.0%	$9,938,091	8.9%
CBRF. AFH, RCAC	1,657	41.7%	$56,873,120	51.1%
Community Support Program	5	0.1%	$23,010	0.0%
Counseling and Therapeutic Resources	488	12.3%	$464,900	0.4%
Daily Living Skills Training	697	17.5%	$3,719,528	3.3%
Day Center Services	1,218	30.6%	$7,420,000	6.7%
Day Treatment Medical	20	0.5%	$30,430	0.0%
Energy/Housing	17	0.4%	$12,672	0.0%
Equipment and Supplies	1,347	33.9%	$1,753,046	1.6%
Financial Management services	1,244	31.3%	$381,550	0.3%
Home Health/Nursing	354	8.9%	$1,146,908	1.0%
Meals	72	1.8%	$53,445	0.0%
Nursing Home/ICF-MR	102	2.6%	$1,555,142	1.4%
Other LTC Services	183	4.6%	$86,304	0.1%
Pre-Vocational Training	1,440	36.2%	$7,206,389	6.5%
Recreational Activities	143	3.6%	$27,266	0.0%
Respite	588	14.8%	$1,673,718	1.5%
Supported Employment	874	22.0%	$3,223,518	2.9%
Supportive Home Care	970	24.4%	$11,175,896	10.0%
Transportation	1,877	47.2%	$3,792,481	3.4%
Total Unduplicated	3,977		$111,227,735	

Source: Encounter data submitted by each MCO

Notes:

1) The distribution of services provided by Family Care Programs from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.
2) At the time of publication the encounter data from Care Wisconsin and CHP were not certified and are not included in this table.

Table 32b: Top Services Provided to Family Care Partnership & PACE Members with Developmental Disabilities during 2008

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	45	13.8%	$306,271	1.1%
Case Management	325	100.0%	$1,535,154	5.3%
CBRF, AFH, GH	124	38.2%	$3,073,363	10.7%
Consumer Directed Supports	29	8.9%	$17,579	0.1%
Equipment & Supplies	230	70.8%	$66,845	0.2%
Home Health/Nursing	27	8.3%	$32,535	0.1%
Meals	37	11.4%	$37,066	0.1%
Nursing Home	27	8.3%	$47,282	0.2%
Other LTC Services	325	100.0%	$311,368	1.1%
Recreational Activities	3	0.9%	$295	0.0%
Respite	33	10.2%	$43,399	0.2%
Supportive Home Care	67	20.6%	$57,365	0.2%
Transportation	137	42.2%	$324,356	1.1%
Total LTC Service Costs			$5,852,878	
Acute Care Services				
Anesthesia	44	13.5%	$8,273	0.0%
Dental	93	28.6%	$60,200	0.2%
E&M Care (Office calls, NH, Hosp Visits)	230	70.8%	$126,414	0.4%
ER	38	11.7%	$9,391	0.0%
Inpatient Hospital	24	7.4%	$272,723	1.0%
Medications	301	92.6%	$810,952	2.8%
MH & AODA Outpatient Therapy	139	42.8%	$46,254	0.2%
Nutrition Intervention/Counseling	37	11.4%	$32,378	0.1%
Physician Pathology & Lab	151	46.5%	$6,448	0.0%
Physician Radiology	195	60.0%	$54,348	0.2%
Physician Surgery	142	43.7%	$48,182	0.2%
Physician/other medical services	325	100.0%	$128,796	0.4%
Total Acute Care Service Costs			$1,604,359	
Total Acute & LTC Service Costs			$7,457,237	

Notes:
A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 33: Use of Purchased Residential Services for Members with Developmental Disabilities during 2008
Percent of Total Member Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	68.7%
Group residences	30.7%
Nursing facilities	0.6%
Total	100.0%

Family Care Partnership & PACE	Percent of Total Eligible Days
Natural (non-purchased) residential settings	69.4%
Group residences	30.1%
Nursing facilities	0.5%
Total	100.0%

Source: Encounter data submitted by each MCO.

Table 34: Changes in Employment Status for members with Developmental Disabilities during 2008
(Refers to Tables 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care DD (N=41)	FC Partnership & PACE DD (N=2)
No Change: Still Retired and Satisfied	95.1%	100.0%
Now Have Employment and Satisfied	4.9%	0.0%
Not Satisfied: Still Retired but Desiring Employment	0.0%	0.0%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care DD (N=174)	FC Partnership & PACE DD (N=13)
Now Have a Job, Satisfied	19.5%	15.4%
No Longer Desire Employment, Satisfied	17.2%	7.7%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	63.2%	76.9%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care DD (N=1391)	FC Partnership & PACE DD (N=25)
No Change: Still Employed in Desired Job	91.9%	80.0%
Now Retired or Unemployed but Satisfied	2.2%	8.0%
Now Out of a Job or Desiring a Different One	5.8%	12.0%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2008, compared with functional screens from one year earlier.
Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 4—Focus on Physical Disabilities Target Group

Table 35: Members with Physical Disabilities by MCO on December 31, 2008

MCO and Program	Members with Physical Disabilities	Percent of Total MCO Membership
Milwaukee - Family Care	10	0.3%
Fond du Lac - Family Care	178	17.3%
Community Care of Central WI Family Care	291	15.3%
Southwest Family Care Alliance - Family Care	140	21.4%
Western WI Cares - Family Care	616	29.7%
CCI - Family Care	601	17.7%
CCI - Partnership & PACE	173	16.3%
Care WI - Family Care	310	12.8%
Care WI - Partnership	409	38.6%
CHP - Family Care	70	10.1%
CHP - Partnership	548	31.7%
All MCOs	3,356	14.7%

Source: Each member's most recently completed functional screen as of December 31, 2008.
Note: *The Milwaukee County Family Care Program, operated by the county's Department of Aging, serves people with disabilities over the age of 60, while other MCOs serve adults 18 and older, considering those 65 and older to be frail elders. For comparability within this table, frail elders in all MCOs are those who are 65 and older, and Milwaukee members between the ages of 60 and 64 are reported as members with either developmental or physical disabilities.*

Table 36: Current and Preferred Living Situation for Members with Physical Disabilities
All Members Active on December 31, 2008.
The shaded boxes designate the percent of member who are currently living in their preferred living setting for each residence choice.

Family Care Current Residence	Preferred Residence Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	Total number of members in living setting
Currently lives in Home Setting	1,731	8	0	8	1,747
Currently lives in Group Setting	87	242	1	39	369
Currently lives in Nursing facility	45	21	17	8	91
Currently lives in Other setting	6	2	0	1	9
Total number of members who would prefer setting	1,869	273	18	56	2,216

Family Care Partnership & PACE Current Residence	Preferred Residence Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	Total number of members in living setting
Currently lives in Home Setting	1,014	2	0	7	1,023
Currently lives in Group Setting	22	40	0	14	76
Currently lives in Nursing facility	23	1	5	3	32
Currently lives in Other setting	6	2	1	1	10
Total number of members who would prefer setting	1,065	45	6	25	1,141

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 37: Most Common Health Diagnoses Among Members with Physical Disabilities on December 31, 2008
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnosis	FC	FC Partnership & PACE
Alcohol or Drug Abuse	12.5%	17.3%
Allergies	17.5%	22.0%
Anemia/Coagulation Defects	11.5%	28.0%
Angina/Coronary Artery Disease	12.5%	24.8%
Anxiety Disorder	23.8%	39.2%
Arthritis	31.0%	49.6%
Asthma	26.9%	45.0%
Blood/Lymph Disorders	10.8%	25.6%
Brain Injury After age 22	6.9%	3.1%
Cerebral Vascular Accident	12.6%	15.0%
Chronic Pain/Fatigue	39.1%	59.8%
Congestive Heart Failure	8.6%	15.4%
Depression	52.4%	64.9%
Diabetes Mellitus	32.3%	43.5%
Heart Rate Disorders	8.1%	11.9%
Hip-Fracture	18.1%	27.9%
Hypertension	43.9%	64.6%
Hypo/HyperThyroidism	14.5%	16.7%
Liver Disease	6.2%	8.8%
Multiple Sclerosis/ALS	9.4%	6.6%
Nutritional Imbalances	33.5%	57.8%
Osteoporosis	9.8%	15.6%
Other Diagnoses	32.0%	56.5%
Other Digestive Disorders[4]	39.9%	64.5%
Other Disorders GU System[3]	18.1%	31.9%
Other Heart Conditions	7.5%	16.7%
Other Mental Illness	13.3%	18.1%
Other Nerve Disorders[5]	27.0%	40.6%
Other Sensory Disorders[6]	5.8%	12.0%
Renal Failure/Kidney Disease	10.0%	17.2%
Respiratory	16.3%	31.7%
Seizure Disorder After age 22	9.8%	9.1%
Skin Diseases	5.8%	16.1%
Urinary Tract Infection	7.6%	14.6%
Visual Impairment[7]	15.3%	23.8%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 38: Multiple Diagnoses Among Members with Physical Disabilities on December 31, 2008

MCO and Program	Family Care	FC Partnership & PACE
0-4 Diagnoses	21.9%	6.4%
5-9 Diagnoses	51.2%	33.1%
10+ Diagnoses	26.9%	60.5%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 39: Employment Status Among Members with Physical Disabilities on December 31, 2008

Family Care	No. of Members with Physical Disabilities	Percent of Members with Physical Disabilities
Retired	173	7.6%
Working	276	12.2%
Not Working	1,822	80.2%
FC-Total	2,271	100.0%
FC Partnership & PACE		
Retired	91	7.8%
Working	77	6.6%
Not Working	997	85.6%
FC Partnership Total	1,165	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 40a: Top Services Provided to Family Care Members with Physical Disabilities during 2008

	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care	56	2.7%	$150,928	0.4%
Case/Care Management	2,041	100.0%	$6,581,178	18.8%
CBRF, AFH, RCAC	388	19.0%	$8,960,939	25.6%
Community Support Program	21	1.0%	$93,839	0.3%
Counseling and Therapeutic Resources	630	30.9%	$602,041	1.7%
Daily Living Skills Training	115	5.6%	$657,214	1.9%
Day Center Services	55	2.7%	$136,254	0.4%
Day Treatment Medical	22	1.1%	$24,938	0.1%
Energy/Housing	35	1.7%	$37,324	0.1%
Equipment and Supplies	1,551	76.0%	$1,946,047	5.6%
Financial Management services	384	18.8%	$137,559	0.4%
Home Health/Nursing	587	28.8%	$1,866,375	5.3%
Meals	424	20.8%	$363,310	1.0%
Nursing Home/ICF-MR	241	11.8%	$3,009,997	8.6%
Other LTC Services	139	6.8%	$41,925	0.1%
Pre-Vocational Training	71	3.5%	$240,175	0.7%
Recreational Activities	49	2.4%	$13,684	0.0%
Respite	91	4.5%	$429,329	1.2%
Supported Employment	38	1.9%	$93,924	0.3%
Supportive Home Care	1,269	62.2%	$8,732,889	25.0%
Transportation	957	46.9%	$849,895	2.4%
Total Unduplicated	2,041		$34,969,762	

Source: Encounter data submitted by each MCO

Notes:

1) The distribution of services provided by Family Care Programs from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.
2) At the time of publication the encounter data from Care Wisconsin and CHP were not certified and are not included in this table.

Table 40b: Top Services Provided to Family Care Partnership & PACE Members with Physical Disabilities during 2008

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	189	14.6%	$1,108,049	2.5%
Case Management	1,295	100.0%	$10,161,597	23.0%
CBRF, AFH, GH	78	6.0%	$10,161,597	23.0%
Consumer Directed Supports*	50	3.9%	$18,656	0.0%
Equipment & Supplies	1,260	97.3%	$821,521	1.9%
Home Health/Nursing	219	16.9%	$715,646	1.6%
Meals	282	21.8%	$369,147	0.8%
Nursing Home	494	38.1%	$2,212,114	5.0%
Other LTC Services	1,295	100.0%	$714,072	1.6%
Recreational Activities	68	5.3%	$52,711	0.1%
Respite	10	0.8%	$19,123	0.0%
Supportive Home Care	478	36.9%	$387,936	0.9%
Transportation	921	71.1%	$2,140,945	4.8%
Total LTC Service Costs			$28,883,114	
Acute Care Services				
Anesthesia	363	28.0%	$80,565	0.2%
Dental	594	45.9%	$490,524	1.1%
E&M Care (Office calls, NH, Hosp Visits)	1,315	101.5%	$1,793,056	4.1%
ER	307	23.7%	$110,048	0.2%
Inpatient Hospital	358	27.6%	$7,381,041	16.7%
Medications	1,245	96.1%	$1,868,816	4.2%
MH & AODA Outpatient Therapy	910	70.3%	$571,489	1.3%
Nutrition Intervention/Counseling	206	15.9%	$195,608	0.4%
Physician Pathology & Lab	1,080	83.4%	$92,339	0.2%
Physician Radiology	1,008	77.8%	$946,114	2.1%
Physician Surgery	980	75.7%	$895,609	2.0%
Physician/other medical services	1,295	100.0%	$951,394	2.1%
Total Acute Care Service Costs			$15,376,603	
Total Acute and LTC Service Costs			$44,259,717	

Notes:
A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 41: Use of Purchased Residential Services for Members with Physical Disabilities during 2007
Percent of total member-days spent in residential settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	84.0%
Group residences	12.6%
Nursing facilities	3.4%
Total	100.0%
Family Care Partnership & PACE	
Natural (non-purchased) residential settings	90.0%
Group residences	8.4%
Nursing facilities	1.6%
Total	100.0%

Source: Encounter data submitted by each MCO

Table 42: Changes in Employment Status for Members with Physical Disabilities during 2008
(Refers to Table 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care PD(N=62)	FC Partnership & PACE PD (N=32)
No Change: Still Retired and Satisfied	100.0%	100.0%
Now Have Employment and Satisfied	0.0%	0.0%
Not Satisfied: Still Retired but Desiring Employment	0.0%	0.0%
Total	100.0%	100.0%

Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	Family Care PD (N=112)	FC Partnership & PACE PD (N=83)
Now Have a Job, Satisfied	4.5%	1.2%
No Longer Desire Employment, Satisfied	27.7%	25.3%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	67.9%	73.5%
Total	100.0%	100.0%

Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	Family Care PD (N=95)	FC Partnership & PACE PD (N=31)
No Change: Still Employed in Desired Job	76.8%	74.2%
Now Retired or Unemployed but Satisfied	6.3%	22.6%
Now Out of a Job or Desiring a Different One	16.8%	3.2%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2008, compared with functional screens from one year earlier.
Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Appendix 5—Additional Data on Members with Mental Health/ Substance Abuse Issue

While the statutes governing the managed long-term care programs limit eligibility to frail elders and to those adults who have a physical disability or a developmental disability, many individuals with these disabilities, just like people without disabilities, also experience issues with mental health or with substance abuse.

Some mental health or substance abuse issues are more prevalent among people with disabilities than in the general population. For example, major depressive disorder affects approximately 6.7 percent of the U.S. population age 18 and older at any given time, but 20.6 percent of the individuals who enrolled in Family Care during 2008 reported a diagnosis of depression at the time of their enrollment.

In addition to the disabilities that qualified them for Family Care membership, 7.8 percent of the members had relatively manageable chronic mental illnesses such as schizophrenia and bipolar disorder, while 7.4 percent had harder-to-manage diagnoses such as personality disorders or serious substance abuse issues.

For these reasons and others, it is sometimes useful to look specifically at the subgroup of Family Care members with mental health or substance abuse issues. Table 43 shows the number of members in each programs' three target groups who also have mental health (MH) or substance abuse (SA) issues.

Table 43: Family Care Members by Target Group with Mental Health and Substance Abuse Diagnoses on December 31, 2008

	Frail Elders	Members with Developmental Disabilities	Members with Physical Disabilities
Anxiety	2,227	959	529
Depression	3,928	860	1,162
Bipolar	335	213	161
Schizophrenia	703	281	145
Other MH	748	838	295
SA	530	103	276
Behavioral	120	655	61
All	8,591	3,909	2,629

Note: Members are counted in the totals for each diagnosis they have, and members may have more than one listed diagnosis.

Table 44: Current and Preferred Living Situation for Members with Mental Health/Substance Abuse
All Members Active on December 31, 2008.
The shaded boxes designate the percent of member who are currently living in their preferred living setting for each residence choice.

Family Care	Preferred Residence				Total number of members in living setting
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	5,232	61	2	100	5,395
Currently lives in Group Setting	544	2,537	9	705	3,795
Currently lives in Nursing facility	271	165	347	217	1,000
Currently lives in Other setting	20	10		4	34
Total number of members who would prefer setting	6,067	2,773	358	1,026	10,224

Family Care Partnership & PACE	Preferred Residence				Total number of members in living setting
Current Residence	Prefers to live in Home Setting	Prefers to live in Residential	Prefers to live in Institutional	Prefers to live in Other setting	
Currently lives in Home Setting	1,960	8		41	2,009
Currently lives in Group Setting	113	292	1	159	565
Currently lives in Nursing facility	91	17	69	61	238
Currently lives in Other setting	7	4		1	12
Total number of members who would prefer setting	2,171	321	70	262	2,824

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 45a: Most Common Health Diagnoses Among Members with Mental Health/Substance Abuse on December 31, 2008
Diagnoses affecting 10% or more of Family Care and/or Family Care Partnership members
List is alphabetical.

Common Health Diagnosis	FC	FC Partnership
Alcohol or Drug Abuse	9.5%	10.7%
Allergies	18.6%	21.8%
Alzheimer's Other Dementia	24.9%	17.6%
Anemia/Coagulation Defects	16.9%	25.7%
Angina/Coronary Artery Disease	21.4%	26.3%
Arthritis	47.5%	47.6%
Asthma	26.2%	30.4%
Blood/Lymph Disorders	14.7%	25.4%
Cancer	9.4%	9.8%
Cerebral Vascular Accident	14.5%	13.0%
Chronic Pain/Fatigue	33.9%	40.0%
Congestive Heart Failure	14.2%	16.7%
Dehydration/Fluid Imbalance	4.8%	9.0%
Diabetes Mellitus	30.2%	27.9%
Heart Rate Disorders	13.1%	16.1%
Hip-Fracture	24.5%	26.3%
Hypertension	57.3%	54.3%
Hypo/HyperThyroidism	18.6%	16.2%
Mental Retardation	24.4%	4.1%
Nutritional Imbalances	40.8%	47.9%
Osteoporosis	15.8%	20.6%
Other Diagnoses	25.5%	39.8%
Other Digestive Disorders[4]	47.5%	55.5%
Other Disorders GU System[3]	22.2%	29.9%
Other Heart Conditions	10.6%	15.6%
Other Nerve Disorders[5]	22.1%	30.0%
Other Sensory Disorders[6]	11.8%	15.9%
Renal Failure/Kidney Disease	10.8%	19.0%
Respiratory	15.2%	20.7%
Skin Diseases	7.6%	15.0%
Urinary Tract Infection	8.6%	12.8%
Visual Impairment[7]	30.2%	33.3%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 45b: Percentage of Members with Mental Health and Substance Abuse Diagnoses on December 31, 2008

MCO and Program	Anxiety	Depression	Bipolar	Schizophrenia	Other MH	Substance Abuse	Behavioral
Milwaukee —Family Care	20.5%	36.7%	3.4%	7.6%	7.9%	6.0%	1.2%
Fond du Lac —Family Care	24.1%	34.3%	3.1%	5.7%	11.0%	6.0%	5.5%
Community Care of Central WI	17.3%	29.0%	4.3%	3.9%	9.7%	2.5%	9.2%
Southwest FC Alliance	20.4%	32.2%	4.5%	4.2%	9.4%	4.5%	3.8%
Western Wisconsin Cares	20.3%	37.6%	3.9%	5.3%	11.5%	7.7%	4.7%
CCI —Family Care	17.8%	25.0%	4.5%	6.5%	12.0%	3.2%	6.1%
CCI —Partnership & PACE	25.6%	49.3%	4.0%	7.7%	8.6%	12.1%	1.9%
Care WI—Family Care	19.0%	24.0%	3.6%	3.6%	11.3%	3.4%	5.5%
Care WI—Partnership	31.5%	55.5%	3.8%	3.8%	7.2%	10.6%	2.1%
CHP —Family Care	24.0%	27.0%	3.5%	5.7%	11.9%	2.6%	10.1%
CHP —Partnership	40.3%	55.2%	4.5%	4.0%	19.8%	8.1%	5.0%
All MCOs	22.3%	35.6%	3.8%	5.8%	10.6%	5.7%	4.3%

Note: Members are counted in the totals for each diagnosis they have, and members may have more than one listed diagnosis.

Table 46: Multiple Diagnoses Among Members with Mental Health/Substance Abuse on December 31, 2008

MCO and Program	Family Care	FC Partnership & PACE
0-4 Diagnoses	13.7%	2.3%
5-9 Diagnoses	38.2%	16.0%
10+ Diagnoses	48.0%	81.7%
Total	100.0%	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 47: Employment Status Among Members with Mental Health/Substance Abuse on December 31, 2008

Family Care	No. of Members with MH/SA	Percent of Members with MH/SA	FC Partnership & PACE	No. of Members with MH/SA	Percent of Members with MH/SA
Retired	4,208	41.2%	Retired	1,290	45.7%
Working	1,891	18.5%	Working	162	5.7%
Not Working	4,125	40.3%	Not Working	1,372	48.6%
Total	10,224	100.0%	Total	2,824	100.0%

Source: Each member's most recently completed functional screen as of December 31, 2008.

Table 48a: Top Services Provided to Family Care Members with Mental Health/Substance Abuse during 2008

	Number of Members Served	Percent of Members	Expenditures	Percent of Expenditures
Adult Day Care	671	6.8%	$3,331,871	1.3%
Case/Care Management	9,884	100.0%	$32,614,536	12.9%
CBRF, AFH, RCAC	3,847	38.9%	$104,632,582	41.3%
Community Support Program	48	0.5%	$211,977	0.1%
Counseling and Therapeutic Resources	2,507	25.4%	$1,777,285	0.7%
Daily Living Skills Training	562	5.7%	$3,482,770	1.4%
Day Center Services	739	7.5%	$4,728,880	1.9%
Day Treatment Medical	67	0.7%	$136,139	0.1%
Energy/Housing	279	2.8%	$164,278	0.1%
Equipment and Supplies	6,411	64.9%	$6,207,647	2.5%
Financial Management services	2,280	23.1%	$1,313,385	0.5%
Home Health/Nursing	1,349	13.6%	$5,861,541	2.3%
Meals	1,798	18.2%	$2,799,426	1.1%
Nursing Home/ICF-MR	1,703	17.2%	$39,030,178	15.4%
Other LTC Services	737	7.5%	$339,591	0.1%
Pre-Vocational Training	738	7.5%	$3,411,609	1.3%
Recreational Activities	134	1.4%	$25,607	0.0%
Respite	449	4.5%	$1,316,525	0.5%
Supported Employment	458	4.6%	$1,928,470	0.8%
Supportive Home Care	4,530	45.8%	$34,927,550	13.8%
Transportation	5,056	51.2%	$5,108,749	2.0%
Total Unduplicated	9884		$253,350,596	

Source: Encounter data submitted by each MCO

Notes:

1) The distribution of services provided by Family Care Programs from January 1, 2008 through December 31, 2008 utilizes the common procedure and revenue codes within the encounter coding system. The distribution of service expenditures correlates only partially with the distribution of members who received these services during the year. Expenditure levels are explainable by the duration and quantities of providing the services to MCO members, and to the per-unit costs of the services.
2) At the time of publication the encounter data from Care Wisconsin and CHP were not certified and are not included in this table.

Table 48b: Top Services Provided to Family Care Partnership & PACE Members with Mental Health/Substance Abuse during 2008

Long-Term Care Services	Number of Members Served	Percent of Members Served	Expenditures	Percent of Expenditures
Adult Day Care/Day Center	809	24.6%	$5,114,019	4.3%
Case Management	3,293	100.0%	$28,878,721	24.3%
CBRF, AFH, GH	500	15.2%	$10,990,794	9.2%
Consumer Directed Supports	291	8.8%	$90,771	0.1%
Equipment & Supplies	2,976	90.4%	$1,326,245	1.1%
Home Health/Nursing	625	19.0%	1,572,897	1.3%
Meals	868	26.4%	$939,113	0.8%
Nursing Home	451	13.7%	$10,955,055	9.2%
Other LTC Services	3,293	100.0%	$1,564,246	1.3%
Recreational Activities	78	2.4%	$158,125	0.1%
Respite	0	0.0%	$0	0.0%
Supportive Home Care	1,157	35.1%	$1,455,320	1.2%
Transportation	2,791	84.8%	$6,171,513	5.2%
Total LTC Service Costs			$69,216,819	
Acute Care Services				
Anesthesia	1,342	40.8%	$256,993	0.2%
Dental	1,661	50.4%	$1,275,306	1.1%
E&M Care (Office calls, NH, Hosp Visits)	3,089	93.8%	$4,773,101	4.0%
ER	475	14.4%	$207,703	0.2%
Inpatient Hospital	1,052	31.9%	$15,776,892	13.3%
Medications	3,158	95.9%	$17,262,595	14.5%
MH & AODA Outpatient Therapy	1,427	43.3%	$605,154	0.5%
Nutrition Intervention/Counseling	864	26.2%	$715,244	0.6%
Physician Pathology & Lab	2,852	86.6%	$218,234	0.2%
Physician Radiology	2,630	79.9%	$2,237,918	1.9%
Physician Surgery	2,812	85.4%	$3,029,622	2.5%
Physician/other medical services	3,293	100.0%	$3,304,878	2.8%
Total Acute Care Service Costs			$49,663,640	
Total Acute and LTC Service Costs			$118,880,459	100.0%

Notes:
A portion of some long-term care services are paid as an acute care service. A good example is a nursing home stay for rehabilitation. A portion of some acute care services are paid as long-term care services. A good example is the inpatient hospital deductible.

Table 49: Use of Purchased Residential Services for Members with Mental Health/Substance Abuse during 2008
Percent of Total Member-Days Spent in Residential Settings

Family Care	Percent of Total Eligible Days
Natural (non-purchased) residential settings	60.6%
Group residences	30.1%
Nursing facilities	9.3%
Total	100.0%
Family Care Partnership & PACE	
Natural (non-purchased) residential settings	62.4%
Group residences	30.3%
Nursing facilities	7.3%
Total	

Source: Encounter data submitted by each MCO

Table 50: Changes in Employment Status for Members with Mental Health/Substance Abuse during 2008
(Refers to Table 17 in main report)

Year-later Employment Status of Retired Members on Earlier Screen	Family Care MH/SA (N=2034)	FC Partnership & PACE MH/SA (N=758)
No Change: Still Retired and Satisfied	99.7%	99.6%
Now Have Employment and Satisfied	0.1%	0.1%
Not Satisfied: Still Retired but Desiring Employment	0.2%	0.3%
Total	100.0%	100.0%
Year-later Employment Status of Unemployed Members who Desired Employment on Earlier Screen	**Family Care MH/SA (N=207)**	**FC Partnership & PACE MH/SA (N=84)**
Now Have a Job, Satisfied	11.6%	1.2%
No Longer Desire Employment, Satisfied	21.7%	21.4%
Not Satisfied: Still Unemployed or Employed in an Unsatisfactory Job	66.7%	77.4%
Total	100.0%	100.0%
Year-later Employment Status of Members who were employed and satisfied with job on Earlier Screen	**Family Care MH/SA (N=756)**	**FC Partnership & PACE MH/SA (N=40)**
No Change: Still Employed in Desired Job	87.4%	72.5%
Now Retired or Unemployed but Satisfied	3.7%	22.5%
Now Out of a Job or Desiring a Different One	8.9%	5.0%
Total	100.0%	100.0%

Source: Functional screen completed for each member during 2008, compared with functional screens from one year earlier.
Note: The information is collected from the screener and may include errors. The member is answering questions regarding employment and desire of employment without full knowledge of ramifications.

Care Wisconsin, Inc.

2802 International Lane, Madison, WI 53704
Corporate: 608-240-0020
General Info: 800-963-0035
Member Services: 800-963-0035
TTY: WI Relay 711
24 Hour: 800-963-0035
FAX: 608-245-3077
Web: www.carewisc.org
Family Care Counties Served:
Columbia, Dodge, Jefferson, Green Lake, Marquette, Washington, Waukesha, Waushara
Family Care Partnership Counties Served:
Columbia, Dane, Dodge, Jefferson, Sauk

Community Care, Inc.

1555 S. Layton Blvd, Milwaukee, WI 53215
Corporate: 414-385-6600
General Info: 866-992-6600
Member Services: 866-992-6600
TTY: 866-288-9909
24 Hour: 866-992-660
FAX: 414-385-6628
Web: www.communitycareinc.org
Family Care Counties Served:
Kenosha, Ozaukee, Racine, Sheboygan, Washington, Waukesha
Family Care Partnership Counties Served:
Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha
PACE Counties Served:
Milwaukee, Waukesha

Community Care of Central Wisconsin

3349 Church St., Ste. 1,
Stevens Point, WI 54481
Corporate: 715-345-5968
General Info: 877-622-6700
TTY: 715-344-2140
24 Hour: 715-345-5968
FAX: 715-345-5725
Web: www.communitycareofcentralwisconsin.org
Family Care Counties Served:
Marathon, Portage, Wood

Community Health Partnership

2240 EastRidge Center, Eau Claire, WI 54701
Corporate: 715-838-2900
General Info: 800-842-1814
Member Services: 800-842-1814
TTY: 715-838-2900
24 Hour: 800-842-1814
FAX: 715-838-2910
Web: www.communityhealthpartnership.com
Family Care Counties Served:
Chippewa, Dunn, Eau Claire, Pierce, St. Croix,
Family Care Partnership Counties Served:
Chippewa, Dunn, Eau Claire, Pierce, St. Croix

Creative Care Options of Fond du Lac County

50 North Portland Street,
Fond du Lac, WI 54935-3412
Corporate: 920-906-5100
General Info: 877-227-3335
Member Services: 920-906-5100
TTY: 800-947-3529
24 Hour: 920-906-5177
FAX: 920-906-5103
Web: www.fdlco.wi.gov
Family Care Counties Served:
Fond du Lac

Milwaukee County Department of Aging

310 W. Wisconsin Avenue, 6th Floor East
Milwaukee, WI 53203

Corporate:	414-289-5950
General Info:	866-229-9695
TTY:	414-289-8584
24 Hour:	414-289-6874
FAX:	414-289-8525

Web: www.milwaukee.gov/Familycare

Family Care Counties Served:
Milwaukee

NorthernBridges*

15954 Rivers Edge Dr., Suite 300
Hayward, WI 54843

Corporate:	715-934-2266
General Info:	866-306-6499
TTY:	800-947-3529
FAX:	715-934-2268

Web: www.northernbridges.com

Family Care Counties Served:
Barron, Burnett, Douglas, Polk, Washburn

Southwest Family Care Alliance

26220 Executive Lane, Suite A
PO Box 111
Richland Center, WI 53581

Corporate:	608-647-4729
General Info:	608-647-4729
TTY:	800-947-3529
FAX:	608-647-4754

Web: www.familycarealliance.org

Family Care Counties Served:
Green, Richland, Sauk

Western Wisconsin Cares

1407 Saint Andrew St., Suite 100
La Crosse, WI 54603

Corporate:	608-785-6266
General Info:	608-785-6266
TTY:	608-785-9787
FAX:	608-785-6315

Website www.wwcares.org

Family Care Counties Served:
Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon

*Note: NorthernBridges started enrolling members in May 2009. They are not included in the data in the 2008 annual report.

Family Care Vision

The result of Family Care expansion will be a complete rebalancing of Wisconsin's long-term care system.

Aging and disability resource centers will endeavor to keep individuals financially independent and physically healthy by informing people of the long-term care service options available to them, providing healthy aging and prevention programs and if they need assistance, informing them of the publicly-funded long-term care programs that can help them.

The resource centers will help people through eligibility and enrollment in those programs.

Every Wisconsin citizen who needs long-term care will have equal access to in-home services and institutional care and everything in-between with no waiting.

For every eligible person, self-directed options will be available – either within a managed care organization or through IRIS, our self-directed supports waiver.

Our contracts with managed care organizations and our monitoring will focus on performance in achieving enrollees' quality of life outcomes, including health and safety, community integration and self-determination and choice as well as fiscal integrity and cost effectiveness.

Wisconsin Department of Health Services
Division of Long Term Care
Office of Family Care Expansion
P.O. Box 7851
Madison, Wisconsin 53707-7851
dhs.wisconsin.gov/LTCare

July, 2009