
Joint Committee on Finance

Long-Term Care Expansion Report



Wisconsin Department of Health Services

P-00590 (12/2013)

Executive Summary

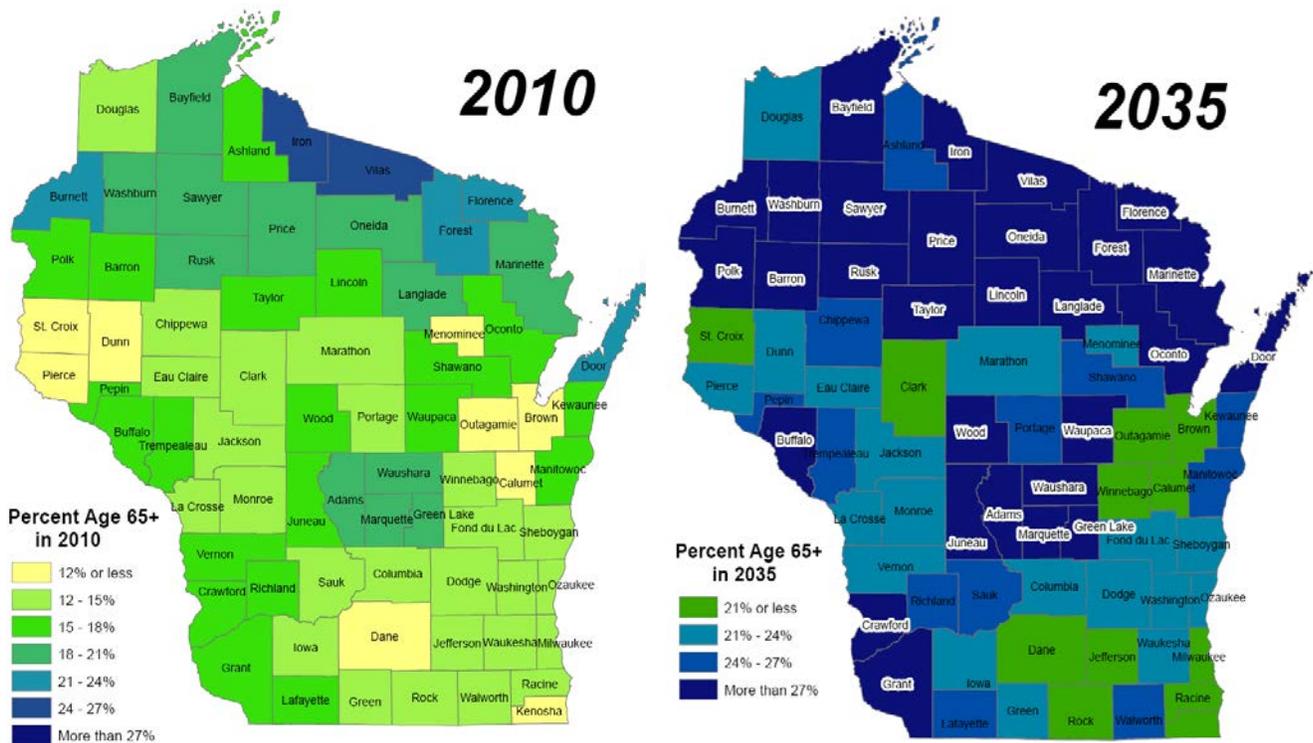
The Department of Health Services (DHS) is providing this report on the future of publicly-funded community-based long-term care in Wisconsin. The Joint Committee on Finance directed the Department to develop a projection of the expected future change in the need for publicly-funded community-based long-term care. The Department considered the factors identified by the Joint Committee on Finance as noted in each section below.

The projected future growth trends in populations likely to access long-term care services.

Wisconsin’s long-term care population will increase dramatically between 2010 and 2035. The table below demonstrates the shift to an aged population. The aging population is projected to grow from just over 900,000 people in 2010 to over a million people by 2020. This growth in the aging population will require a cost-effective system of quality supports to manage limited public resources to ensure that the needs of Wisconsin’s most vulnerable citizens are addressed. The goal of Wisconsin’s managed long-term care system is to provide the right service, in the right amount and in the right setting. Critical to the Department’s success in bending an otherwise rapidly increasing cost curve is the promotion of:

“The goal of Wisconsin’s managed long-term care system is to provide the right service, in the right amount, and in the right setting.”

- The wise use of personal resources to delay entry into publicly funded supports;
- Healthy aging and achieving the best health possible for people with complex needs; and
- Coordinated, community-based supports that help people to maintain better health and independence.



Identify the potential or projected shifts in the use of alternatives that are allowed under the federal Medicaid program for these populations. Family Care provides the foundation for the next phase in the Department’s work to transform the long-term care system from one dominated by institutional care in nursing homes to one where people with long-term care needs have the opportunity to receive less intensive and less expensive services in their homes and community-integrated settings. The expansion of Family Care strengthens the Department’s ability to assist people seeking to relocate from a nursing home into a community setting or choosing to receive care in their own homes rather than move into a nursing home. In the counties that operate the legacy waiver system, frail elders and people with severe disabilities must enter a nursing home to gain immediate access to long-term care or add their names to a wait list for support in their own homes or in a community-integrated setting. Approximately 1,600 Wisconsin residents in these 15 counties are waiting and may be relying on more costly medical supports, including Medicaid-reimbursed physician, hospital, and personal care services, to try to address long-term care needs in the absence of access to home and community-based long-term care services.

Evaluate the comparative cost efficiency of service options allowed under the federal Medicaid program to meet the needs of these populations. The Family Care program has demonstrated that a managed long-term care system increases quality while controlling costs. These capabilities include the following:

- A capitated rate payment structure that drives Managed Care Organizations to continuously improve and provide the most cost-effective care.
- The creation of equal access to long-term care services in an individual’s home, community-based settings, or nursing homes. This access ensures that the level of service matches a member’s needs, which is demonstrated to delay entry into nursing homes and reduce long-term care service costs.
- The Family Care program generates efficiencies through economies of scale as the Managed Care Organizations (MCOs) develop regional and comprehensive provider networks that increase the variety of services available to member at negotiated, competitive rates.
- Reformed funding and service models that reward innovations in quality care and cost control.

“The Family Care program has demonstrated that a managed long-term care system increases quality while controlling costs.”

Determine strategies to control the growth in long-term care costs in the Medical Assistance program.

“Expanding Family Care to the remainder of the state reduces the growth of long-term care costs by \$34.7 million (AF) when compared to the cost of maintaining the legacy waivers over the next ten years.”

The Department’s analysis shows that statewide expansion of Family Care effectively controls cost growth for publicly-funded long-term care. The Family Care program is the cost-effective solution to ensure that Wisconsin’s elderly and residents with severe disabilities receive needed care and quality supports. Expanding Family Care to the remainder of the state reduces the growth of long-term care costs by \$34.7 million, all funds (AF), when compared to the cost of maintaining the legacy waivers over the next ten years. This is illustrated by the chart below.

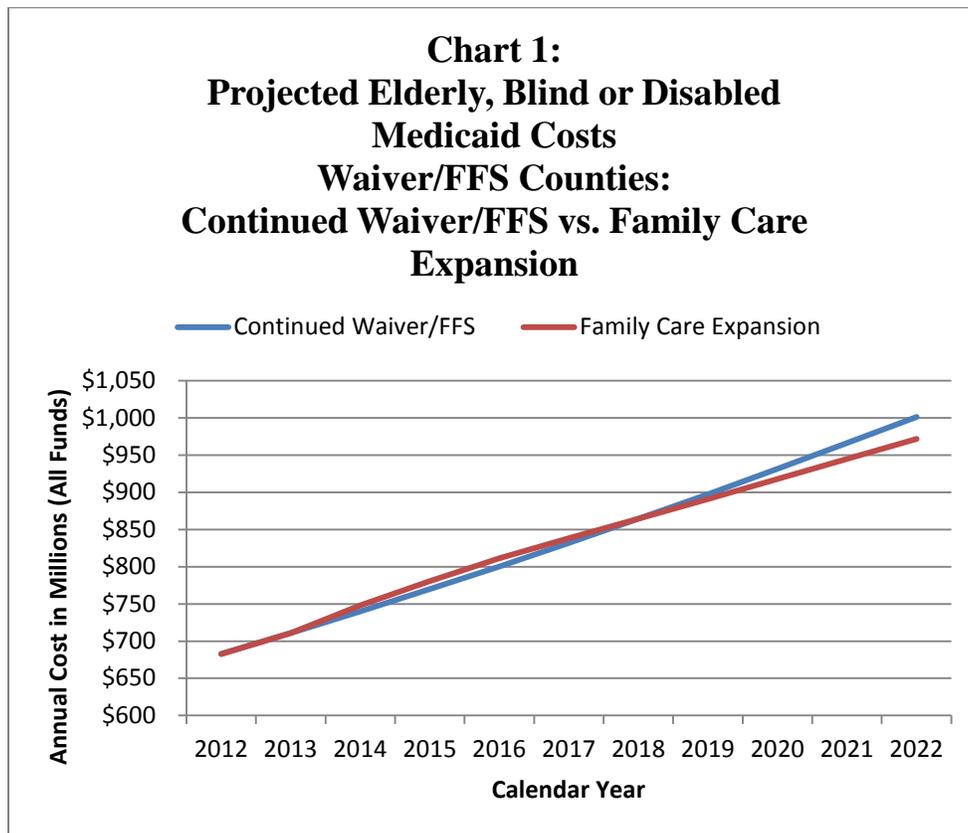
Although, the Family Care program broadens Medicaid members’ access to long-term care services, which has the potential to increase Medicaid enrollment; the cost savings associated with the managed long-term care program model and the greater availability of services

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under entitlement delay the need for more intensive and expensive services. The Department projects that the cost of operating Family Care will be less than the cost of maintaining the legacy waiver program within approximately seven years and the savings compared to the legacy waiver program will increase in future years. A managed long-term care system generates cost savings over the current waiver system by reducing the average cost per member, even though the overall cost for long term-care services will continue to increase due to inflation and population increases.

| Projected EBD Medicaid Per Member Per Month Costs in Waiver/FFS Counties: Continued Waiver/FFS vs. Family Care Expansion | | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|-------------|
| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| Continued Waiver/FFS | \$1,701.27 | \$1,716.94 | \$1,732.75 | \$1,748.71 | \$1,764.82 | \$1,781.07 |
| Family Care Expansion | \$1,701.27 | \$1,713.18 | \$1,721.75 | \$1,714.88 | \$1,719.44 | \$1,724.01 |
| Difference | \$0.00 | (\$3.76) | (\$11.01) | (\$33.83) | (\$45.38) | (\$57.06) |
| | 2018 | 2019 | 2020 | 2021 | 2022 | |
| 15 Waiver/FFS Counties | \$1,797.48 | \$1,814.03 | \$1,830.74 | \$1,847.60 | \$1,864.62 | |
| Family Care Counties | \$1,728.60 | \$1,733.19 | \$1,737.80 | \$1,742.42 | \$1,747.06 | |
| Difference | (\$68.88) | (\$80.84) | (\$92.94) | (\$105.18) | (\$117.56) | |

Cost savings result from ensuring that services are delivered in the right amount, at the right time, and in the right setting. A long term care managed care system facilitates these goals by aligning reimbursement incentives and integrating accountability.



Propose strategies to promote keeping individuals in their own homes to reduce or delay entry into publicly funded long-term care programs. The managed long-term care system built around Family Care and IRIS, the self-directed alternative to Family Care, seeks to maintain people's independence and delay the need for intensive and expensive long-term care services, such as admission into a nursing home. The strategies used include the following:

- The Aging and Disability Resource Centers (ADRCs) provide information and referral services to promote the wise use of personal resources and connect people to community resources to delay the need for more intensive supports and reliance on publicly-funded long-care programs.
- A coordinated, comprehensive long-term care system delivered through managed and self-directed care that provides timely access to supports, including preventative and early intervention services, by covering care in people's homes, community-integrated settings, and nursing homes

The Department of Health Services' conclusion. The expansion of Family Care, and the entitlement of support in homes and community-integrated settings, allows Wisconsin residents to receive cost-effective long-term supports. Managed long-term care is the most effective strategy to meet the needs of Wisconsin's residents. Family Care expansion will eliminate waiting lists for 1,600 people in fifteen counties while reducing the growth of state spending by \$34.7 million over the coming ten years.

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INTRODUCTION

The Joint Committee on Finance requested in the *2013-15 Wisconsin Biennial Budget*, that the Department of Health Services (DHS) provide a report on the publicly-funded long-term care system to inform whether the State should consider completion of statewide expansion of the Family Care managed care program. The Committee directed the Department “to develop a comprehensive projection of the expected future change in the need for publicly-funded community-based long-term care” and to consider the following:

1. Project future growth trends in populations likely to access services;
2. Determine the potential for, or project shifts in the use of Medicaid-allowable alternatives for this population;
3. Compare the cost-efficiency of various Medicaid-allowable service options to meet the needs of this population;
4. Develop strategies to control the growth in Medicaid long-term care costs; and
5. Develop strategies to promote people staying in their own homes to reduce or delay entry into publicly-funded long-term care programs.

The expansion of the Family Care program into new counties in Wisconsin was suspended as of April 2011. Thus, the Wisconsin Medicaid long-term care services remain in an extended transition between two publicly-funded long-term care systems: one built around the county-administered legacy Medicaid waiver programs with an entitlement to care in a nursing home¹; the other based upon managed or self-directed long-term care principles that assure timely access to services in peoples’ homes, community-integrated settings, and nursing homes. People who qualify for Medicaid long-term care services in the remaining 15 legacy system must make the difficult choice to wait for needed community supports, or must move to a nursing home to get urgently needed care. This creates a serious inequality in the State of Wisconsin with approximately 1,600 people waiting for access to home and community-based long-term care services as of October 2013.

The Wisconsin Department of Health Services has led a transformation of the state’s long-term care system over the past three decades. This increased the availability of cost-effective community supports and services, rather than the use of costly nursing home services, whenever appropriate to a person’s needs. The Family Care program and IRIS (Include, Respect, I Self-Direct), the self-directed alternative to managed care, are the culmination of these efforts. The Department’s analysis shows that these

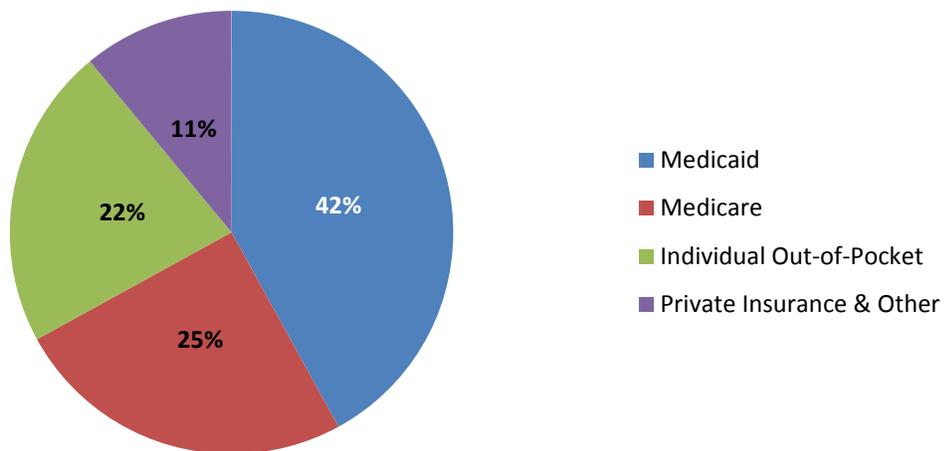
¹ Unless noted otherwise, this report will use the more colloquial term “nursing home” to refer to all institutional settings in which an individual who require long-term care services may reside (i.e. Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs-IDD), Institutes for Mental Disease (IMDs) licensed as a skilled nursing facility, or State Centers for Developmental Disabilities).

programs, in coordination with the Department’s other long-term care programs and initiatives, provide the capacity to manage the growth of long-term care costs while ensuring that Wisconsin residents have timely access to quality long-term care services without compelling entry into a nursing home.

SECTION A: ACCESSING LONG TERM CARE SERVICES

An examination of peoples’ access to private pay and publicly funded services is essential to understand the challenges of serving the long-term care needs of Wisconsin residents. Managed long-term care systems address these challenges. The major payment sources for services for frail elderly and individuals with disabilities are Medicare, private pay including out-of-pocket or private insurance, and Medicaid. Nationally, Medicaid is the largest single source of payment for long-term care, accounting for 42 percent of total spending, followed by Medicare at 25 percent, out-of-pocket spending at 22 percent and private insurance or other sources at 11 percent.²

Chart 2: National Expenditures on Long-Term Care Services by Payment Source, CY 2007



MEDICARE

Medicare is the publicly-funded program many people most closely associate with meeting the health care needs of elderly individuals and individuals with disabilities. However, Medicare only covers long-term care services under limited circumstances, such as nursing home stays of 100 days or fewer and home health care in certain situations. Medicare generally provides these services when a person requires these services on a temporary basis, such as rehabilitation from surgery.

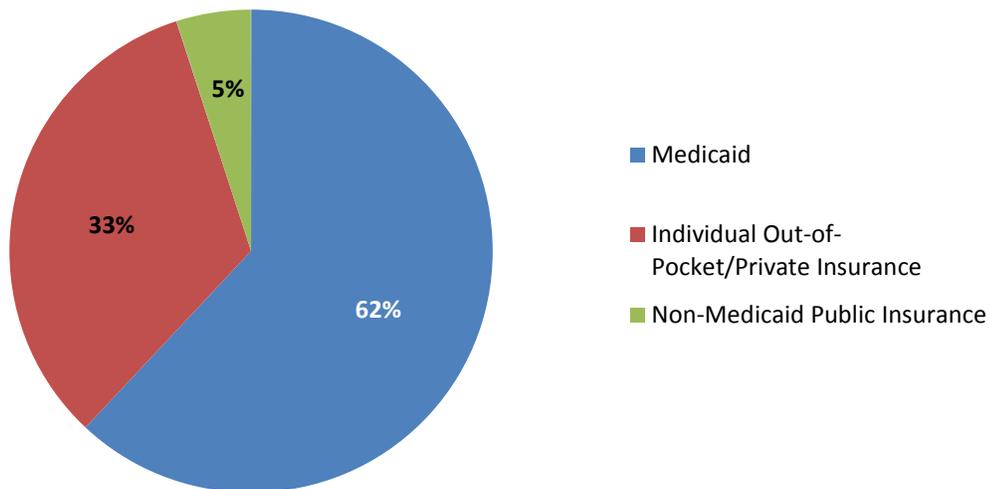
² Wisconsin Department of Health Services. (2012). “2011-2013 Long Term Care Sustainability Plan.” <http://www.dhs.wisconsin.gov/lcreform/>; These figures are based on the proportion of national spending on nursing home and home health care services in 2007.

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Medicare may help pay for primary care physician visits, inpatient and outpatient hospital care, pharmaceuticals, and rehabilitative stays in a nursing home for individuals requiring long-term care. Medicare does not cover residential stays in nursing homes nor on-going home care services that assist individuals with the activities of daily living which allow them to remain in their own homes or community-integrated residential settings. Thus, Medicare recipients need to pay for long-term care services either on their own (i.e. private pay) or through Medicaid. Appendix A shows the long-term care services included in Medicare, as compared to Medicaid.

The Medicare share of long-term care required within “the broad range of supportive services needed by people who have limitations in their capacity for self-care because of a physical, cognitive, or mental disability or condition,” becomes essentially non-existent. An analysis of 2011 spending for permanent and on-going long-term care showed that Medicaid constituted 62 percent of these expenditures; the remaining spending was covered by out-of-pocket spending and private insurance at 33 percent and non-Medicaid public insurance at five percent.³

Chart 3: National Expenditures on Permanent and On-going Long-Term Care Services, CY 2011



PRIVATE PAY AND NATURAL SUPPORTS

Many Wisconsin residents do not use public assistance in covering the cost of long-term care, rather they use their own funds or private insurance to pay for residential stays in a nursing home, residential care apartment complex (RCAC), community based residential facility (CBRF), adult family home or community support services – such as assistance with dressing, eating, and housework, home-delivered meals, or transportation to medical care – that allow them to remain in their own homes. This

³ O’Shaughnessy, C.V. (2013). “The Basics: National Spending for Long-Term Services and Supports (LTSS), 2011.” National Health Policy Forum, February 1, 2013.

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private pay population relies on their own financial resources such as private long-term care insurance, and support from their community, family, and friends to meet their long-term care needs. Although, people may find resources in their communities or have family members and friends who can assist with meeting their needs, the availability of these natural supports varies between regions of the state and individual circumstances.

WISCONSIN'S MEDICAID LONG-TERM CARE SERVICES

Wisconsin Medicaid provides acute and primary care, as well as long-term care services, to low-income people who meet a nursing home level of care. People who enroll in a Medicaid long-term care program must meet both functional and financial eligibility criteria. Entry into a publicly-funded long-term care program requires that a person meet “nursing home level of care”⁴ criteria, and has limited income and assets (See Appendix B for greater detail on eligibility criteria). People enrolling in a Medicaid long-term care program require a high level of medical care or assistance with activities of daily living, such as dressing, eating, and money management, and lack the personal resources to access this care and assistance.

People enrolled in Wisconsin Medicaid with long-term care needs receive acute and primary care services through Medicaid Fee-For-Service (FFS), or the “Medicaid card”. They receive long-term care services through either a Medicaid FFS residential stay in a nursing home or enrollment in a long-term care program offering Medicaid home- and community-based services (HCBS) waiver services.⁵ The Department of Health Services operates the following Medicaid HCBS waiver long-term care programs for adults:

- County-operated “legacy waiver” programs: Community Options Waiver Program (COP-W) and Community Integration Program (CIP);
- Managed long-term care programs: Family Care, Family Care Partnership, and Program of All-Inclusive Care for the Elderly (PACE); and
- Self-directed long-term care: IRIS (Include, Respect, I Self-Direct).

Recently, the Department has focused on how health care services, both acute and primary and long-term care, can be better integrated between Medicaid and Medicare. The Wisconsin Integrated Demonstration (WID) pursues incorporating the full spectrum of health care cost and utilization across Medicare and Medicaid for individuals dually served by both of these health care programs. As a demonstration grant recipient state, Wisconsin is able to access ongoing Medicare data for our state’s Medicaid population. This data is being used to identify and inform continued integration of care and cost for the services received by people who are dually eligible for Medicare and Medicaid.

PARALLEL MEDICAID LONG-TERM CARE SYSTEMS

⁴ The Family Care program serves both nursing home and non-nursing home level of care individuals. However, the non-nursing home members constitute a small proportion of program members – 3.4% - and program expenditures – 0.6%.

⁵ For enrollees in Family Care Partnership and Program of All-Inclusive Care for the Elderly (PACE) both acute and primary and long-term care services are provided through managed care.

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Currently, the Department operates different home- and community-based long-term care programs for adults in different parts of the state, as shown in Appendix C. In 15 of Wisconsin's 72 counties,⁶ access to Medicaid long-term care services outside of a nursing home is provided through the county-administered legacy waiver programs. In the other 57 counties, the Department contracts with managed care organizations to operate the Family Care managed care program and offers a self-directed alternative to managed care, IRIS. The continuation of these parallel Medicaid long-term care systems provides no additional value for residents of the State.

The types of long-term care services that can be accessed through Medicaid programs vary between regions of the state. Counties without Family Care rely on a waiver/FFS system consisting of home- and community-based services provided through the county-administered legacy waiver programs and access to institutional services through state-operated Medicaid FFS. In these counties, all individuals who meet a nursing home level of care, and who are eligible for Medicaid may receive long-term care services in a nursing home. These individuals may face a delay in receiving long-term care services in their own homes or in a community-integrated setting. State and county funding for the legacy waiver programs has not kept pace with the demand, resulting in waitlists for long-term care services. Peoples on waitlists and other Medicaid enrollees who choose to remain in their own homes rather than enter a nursing home can continue to use acute and primary care and personal care⁷ services through Medicaid FFS. However, these services can only meet a person's long-term care needs on a short-term basis, and reliance on these services can result in their health declining over time.

Residents of counties with Family Care can participate in the managed long-term care system that allows individuals with a nursing home level of care who are eligible for Medicaid the choice between receiving long-term care services in the community or in a nursing home. Residents may access long-term care services as needed through Family Care (a managed care program that covers home, community-based, and institutional settings), the IRIS program (a self-directed care alternative to managed care that provides home- and community-based services), or an institutional setting funded by Medicaid FFS. All 57 counties that have transitioned to the managed long-term care system completed the three-year transition to entitlement and the elimination of waitlists for home- and community-based long-term care services by April 2014. Appendix C shows the extent of managed long-term care coverage in the state.

⁶ Both the county-administered waiver programs and the managed long-term care program Family Care Partnership operate in Dane County. The county is included in the count of wavier counties due to the continued existence of waitlists for home- and community-based services.

⁷ Personal care services are medically-necessary related to assisting a member with activities of daily living (ADL) necessary to maintain the member in his or her place of residence in the community or supportive of nursing care and delegated to a personal care worker by a registered nurse. Fee-For-Service Medicaid covers these services if they are ordered by the member's physician.

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The Family Care program increases the choices available for Medicaid members needing long-term care. Members can choose from among providers in their managed care organization's contracted provider network; MCOs are also required to consider requests to go outside the network for services upon member request. For providers who come into the member's home or provide intimate personal care, the managed care organization must purchase services from whoever the member chooses, as long as that person meets the managed care organization's requirements and accepts its rates. In addition, members may self-direct all or some of their services for greater self-determination. Under the self-directed option within Family Care, members have control over the budget set for some services, and for hiring and supervising direct care workers. If a member's managed care organization denies, terminates, or reduces services, then the member can appeal that decision through a variety of channels, including directly with the MCO or by using the State Medicaid Fair Hearing process.

The continuation of parallel long-term care systems raises issues of inequity between Wisconsin residents. Residents of counties without Family Care have less access to long-term care services in their own homes or to community-integrated long-term care settings, such as residential care apartment complexes (RCAC), community based residential facilities (CBRF), or adult family homes. At the end of October 2013, approximately 1,600 Wisconsin residents were on waitlists to receive long-term care services in their own home or a community-integrated setting for county legacy programs. The difference in access to these services results from the funding structure of the legacy waivers, which combines the annually budgeted amount of State funds with available county funding and federal "match" funds.⁸ As a result, access to home- and community-based services through the legacy waiver programs is limited by the amount of state and local funding available. If funding is not available, county residents seeking long-term care services in their homes or a community-integrated setting who do not have sufficient resources to pay for these services, then they have a choice between entering a nursing home, which is an entitlement under federal Medicaid rules, or joining a waitlist for these services. In contrast, the Family Care program allows residents with a nursing home level of care and financial eligibility for Medicaid to receive long-term care services in a nursing home, a community-integrated setting, or their own home.⁹ Many residents in counties without Family Care may feel that they are being denied access to services simply because of where they live and how the State chooses to fund the different long-term care programs.

⁸ The federal Medicaid program provides funds for Medicaid service based on state and local spending on these services. While this match amount varies annually, it is in the range of \$3 federal for every \$2 of state and local expenditure (i.e. a 60%-40% split for Medicaid services)

⁹ When a Family Care expands to a new county, there is a three-year transition period when individuals in the legacy waiver programs, on county waitlists, and in institutional settings are enrolled in Family Care. At the end of this period, all residents meeting Family Care eligibility requirements may receive long-term care services in an institution, community-integrated setting, or their own home and county waitlists are discontinued.

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The continued operation of both the waiver/FFS and managed long-term care systems provides no added value for the State. The Department oversees and supports the operations of both types of publicly-funded long-term care systems. This entails maintaining separate staff and information systems to serve both the legacy waiver programs and the managed long-term care and IRIS programs. Although DHS has gradually reduced the resources supporting the legacy waiver programs as Family Care expands to new counties, the last expansion occurred in April 2011. Since that time, DHS has maintained its staff and data system for tracking county and state expenditures in the legacy waiver programs to enable the waiver program operations to continue.

Support for these parallel, publicly-funded long term care systems is an inefficient use of DHS resources and artificially inflates the public costs of providing long-term care. The DHS allocation of resources for legacy waiver programs was based on the continued phasing down of legacy waiver programs and expansion of managed long-term care programs. Although, DHS has been able to support the parallel systems for the last three years, continuing this support means delaying reallocation of resources towards other Department priorities. Each of the remaining 15 legacy system counties also operate separate administrative infrastructures related to the CIP and COP waiver programs. This creates additional duplication of expenditures.

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SECTION B: CURRENT COSTS OF PUBLICLY-FUNDED LONG-TERM CARE PROGRAMS

Medicaid expenditures for long-term care services to adults¹⁰ in SFY 2012 were \$2.64 billion. These expenditures constituted 43% of overall Medicaid expenditures in Wisconsin.

Costs for publicly-funded long-term services differ. The most significant difference is the cost between providing long-term care in a nursing home and providing these services in an individual's home or a community-integrated setting. Beginning in the 1980s, DHS has sought to increase access to long-term care services outside of a nursing home. These efforts have been driven by the preferences of most people, as well as the reduced long-term care costs associated with home- and community-based settings. The Department reports annually on the reduced costs associated with frail elders and individuals with a physical disability who relocate from a Skilled Nursing Facility funded through the State's Medicaid FFS program into a home- or community-based setting funded through either the legacy waiver or managed long-term care programs.

The table below shows that people relocating during State Fiscal Year (SFY) 2012 experienced lower long-term care costs of approximately \$1.08 million in a single year. The savings in SFY 2011 savings for relocations were \$2.23 million. The people who relocated to community-settings continue to generate Medicaid savings by avoiding nursing home expenditures. These savings are invested in the long-term care system to improve access to home- and community-based services for other Wisconsin residents.

| Table 1: SFY 2012 Medicaid Costs for Individuals Relocating from a Nursing Home¹¹ to a Home- or Community-Based Setting | | | | |
|---|---|---|-----------------------------------|---------------------------|
| | <i>Ave. Institutional Costs per Day</i> | <i>Ave. Community Costs per Day</i> | <i>Ave. Daily Savings</i> | <i>Annual Savings</i> |
| Nursing Home Relocations (Family Care) | \$143.90 | \$107.82 | \$36.08 | \$ 802,978 |
| Nursing Home Relocations (Partnership) | \$148.69 | \$101.84 | \$46.85 | \$ 120,272 |
| Nursing Home Relocations (Legacy Waiver) | \$141.76 | \$120.78 | \$20.98 | \$ 158,978 |
| Total NH Relocations in SFY 12 | \$143.78 | \$110.38 | \$33.40 | \$ 1,082,227 |

The cost structures of the programs that enable individuals to receive long-term care services in their own homes or community-integrated settings differ. In recent years, DHS has compared Medicaid long-term care program and Fee-For-Service costs for Family Care, IRIS, and legacy waiver members. This analysis has shown that the average costs for the legacy waiver programs have been higher than the programs available in counties with managed long-term care (Family Care and IRIS) as shown in Table 2 below. Appendix D provides a further comparison between Family Care and IRIS.

¹⁰ This figure includes spending on nursing homes, ICFs-ID, State Centers for Individuals with Developmental Disabilities, home care services paid by Medicaid Fee-For-Service, the adult legacy waiver programs, managed long-term care programs, and IRIS.

¹¹ This analysis includes frail elders and individuals with a physical disability who relocated from a Skilled Nursing Facility.

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| | 2010 | 2011 | 2012 |
|---------------------|----------------|----------------|----------------|
| IRIS/Family Care | \$ 3,252 | \$3,242 | \$3,176 |
| Legacy Waiver | \$3,761 | \$3,815 | \$3,834 |
| <i>All Programs</i> | <i>\$3,359</i> | <i>\$3,326</i> | <i>\$3,267</i> |

The population of individuals enrolled in each program compared above may differ. The enrolled population for one program may be healthier, on average, or require fewer care needs than the members in another program, or the programs may have differing proportions of members in each long-term care target group.¹² To control for these differences, DHS “risk adjusts” the average costs and compares costs across each target group. These adjustments provide average costs if each program served members with similar health status and care needs.

The average “risk adjusted” monthly costs in 2012 for Family Care and IRIS were either lower or similar to waiver costs across all three of the target groups as shown in Table 3 below. The costs for the programs available in counties with managed long-term care remain lower despite the fact that the Family Care benefit package includes nursing home services. These services are not a part of the legacy waiver programs. Nursing home services are on average, more expensive than services provided in a home or community-integrated setting. The inclusion of nursing home services is the likely cause of Family Care costs for frail elders being slightly higher than waiver costs for this population. If the nursing home costs of individuals in waiver counties were added to this comparison, then average costs in Family Care would be lower for all three target groups.

| | DD | PD | FE |
|---------------------------|---------------|---------------|---------------|
| Waiver Programs | \$4,878 | \$3,379 | \$2,465 |
| <i>Dec 2012 Members</i> | <i>3,334</i> | <i>1,302</i> | <i>1,515</i> |
| IRIS/Family Care Programs | \$3,690 | \$2,873 | \$2,502 |
| Difference from Waiver | (\$1,168) | (\$505) | \$38 |
| Difference as % of Waiver | -24% | -15% | 2% |
| <i>Dec 2012 Members</i> | <i>18,017</i> | <i>13,916</i> | <i>10,143</i> |

DD: Developmental Disability

PD: Physical Disability

FE: Frail Elderly

¹² Medicaid long-term care programs serve three target groups: frail elders, individuals with physical disabilities, and individuals with developmental disabilities. The types of services used and the average costs differ between these groups.

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The Family Care program has seen the average monthly expenditure per member on acute and primary care services decline while expenditures on these services have increased for legacy waiver members, as shown in Table 4. The different costs between areas served by the legacy waivers and those served by Family Care indicate that when access to home- and community-based services is limited, individuals may consume other Medicaid services to meet their long-term care needs, and to avoid, or delay, entry into a nursing home. In legacy waiver counties, people are likely to try to meet their needs based on the services they can access, which may not be an ideal match; within managed long-term care programs, members receive broad access to home- and community-based services and care management that can connect them to the local services that are best equipped to meet their needs and personal outcomes.

| | <i>Family Care</i> | | | | <i>Waiver</i> | | | |
|----------------------------|--------------------|-------|-------|-------|---------------|---------|-------|---------|
| | DD | PD | FE | All | DD | PD | FE | All |
| 2010 | \$244 | \$458 | \$125 | \$282 | \$1,117 | \$1,727 | \$624 | \$1,140 |
| 2011 | \$246 | \$472 | \$107 | \$279 | \$1,216 | \$1,709 | \$590 | \$1,184 |
| 2012 | \$233 | \$466 | \$80 | \$265 | \$1,188 | \$1,738 | \$602 | \$1,157 |
| Change 2010 to 2012 | -5% | 2% | -36% | -6% | 6% | 1% | -4% | 1% |

** Some differences in the average cost between programs are a function of the difference in the waiver and Family Care benefit package. The Family Care program includes more services, leaving fewer services to be accessed through Medicaid Fee-For-Service.*

DD: Developmental Disability
 PD: Physical Disability
 FE: Frail Elderly

Managed long-term care programs and the legacy waiver programs also exhibit different proportions of spending on administration. In recent years, administrative expenditures have been greater for the legacy waiver programs than for Family Care managed care organizations. The estimated 2012 per member per month expenditures for administration within the legacy waiver programs were \$131 or 4.5 percent of program expenditures; for Family Care managed care organizations the per member per month expenditures were \$119 or 4.2 percent of overall expenditures. In 2011 the legacy waiver figures were \$138 (4.8 percent), and the Family Care figures were \$123 (4.2 percent).

Family Care spends less on administrative functions through economies of scale. The legacy waiver programs are operated at the county level with county governance structures and boundaries which limit the opportunities to pool resources. The Family Care program operates on a regional basis where operational costs can be spread across a wider area. Managed care organizations operating in multiple regions, a phenomenon that has increased in recent years, develop even greater efficiencies. The State provides managed care organizations with access to its Third Party Administrator (TPA) Master

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Contract for claims processing. Pooling this work across managed care organizations lowers costs.

Mental Health or Challenging Behaviors

The presence of mental health or challenging behavioral needs can pose unique support needs that often increase long-term care costs. The responsibility for services for people with mental health or challenging behavioral needs in community based settings is shared between long-term care programs, which are responsible for meeting long term care needs and delivering effective behavior support plans, and the county-operated mental health crisis system. Effective coordinated supports along with crisis intervention and stabilization for people with mental health or challenging behavioral needs increase the stability for people within community settings; rather than placement into more intensive and expensive settings such as inpatient psychiatric treatment, state mental health institutes, and intensive treatment programs at the State Centers for Individuals with Developmental Disabilities. Stabilizing behavioral and mental health conditions and enabling people to remain in community-integrated settings reduces the costs to publicly-funded programs both at the state and county level; and allows people to live a more independent life.

The Department has collaborated with other stakeholders in a variety of ways to address the needs of individuals with mental health or challenging behavioral needs. The Department has convened and facilitated meetings between managed care organizations and County Human Service Agencies to increase effective working relationships between counties and managed care organizations. These collaborative prevention and planning efforts are intended to create a comprehensive community crisis response.

The Department is developing a three year plan that coordinates with managed care organizations, County Human Service agencies, Law Enforcement and State staff to establish appropriate behavior intervention plans, proper treatment and services within the least restrictive environment for the member. This effort will begin with a pilot program in regions with the greatest number of emergency detentions to State Mental Health Institutes and will focus on the following actions:

- Improve coordination between managed care organizations, counties, service providers, and law enforcement agencies;
- Increase county capacity for crisis response capacity to avoid police calls;
- Release a request for information to collect input from service providers regarding the supports needed to assist people with complex needs or challenging behaviors;
- Provide guidance for managed care organizations and counties to standardize and formalize crisis planning and intervention; and
- Develop teams staffed by Department employees to provide guidance and support to managed care organizations and counties with community placement and crisis planning for people with challenging behaviors.

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The Department also continues to leverage the skill set, professional expertise, and infrastructure available at the State Centers for Individuals with Developmental Disabilities. The Intensive Treatment Program (ITP) units at the Centers for Individuals with Developmental Disabilities provide a setting where people admitted to a State Mental Health Institute under an emergency detention can be transferred to receive services that can stabilize their condition before they return to a community setting.

Wisconsin Long-Term Care Functional Screen Pilot

The Department has worked with a wide range of stakeholders including ADRCs, managed care organizations, counties, providers, and the Long-Term Care Council to develop a pilot behavioral assessment to supplement information gathered by the Wisconsin Long Term Care Functional Screen during 2013. The results of the pilot will determine the most effective strategies to increase the knowledge and understanding of people with long-term care needs who also have complex mental health or behavioral needs. This will also include early identification of dementia related symptoms which will promote effective services and interventions to help avoid crises from occurring. This assures that long-term supports are responsive to people's needs and will also reduce the need for more costly services.

SECTION C: STRATEGIES TO CONTROL COSTS FOR LONG-TERM CARE

The DHS has integrated an array of strategies into managed care to make publicly-funded long-term care programs cost-effective on an ongoing basis while meeting the needs of current and future program participants.

The DHS efforts to control the cost of long-term care begin before people enter publicly-funded long-term care programs. Wisconsin has established Aging and Disability Resource Centers (ADRCs) as a place for people to contact when faced with a long-term disability or age-related needs. ADRCs are available in each county within the State as of March 2013. ADRCs assist people to manage their long-term care needs within their own personal resources by providing information to help them, and their families, make better and less costly choices about long-term care. ADRCs connect people to available resources, or help people become aware of their options when considering their need for long-term care services. This includes the unique considerations related to out-of-home care. The ADRCs averaged over 35,000 contacts per month in 2012. Only five percent of these contacts related to enrollment in Family Care or IRIS. The majority of ADRC work relates to information and referral to community resources, as well as guidance to people in order to facilitate wise choices with their personal resources.

DHS invests in building effective ADRCs. ADRCs are critical to a cost-effective long-term care system. Public awareness of ADRC services and highly skilled ADRC staff assure that people have timely access to assistance. The Department, in collaboration with local ADRCs, will implement a marketing plan to increase the numbers of people who contact the ADRC to take advantage of these services. DHS used federal grant funds to develop five 30-second video public service announcements for local ADRCs use in local media markets. These announcements began in November of 2013. The goal is to reach people as early as possible so that they are able to make frugal choices with their personal resources and to assure timely diagnostic and evaluative services to prevent long-term complications from various complex and chronic conditions. These efforts are demonstrated to reduce long-term care needs and costs.

The Department updated the pre-admission brochure, *Are You Considering Assisted Living or a Nursing Home?*, to better inform people about the assistance that ADRCs offer as they consider their options. This includes understanding the cost-effective supports that allow people to remain their own homes: the availability of other community-based options; and whether publicly-funded long term care is needed. The brochure also informs people that managed long-term care programs may not fund residential care settings if other cost-effective care settings will meet the person's needs. The brochure can be accessed at this website: <http://www.dhs.wisconsin.gov/adrc/professionals/programsservices/pac.htm>.

DHS provided training to over 250 ADRC staff during 2012 and 2013. The training focused on effective conversations with people and their families regarding home care options and the financial impact of various home and residential options. An additional

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70 staff received skills training and follow up coaching to apply motivational interview techniques. These techniques are demonstrated to help people to make a decision to seek, accept and pay for services at a time when their care needs are less intense and personal resources are still available.

DHS created tools that assist individuals and their families to compare the costs of long-term care options. The tool calculates the estimated cost of different services, such as supports within one's home compared to costs in a skilled care setting. This supports thoughtful long-term care decision-making. The tool can be used by the person and their family, or with support from ADRC staff.

The Department continues to develop and strengthen its efforts to provide individuals the opportunity to relocate from nursing homes into community settings because, on average, it costs less to receive long-term care at home or in a community based setting than in a nursing home. Living at home with needed help and services can be safe and less costly whether it is privately or publically paid care. DHS efforts to promote community relocations include:

- Technical assistance to ADRC staff regarding effective strategies to reach out to people in nursing homes;
- Staff resources to help people who either were in the nursing home long-term, or who had entered for rehabilitation stay, and were at risk for becoming a long-term resident, to find community settings for relocation;
- Five "community living specialists" through a DHS contract to work with nursing homes that had high proportions of Medicaid residents to assist people with relocation to non-institutional settings;
- Leverage of enhanced federal funding through the Money Follows the Person (MFP) Rebalancing Demonstration grant to help people transition to the community;
- Use of MFP savings to support additional ADRC work with nursing home residents and the community living specialists noted above;
- DHS provides a payment of \$1,000 to a managed care organization for each member who is relocated from an institution into a community setting consistent with the Money Follows the Person guidelines to incentivize managed care organizations to successfully relocate members under the program and thus increase federal revenue; and
- Use of Money Follows the Person funds to develop an automated system for nursing homes to make the referrals to ADRCs that are required under recent federal Minimum Data Set 3.0 enhancements. The automated system allows the Department to ensure nursing home compliance and to track outcomes for individuals who have been referred.

The Department has collaborated with the nursing home industry to reduce excess capacity and modernize remaining facilities. The Department has enforced a

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moratorium on the creation of new nursing home beds since 1981. This moratorium in combination with the fee a facility pays on each of its licensed beds has reduced the number of licensed beds in skilled nursing facilities by 16 percent between 2003 and 2013. The Department and the facility collaborate to identify community settings that meet residents' needs when relocating during facility downsizing or closures. The Department expedites rate-setting for facilities undergoing a significant downsizing, in order to allow the facility to access enhanced revenues during this process. Small skilled nursing facilities may receive additional funding to support their direct care operations, or an accelerated cost report to ease administrative burden. Nursing homes that are modernizing their facility, or implementing resident-centered or dementia capable design are eligible for a rate incentive. This incentive is budget neutral for the State as the additional capabilities lead to less utilization of intensive services which offset the cost of the rate enhancement.

A fundamental strategy for managing costs for recipients of long-term care is investing in preventative and less intensive services that reduce the need for higher cost services. The Department has implemented a number of initiatives and services that can limit unnecessary hospitalizations, emergency room visits, and nursing home placements.

Medication Compliance

The Department and managed care organizations have jointly piloted a medication compliance program to reduce preventable use of the hospital and nursing homes. This includes the positive health outcomes of increased compliance with prescribed medication regimens and prevention of negative health outcomes as a result of medication errors. The pilot includes specialized medication compliance screening for all members of managed care organization who live in their own homes, or homes of family members. People who may benefit from medication management are provided with an automated, in-home medication dispensing systems, or other medication-management interventions, to ensure members are using their medications as prescribed.

As of November 2013, 15,354 members have been screened and a total of 218 devices have been authorized by the nine managed care organizations. Other members received alternate interventions to promote medication adherence. All screens, as part of this pilot, will be completed by the end of 2013. DHS will perform a pre- and post-intervention analysis in 2014 to determine the impact of the initiative on improved medication management and to determine the impact on the use of hospitals, emergency rooms and nursing homes.

Dementia Care

Long-term care programs must also strengthen the ability to address the needs of people with Alzheimer's disease and other dementias. This will ensure proper support and a cost-effective approach to reduce costly hospital stays, emergency room visits, and nursing home admissions. The need for dementia care is prevalent with almost one-

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in-five Family Care members with diagnosed dementia. Studies show that early screening to identify symptoms of dementia, and support for the person with dementia and their families, can delay entry into a nursing home by one-and-a-half years on average. DHS efforts have focused on both increased identification of dementia-related diagnoses and effective interventions once dementia is diagnosed. Specific DHS efforts include:

- DHS sponsored training of 445 county staff members, including ADRC staff, Adult Protective Services staff, and county waiver program case managers on detection of possible dementia since July of 2012;
- Managed care organizations increasing early screening to identify symptoms of dementia and increasing access to support for people with dementia and their families; DHS working with managed care organizations to develop evidence-based dementia care guidelines to be implemented across the managed long-term care programs to strengthen capabilities for screening, diagnosis, care management and monitoring, serving members with challenging behaviors, and caregiver assessment and support; and
- Five ADRCs creating dementia care specialists in February of 2013. The specialists have implemented two evidence-based programs, LEPS and Memory Care Connections which have already delayed in nursing home placement for up to five months.

Fall Prevention

People falling can lead to injury and significant long-term care costs. DHS and managed long-term care managed care organizations continue to expand falls prevention efforts. This includes the use of evidence-based prevention programs with people who are at high-risk of falling. These efforts focus both on people living in their own homes, who could face a long hospital stay, or require admission to a nursing home due to injuries sustained from a fall, as well as residents of community-integrated settings and nursing homes who would need to receive additional medical care as a result of a fall.

Five managed care organizations have developed, or are in the process of developing, performance improvement projects related to falls prevention. The type of interventions range from evidence-based exercise programs to nutrition programs. Managed care organizations identify effective interventions as part of these performance improvement projects. This includes development of practice guidelines for implementation with the target group which are implemented across the entire managed care organization enrollment.

DHS is also working with community organizations to increase participation in evidence-based fall prevention programs like Stepping On, Otago, Sure Step, and Tai Chi. This includes work with healthcare professionals to increase screening people for fall-risk and referring people to risk-reduction resources in the community. In November 2012, DHS hosted an all-day session, *The Art and Science of Fall Prevention*, in which over 900 nursing homes, assisted living facilities, and other stakeholders participated. The

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Department continues to fund the Wisconsin Clinical Resource Center, a web-based resource for nursing homes, which includes a main module on fall, fall risk, and fall prevention.

Chronic Disease Self-Management

The Chronic Disease Self-Management Program, known as “Living Well with Chronic Conditions” in Wisconsin (and a Spanish-language version called “Tomando Control de Su Salud”), is an evidence-based intervention shown to improve quality of life and reduce emergency department visits or hospitalization due to people’s chronic conditions. This is also effective in delaying the need for long-term care. Living Well is a six-week course delivered through a partnership between the Department’s Divisions of Long-Term Care and Public Health, as well as area agencies on aging; county aging units and ADRCs; health care providers; and the University of Wisconsin School of Medicine.

A three-year federal Administration on Aging grant is expanding the program’s reach thus increasing access to people with chronic conditions.. The program goals are as follows:

- Develop outreach to health and social service professionals and systems to promote referrals and participation in Living Well and Tomando programs;
- Focus on enrollment of adults age 18-59 with physical disabilities;
- Promote enrollment of tribal members, the Latino community and other minority older adult and adults with disabilities populations;
- Expand number of health care professionals, such as Occupational and Physical Therapists, Nurse Practitioners, pharmacists and vision specialists, and aging network professionals participating in the delivery of Living Well and Tomando programs; and
- Expand Wisconsin’s capacity, including infrastructure support, data collection, fidelity monitoring, and leadership development, to deliver chronic disease self-management programs.

Managed Long Term Care

The managed long-term care programs play an especially important role in controlling the costs of long-term care. DHS works with managed care organizations on efforts that control costs and strengthen care quality. These efforts include the performance initiatives that managed care organizations identify in their annual business plans, program improvement initiatives implemented by DHS, and the fundamental dynamics of a managed care model, which promote identification of cost effective strategies for delivering care.

Promotion of Natural, Unpaid Supports

The managed long-term care programs work to maintain, or foster, members’ independence and reduce reliance on publicly-funded services. These efforts begin with care planning that emphasizes the members’ and their caregivers’ strengths and resources. This shifts away from a focus on services. The managed

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long-term care programs build on the supports members already have in their lives and help members to identify other supports or relationships that can be developed. The member, along with their care team, develops ideas to include families, friends and people in the community in the person's care plan. This maintains and strengthens the assistance a person gets from family, friends, faith connections, and the community, and ensures that public funding is used prudently.

Employment

The types of services offered through managed long-term care programs also reduce the reliance of publicly-funded services. Employment services, accessible through these programs, are one example. Members involved in community-based and meaningful employment have better health outcomes which reduce expenditures for long-term supports and medical care. This increases the cost-effective management of long-term care programs. Specifically, a recent research study, paid employment was found to be significantly related to higher self-reported health status and low per person per month Medicaid expenditures.¹³

Services that support community-based, integrated employment are more cost-effective than services that support facility-based employment. The cost of services to support integrated employment averages \$8.01 per hour worked, while the cost of services to support people in facility-based employment averages \$10.45 per hour worked. Individuals in integrated employment also earn more than people in facility-based employment. In April 2013, the average wage for individuals in integrated employment was \$8.28 per hour, while the average wage for individuals in facility based employment was \$2.43 per hour. Employment for young adults with disabilities is essential to the fiscal viability of long-term care. A focus on employment for young adults, while they continue to live with their family, results in these members having more personal income and resources to support their ability to live in their own homes in the future. Employment development services assure that youth gain job skills and independent living skills to make a successful transition as adults.

The Department's managed long-term care programs have a number of initiatives to increase integrated employment. DHS is working with the Wisconsin Department of Workforce Development's Division of Vocational Rehabilitation to leverage federal funding from the PROMISE grant. The PROMISE grant will coordinate services between key public agencies and uses best practices to prepare young people for the workplace. This joint effort will

¹³ Hall, J.P., Kurth, N.K., & Hunt, S.L. (2013). Employment as a health determinant for working-age, dually-eligible people with disabilities. *Disability and Health Journal*, 6, 100-106; <http://www.ncbi.nlm.nih.gov/pubmed/23507160>

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enroll over 2,000 youth between the ages of 14 and 16 years old in the next five years.

The Division of Long Term Care has created an Employment Initiatives Team. This team includes staff from the Office of Family Care Expansion, IRIS and Children's Long-Term Supports. The focus of this team is to collaborate with the managed long-term care programs, IRIS, and the children's long term support waiver to increase integrated employment. The Department's promotion of employment services includes a requirement for managed care organizations to articulate a plan to increase integrated employment in their annual business plan submissions. The Department has a clear and consistent message regarding employment for people with long-term care needs as follows:

- Employment is possible and beneficial for people with disabilities;
- Community-based employment is a priority;
- Services, such as mentoring, in Children's Long Term Support (CLTS) waivers can lead to employment; and,
- Integrated, community-based and time limited efforts are the focus of prevocational services.

Living at Home

A significant component of the cost of long-term care services relates to a person's living setting. In general, the most cost-effective residence is a person's own home. The DHS contract with, and guidance to, managed care organizations promotes long-term care services to participants in their own homes and apartments. Managed care organizations continually assess members' ability to remain safely in natural living settings and seek to support member's independence in their home. This includes identification of supports and services that will help them live at home safely. This might include building a wheelchair ramp or using technologies, such as medical alert systems or medication dispensing devices. These efforts make it possible for elders and people with disabilities to live independently, in their own homes and communities.

If a member's long-term care outcomes cannot be adequately and cost-effectively supported in at home, or a member's health and safety cannot be sufficiently safeguarded, then managed care organizations work with the member to locate the least restrictive residential setting. This includes community-integrated settings provide greater support without the intense level of care and additional costs associated with moving into a nursing home. Managed care organizations rely on nursing home services once the level of care provided in an institutional setting is required to meet the needs of the member.

Administrative Efficiency

The Department increased the efficiency and cost-effectiveness of managed care organization operations by streamlining and improving requirements and

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practices. The service authorization process has been strengthened to create a standardized and understandable process that managed care organizations consistently implement. DHS has focused on cost-effective and responsible use of public funds as a critical component in service authorization decisions. This includes a greater emphasis on:

- Assessment of the appropriate use of family and community supports and inclusion of these supports in a member's care plan;
- The member's responsibility to choose cost-effective services and supports; and
- Appropriate use of self-directed supports when making service authorization decisions.

The Department streamlined requirements for documentation of service authorization decisions in member records; and for Notice of Action when a managed care organization denies, reduces, or stops a service. These steps reduce the administrative burden on managed care organizations and ensure member rights. DHS also broadened the managed care organizations' flexibility in staffing requirements with regard to the use of social workers and nurse care managers. This level is now dependent on needs of individual members. Further, DHS is developing protocols to more efficiently integrate nursing provided by residential facilities with the Family Care nurse care manager role.

IRIS, Self-Directed Care Program

Wisconsin residents in regions within the managed long-term care programs may choose to enroll in the self-directed program, IRIS as an alternative to managed care. The IRIS program has the largest growth rate of all of Wisconsin's publicly-funded long-term care programs. Therefore, the Department is strengthening the infrastructure for administering the program. This will improve the efficiency of service delivery and participant experience, as well as the Department's oversight to ensure program and fiscal integrity.

The Department has procured a centralized, web-based Information Technology (IT) system that will house all relevant data for participants, guardians, providers, contracted agencies, and Department staff. This system will improve the Department's ability to monitor spending trends, service utilization, and critical incidents. This data will advise adjustments to program design to ensure that the program continues to meet people's needs while remaining cost-efficient and accountable. The centralized IT system also increases the Department's program integrity and efficiency in tracking and monitoring suspected fraud and abuse. The Department's Office of Inspector General (OIG) will oversee all allegations of fraud or abuse. The Department will automate the claims adjudication process, which is currently performed manually. IRIS participants, or their guardians, will have increased access to information to monitor or revise their long-term care plan and to ensure that their spending is within their authorized budget.

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The DHS is further strengthening the IRIS program claims processing capability through use of a third party administrator (TPA) contract. The limited size of the program in its initial years allowed claims to be processed by an accounts payable agency; however, as the program has grown, the Department needs the greater capability of a claims processing system and adjudication agency. This change will strengthen control over claims submissions; enhance security of Personal Health Information; improve consistency in claims processing, provider setup and maintenance, and data management and reporting; and increase access to consistent and accurate data for trending and spending analysis.

The Department has one agency under contract as the IRIS Consultant Agency which is responsible for administering the programmatic component of IRIS and one Financial Services Agency which is responsible for serving as an employer agent and processing vendor claims. The growth of the IRIS program has enabled the Department to broaden the number of agencies it contracts with to administer the program in the future. This will increase the quality of the delivery of service and the cost of the services being delivered through competition. This will also provide participants with greater choices in meeting their needs. Once the IRIS Consultant and Fiscal Employer become services, rather than administrative functions, the Department will qualify for greater federal reimbursement.

A single, standard program-wide IRIS policy and procedure manual is nearing completion. The IRIS Manual creates a consistent, accessible, and transparent standard for all operations. A critical component of the Manual is the *Work Instructions*. These define the roles and responsibilities of all groups involved in the IRIS program including the participant, contracted agencies, and the Department. The *Work Instructions* define key functions, such as: enrollment, plan amendments, service flexibility, and home or vehicle modifications processes.

The Department is using existing technology to improve the business rules and logic of its information systems prior to completion of the comprehensive IT System noted above. This interim system uses SharePoint Sites to manage the following:

- The Critical Incident Site allows the Department to mitigate the health and safety risks for individual participants, as well as identification of trends to advise prevention efforts.
- The Budget Monitoring Site allows to program to track participant spending, enabling the program to identify when members are overspending their individual budget allocations. Such cases are opportunities for greater training and education around budget planning and, when warranted, an adjustment to the member's budget allocation. The site also identifies contracted agencies associated with higher than average member spending so that the Department may determine if a corrective action plan is needed.
- The Fraud Investigation Site manages the fraud and abuse investigation protocol. This logs all reports of fraud or abuse and documents the investigations and

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referral actions. All credible allegations of fraud and abuse are referred to the Department's OIG for appropriate follow up. The site uses a centralized IT module that increases the efficiency of the investigation process. The Department's contracted partners are able to enter information related to the allegation directly into this system. This provides the OIG access to all relevant documentation necessary to determine the appropriate course of action.

Collaboration with Stakeholders

The Department recognizes that engaging all stakeholders is a key component to gain efficiencies, improve care delivery, and reduce costs in its long-term care systems. The Department took deliberate and comprehensive efforts to engage key stakeholders regarding the long term care reform efforts. Examples include the "Promotion of Community Supportive Living", "Connections to Community Living", and "Nursing Home Modernization". Outreach has included meetings with providers and provider associations through forums, provider annual conferences and the Department's Division of Quality Assurance (DQA) Focus conference. The outreach also included discussions with key stakeholders including the Wisconsin Long Term Care Advisory Council; the IRIS Advisory Committee; the State Ombudsman program; Managed Care Organization Leadership and workgroups; Aging and Disability Resource Centers; Independent Living Council of Wisconsin; Director of Nursing Association; and Social Worker Association. This advice has shaped many of the efforts noted in this report and has been crucial to the early success of these efforts. Many leaders within the provider community are bringing innovative ideas and new models of care delivery forward as Wisconsin's long-term care system reform continues.

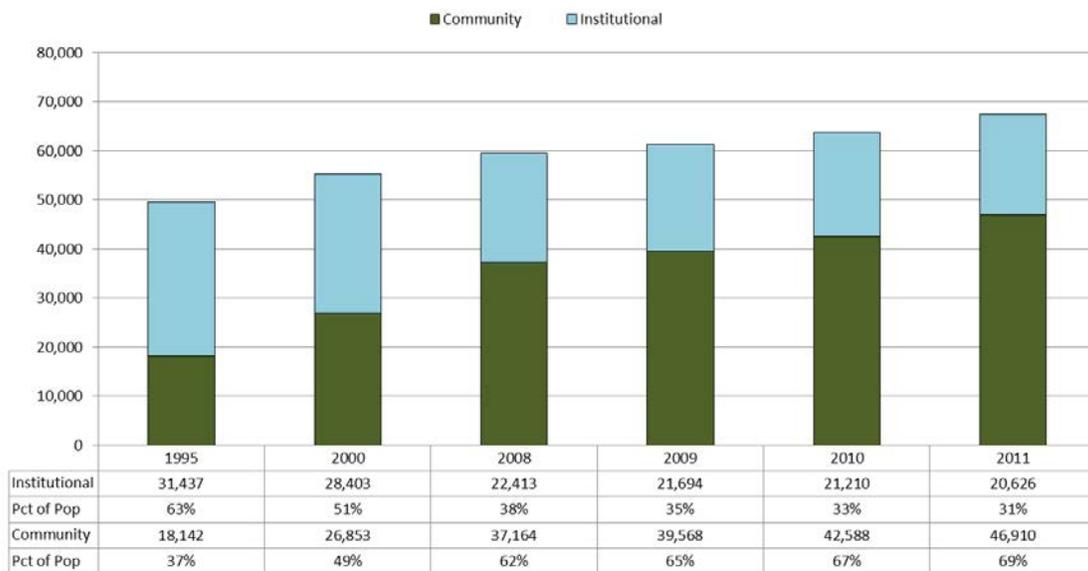
SECTION D: CONTROLLING FUTURE GROWTH IN THE COST OF LONG-TERM CARE

Wisconsin’s managed long-term care system controls costs while ensuring quality care. The legacy waiver programs, as currently constructed, do not allow sufficient access to Medicaid home- and community-based services. Therefore, many Wisconsin residents who need long-term care must rely on the entitlement to Fee-For-Service nursing home services. These are more costly than those received in home or community-based settings.

SUCSESSES AND LIMITATIONS OF THE LEGACY WAIVER PROGRAMS

The county-administered waiver programs were the first step in enabling Wisconsin residents to receive long-term care needs outside of a nursing home. The Community Options Waiver Program (COP-W) and Community Integration Program (CIP) began providing public funding for long-term care services to individuals in their own homes or a community-integrated settings starting in the 1980s. The positive impact of these efforts is demonstrated in the rise in the proportion of the publicly-funded long-term care services in the community rather than in a nursing home. The population of people served in the community grew from 37 percent to 62 percent between 1995 and 2008, when the legacy waiver programs were the dominant avenue for providing home- and community-based services as seen in Chart 4 below. From 2008 forward, the proportion of individuals served in their own homes or community-integrated settings resulted from both the work of the legacy waiver and managed long-term care programs.

Chart 4: Publicly-Funded Adult Long-Term Care Population
1995, 2000, 2008-11
(end of year counts)



* Institutional population includes managed long-term care members residing in a nursing home or ICF-IDD.

The legacy waiver programs have successfully established access to long-term care services outside of a nursing home. However, these programs are not positioned to meet the current or future demand for home- and community-based services and lack the flexibility for innovations that can effectively control costs. In the regions of the state served by legacy waiver programs, many people continue to experience limited access long-term care services to remain in their own homes or to reside in a community-integrated setting. These Wisconsin residents may not receive care that would enable them to better manage their health and delay their need for more intensive and expensive long-term care services available in a nursing home. Faced with a choice between either receiving insufficient care in their own homes, or accessing care in an institution, residents may enter a nursing home prematurely.

Limited access to long-term care services also impact family members who provide caregiver services. This often has an adverse effect for the caregiver's employment, for employers, and the Wisconsin economy. The Employee Benefit Research Institute reported that "one in five (19 percent) retirees left the workforce earlier than planned because of having to care for an ill spouse or other family member," and the National Alliance for Caregiving and AARP found that "nearly seven in ten (68 percent) caregivers report making work accommodations because of caregiving," including cutting back on work hours or stopping work entirely. A report from MetLife Mature Market Institute and National Alliance for Caregiving found that the "average annual cost to employers per full-time caregiver is \$2,110." Another report by those entities and the University of Pittsburgh cited a study that estimated "employers paid about 8 percent more for health care of caregiver employees compared to noncaregivers."¹⁴ The investment in publicly-funded long-term care programs to ensure access to long-term care services may help Wisconsin citizens remain fully engaged in the workforce, maintaining the State and county's tax bases, and may lower operational costs for Wisconsin employers.

THE ROLE OF NURSING HOMES

Nursing homes play an essential role in the long-term care system by providing intensive services and ensuring individuals receive care when they can no longer live independently. However, the 24-hour skilled nursing level of care may exceed the long term care needs of many individuals who could be well supported in their own homes or less intensive care settings. If the alternative home and community based care programs are not available, then the State would be over-paying for nursing home services for Medicaid members with lower levels of need. The cost of publicly-funded long-term care is lower when a home care worker is paid to assist with house and yard work and with activities of daily living, such as dressing, bathing, and money management for people to continue to live in their own homes, rather than the person moving to a skilled care setting, such as a nursing home.

¹⁴ The figures and citations in this paragraph are from AARP Policy Institute, *Understanding the Impact of Family Caregiving on Work* (http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/understanding-impact-family-caregiving-work-AARP-ppi-ltc.pdf)

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Annually, the Department of Health Services submits to the State Legislature *The Report on Relocations and Diversions from Institutions*, as required by §. 51.06 (8). This report illustrates the reduction in long-term care costs that occurs when people have access to home- and community-based supports instead of nursing home care. The State of Wisconsin saved \$1.08 million in SFY12 for frail elders and people with physical disabilities relocating from nursing homes. This is a single year's worth of savings which grows each year that these people remain in community settings. The SFY 11 savings for relocations was \$2.23 million. As the number of people relocated from Nursing Homes grows, the savings to the State in avoided nursing home expenditures grows as well.

The lack of access to home- and community-based services also increases the demand for publicly-funded long-term care. If an individual is unable to meet their long-term care needs through their own private resources and available natural supports, then the individual may deplete their own income and assets paying for the care they need. Once people expend their private pay resources, they become eligible for Medicaid. Meanwhile, a person's health may have deteriorated to the extent that they require intensive services, including entry into a nursing home. This need can be averted for many people through access to preventative care, early intervention services, or other less intensive community-based services.

If access to home- and community-based services remains limited, then reliance on nursing homes to provide long-term care may increase. This reliance will require the State to invest in building nursing home capacity. This would reverse the work of the past decade to increase community-capacity and to match nursing home capacity to the needs of Wisconsin residents. The number of skilled nursing home beds in Wisconsin has declined between July 2003 and July 2013 by 6,577 beds, or 16 percent. The number of beds in Intermediate Care Facilities for individuals with intellectual and developmental disabilities declined in this same timeframe by 1,730 beds, or 70 percent.

It is not cost-effective to expand nursing home capacity to meet the demographic bulge of the *Baby Boomers*. This is because the generation after the *Baby Boomers* is smaller, which will lead to a decline in the demand for long-term care services. Over the last few decades, the State has invested resources to ensuring that the nursing home providers would not collapse during the transition from a long-term care system reliant on nursing homes to one using home- and community-based long-term care services; a similar level of public funds may be needed to reduce nursing home capacity once demand decreases due to these demographic changes. Relying on nursing homes to serve the demographic challenges in the near future would involve spending public funds to build up nursing home capacity, and then spending public funds, again, to phase down nursing homes in the future.

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In the legacy COP and CIP waiver programs, people who are Medicaid eligible with long-term care needs can always access nursing home services, but may not have that same access to less expensive services that would adequately support them in their own homes. This is because there are waiting lists for home and community-based services in the legacy waiver counties. This results in people moving to nursing homes when they could be adequately supported at home with less overall cost to the Medicaid program.

CAPABILITIES OF THE MANAGED LONG-TERM CARE SYSTEM

The managed long-term care programs offer the capability to control the growth of long-term care costs. These capabilities are built on the capacity of managed long-term care programs to limit the growth in long-term care costs by providing the right level of service based on the person's needs and purchasing the right care, in the right setting at a competitive price.

The flexibility the full array of long-term care services allows the managed long-term care programs to fit the level of service to the member's level of need. Managed long-term care programs can serve more people and control the costs of long-term care services by matching services to people's needs. Members are able to choose less intensive services delivered in their own homes or other community-based settings; rather than entering a nursing home. Managed care programs identify the needs and desired outcomes of members; work to maintain or create natural supports available through family and friends; and connect members to the proper services to meet the person's needs and outcomes. This ensures that Wisconsin residents requiring long-term care neither under-consume services which could cause their health to deteriorate, nor over-consume services by entering a nursing home before they require the intensive level of services available in an institutional setting.

The reduced use of nursing home services in regions of Wisconsin with managed long-term care illustrates that the managed long-term care system controls costs. A comparison of nursing home residents in Family Care to residents in Medicaid FFS shows that managed long-term care delays entry into a nursing home until an individual's health needs require an intensive level of care. The analysis found that over 70 percent of nursing home stays in Family Care were for less than two years, while in Fee-For-Service, the majority were for greater than two years with over 30 percent of the stays for four years or longer. A comparison of the health needs¹⁵ of nursing home residents between the two Medicaid programs showed that Family Care nursing home residents have greater health needs on average than FFS residents.

The managed long-term care system relies on a funding structure that promotes the right care at the right price. Managed care organizations are funded on a capitated rate basis to meet the full spectrum of long-term care needs for individuals with a nursing

¹⁵ Based on Resource. Utilization Groups (RUGs) case mix indices

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home level of care. They are responsible for all long-term care services, from the less intensive services available in people's homes and through community-integrated settings to the more intensive care provided in a nursing home. This creates an incentive for managed care organizations to improve members' quality of care and provide access to the services in the community to keep members healthier for longer. The average cost of nursing home stays exceeds those of home- and community-based services, so managed care organizations can control their costs, and the costs of the long-term care system, by maintaining and improving home- and community-based services that delay a member's entry into a nursing home.

The managed long-term care system encourages providers to offer broader services because of confidence that there will be a demand regardless of the individuals enrolled in publicly-funded long-term care programs. There is also confidence in the funding available to support these programs. The managed long-term care changes the dynamic from a long-term care program choosing from the services that are available in an area to a program that works with providers to develop the services that best meet its members' needs. A managed care organization works with providers to develop innovative methods that address needs of the enrolled population.

The concept of managed care organizations to develop services with providers is more than a theory. One managed care organization moved to an outcome-based contract for supported employment, paying the employment services agency based on numbers of hours the member worked, instead of the hours of job coaching provided. Two managed care organizations are actively working with community providers to support members in expanding their supportive relationships in their communities, with the goal of increasing their community integration and reliance on natural relationships rather than paid supports.

The Department uses a funding model for setting capitation rates for managed long-term care services based upon the costs associated with different care needs and medical conditions of members. This is then used to develop a rate for a region based on the prevalence of these care needs and medical conditions within each region. The funding model is built on the average costs associated with needs and conditions, not the cost for specific services. Managed care organizations are funded based on the average cost of the population they serve: populations with more costly care needs on average receive a higher capitation payment; those with populations with less costly care needs on average receive a lower capitation rate. A managed care organization that is able to identify strategies to provide the same quality of care with lower expenditures retains the savings.¹⁶ In this manner, the managed long-term care funding model incentivizes managed care organizations to become more cost-effective.

¹⁶ As in other managed care Medicaid programs, the Department places some limitation on potential managed care organization profit. During the rate setting process, the Department projects the annual surplus a managed care organization may accumulate under the estimated capitation payment and may

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Competition within the managed long-term care programs creates additional opportunities to innovate and develop strategies for controlling costs. The information used to develop capitation rates relies on historic costs in regions that have met program benchmarks for spending. Thus, each managed care organization is competing to beat the average costs of providing long-term care to a population of members with comparable care needs and medical conditions. A managed care organization’s ability to remain below the average costs associated with their members results in the annual surplus or loss the managed care organization will experience. This competition is increasing in Family Care as more regions are being served by multiple managed care organizations. In 2011, the number of counties served by multiple Family Care managed care organizations was three; in 2013, there are 22 counties within regions served by multiple managed care organizations.

The managed long-term care funding structure enables the cost to the State for long-term care services to be driven by the average cost of serving the individuals under a managed care model of service. Managed care organization efforts to deliver the right long-term care services are reflected in future rates. The average cost of services continues to decline due to the innovations and efforts of the managed care organizations, as well as investments by DHS in cost-effective program improvement initiatives. These cost savings will be reflected in future capitated rate setting. This funding model allows the State to share in the service cost savings and “bank” efficiencies when developing payments in future years.

The cost experience of Family Care shows that the managed long-term care controls the cost of long-term care services. The average overall Medicaid costs for Family Care enrollees have declined or remained stable in recent years. An annual analysis of the expenditures for both the long-term care services members receive through the Family Care program and the acute and primary care services received through the Medicaid FFS system found that the average monthly cost of Family Care members with a nursing home level of care declined by almost two percent, from \$3,188 to \$3,128, between 2010 and 2012. This is shown in Table 5 below.

| Table 5: Average Per Member Per Month Medicaid Costs (Program and FFS) for Family Care Members | | | | | |
|---|-------------|-------------|-------------|-------------------|---|
| | <i>2010</i> | <i>2011</i> | <i>2012</i> | <i>Difference</i> | <i>Difference as a percentage of 2010</i> |
| <i>Average Costs</i> | \$3,188 | \$3,183 | \$3,128 | -\$60 | -1.9% |
| <i>Members in Dec</i> | 31,256 | 32,688 | 34,564 | N/A | N/A |

adjust the capitation rate to limit the projected annual surplus. In prior years, this limit has been 2-3% of projected annual revenue.

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Impact on Fee-For-Service Costs

Managed long-term care programs impact the cost of services within the long-term care systems, as well as the cost of services outside of the long-term care benefits. In recent years, Family Care members' Medicaid FFS expenditures, which include acute and primary care that are not provided by managed care organizations, have declined. In 2010, the average monthly FFS expenditures for Family Care members were \$282. The average cost decreased to \$279 in 2011 and \$265 in 2012 for a decline of six percent over the two years. These data are shown in Table 6. This indicates that increased access to home- and community-based long-term care services helps people to be healthier for longer and to require fewer physician visits, hospitalizations, and similar services.

| | <i>2010</i> | <i>2011</i> | <i>2012</i> | <i>Difference</i> | <i>Dif as % of 2010</i> |
|------------------------|-------------|-------------|-------------|-------------------|-------------------------|
| <i>All Members</i> | \$282 | \$279 | \$265 | -\$18 | -6.2% |
| <i>Members in Dec.</i> | 31,256 | 32,688 | 34,564 | | |

The decline in Medicaid FFS expenditures for Family Care members offers evidence that managed care strategies for controlling costs are not driven by provider rate cuts. Underfunding providers would result in insufficient care and members being unable to have their needs met within Family Care. These members would seek other services available outside of the long-term care system, as occurs in legacy waiver counties where access to home- and community-based long-term care services is limited. This is not occurring within managed long-term care as the demand for, and the use of services available outside of the managed long-term care system through Medicaid FFS has declined.

People enrolled in Medicaid with long-term care needs who cannot access home- and community-based services may contribute to higher public long-term care costs even when they do not enter a nursing home. A comparison of 2011 personal care costs and use between people enrolled in the legacy waiver programs; Family Care; IRIS; and the Elderly, Blind, and Disabled (EBD) Medicaid FFS; showed that costs and utilization were lower in the managed care environment of Family Care compared to the other programs. This finding is especially important since Family Care members are, on average, known to be less healthy and require greater care needs than the EBD population in Medicaid FFS. The proportion of member months in which a Family Care member received personal care services is lower, 3.8 percent compared to 5.5 percent; and the personal care services' proportion of Medicaid expenditures is lower, 1.1 percent compared to 10.1 percent. On average, Family Care members use 61 hours of personal care, which is less than the EBD FFS at 109 hours, legacy waivers at 111 hours, or IRIS at 131 hours. The average hourly rate for personal care services in the Family Care program is 5 to 6.5 percent lower than in the other programs. It should be noted that one factor that influences personal care utilization in the legacy waiver and IRIS is

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that federal waivers require that FFS Medicaid card services must be used before waiver services. Table 7 provides this data.

| | Family Care | EBD FFS | Waivers | IRIS |
|----------------------------------|-------------|---------|---------|---------|
| Percent of MMs using PC | 3.8% | 5.5% | 35.5% | 45.9% |
| Percent of Medicaid Costs for PC | 1.1% | 10.1% | 16.5% | 23.9% |
| PC Average Hours per Month | 61 | 109 | 111 | 131 |
| PC Average Hourly Expenditure | \$15.01 | \$15.95 | \$15.81 | \$16.05 |

The lower use and cost of personal care in Family Care is evidence of the impact of managed care on the use and cost of long-term care services. Fee-For-Service personal care services are allowed to the extent needed to meet their medical and care needs. This may lead to employing personal care services when other services would better serve these needs. Family Care includes personal care within the program benefit package and members work with the care team to evaluate the array of services available in their community, including personal care and other services, to determine the best services to meet the member's care needs. This may lead to less use of personal care services when other supports are identified that better serve the member.

Family Care managed care organizations also work with providers in a region to negotiate rates and definitions of service. This work enables the managed care organization to fit the level and type of personal care to the members' needs. For members requiring less intensive personal care, the managed care organization may pay the provider a lower rate or authorize fewer hours of service. In this manner, the managed care assures the right level of services to each person.

An additional component of the differences in rates and use of personal care services between Family Care and other long-term care programs may also be the result of managed care organization contracts with residential providers which include personal care within the residential services rate. Managed care organizations have the freedom to structure provider contracts in a manner that best fits the needs of its members in a cost-effective manner. Some personal care services that an individual would receive separately from residential care, and that would be billed separately to Medicaid, are combined under one residential care rate that is less than the sum of the separate rates.

Medicaid expenditures for personal care services for the EBD Fee-For-Service population have risen while what managed care organizations pay for these services has declined. The total expenditures for personal care services in Medicaid FFS rose over one-third between 2010 and 2012, from \$81.7 million in the first half of 2010 to \$110.4 million in the last half of 2012. Medicaid expenditures on personal care services rose for individuals not enrolled in a long-term care program rose by over \$1.7 million, or 27 percent, between August 2011 and May 2012. In contrast, personal care expenditures in Family Care have declined. The average monthly expenditure per Family Care

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member on home care and home health care, which include personal care, have decreased by almost \$60 per month, or 11 percent, between 2010 and 2012. This is shown in Table 8.

| | 2010 | 2011 | 2012 | Change 2010-2012 | Change (as % of 2010) |
|------------|-----------|----------|----------|------------------|-----------------------|
| <i>DD</i> | \$ 451.41 | \$441.41 | \$427.59 | \$ (23.82) | -5% |
| <i>PD</i> | \$ 710.30 | \$689.66 | \$630.86 | \$ (79.44) | -11% |
| <i>FE</i> | \$ 409.18 | \$360.79 | \$326.03 | \$ (83.15) | -20% |
| <i>All</i> | \$ 523.61 | \$496.80 | \$463.67 | \$ (59.95) | -11% |

DD: Developmental Disability
 PD: Physical Disability
 FE: Frail Elderly

IRIS, Self-Directed Alternative

The innovations within the managed long-term care programs also impact the IRIS program, which is the self-directed alternative to managed care available in all regions of the State with Family Care. People enrolled in IRIS program manage their services within an Individual Budget Allocation (IBA). Beginning in July 2010, the Individual Budget Allocation for new IRIS enrollees was aligned with the managed long-term care funding model. As a result, the average service cost for IRIS members has declined significantly. The average Medicaid expenditures for an IRIS enrollee declined by 17 percent between 2010 and 2012 as shown in Table 9.

| | DD | PD | FE | All | Members in December |
|----------------------------|---------|---------|---------|---------|---------------------|
| 2010 | \$5,153 | \$3,677 | \$2,401 | \$4,159 | 2,943 |
| 2011 | \$4,514 | \$3,147 | \$2,346 | \$3,692 | 5,187 |
| 2012 | \$4,166 | \$2,928 | \$2,396 | \$3,433 | 7,512 |
| <i>Change 2010 to 2012</i> | -19% | -20% | 0% | -17% | |

DD: Developmental Disability
 PD: Physical Disability
 FE: Frail Elderly

SECTION E: PROJECTED COSTS FOR PUBLICLY-FUNDED LONG-TERM CARE SYSTEM

The timely access to long-term care services in individuals' homes or community-integrated settings available within the Medicaid managed long-term care programs are fundamental to controlling the cost of long-term care services. This may seem counterintuitive, but receiving less intensive services earlier can reduce the need for more intensive and expensive services in the future. The design of the state's long-term care system can delay a person reaching a nursing home level of care and can extend the use of private resources to purchase long-term care services. State residents who can access preventative and early intervention services or gain assistance with activities of daily living in their own homes are more likely to maintain their health for a longer period, thus postponing the need for more intensive and expensive services.

A long-term care system that provides all residents with information, consultation, and advice about meeting long-term care needs, allows access to long-term care services prior to entering a nursing home, and works with people to match supports and services to their specific needs creates the capacity for the state to manage long-term care costs. The types and amount of services vary between individuals with long-term care needs; the flexibility of the managed long-term care system can match the level and type of service to the person with long-term care needs.

There have been some concerns raised regarding the expansion of managed long-term care programs. These concerns are, in part, based on the immediate access to long-term care services and a related concern that this will increase Medicaid enrollment and service costs. Although all managed long-term care enrollees would meet the Medicaid EBD, many EBD Medicaid members do not meet the nursing home level of care criteria for enrollment in a managed long-term care program. The Department analyzed the impact of Family Care expansion on the population of Medicaid members most likely to enroll in a managed-long term care, specifically, adults qualifying for Medicaid based on functional criteria for EBD Medicaid. These results are discussed below.

MANAGED LONG-TERM CARE IMPACT ON MEDICAID ENROLLMENT

Access to publicly-funded long-term care services, whether provided in a nursing home or a home- and community-based setting, are limited by the financial and functional eligibility criteria for Medicaid and long-term care programs. Most Wisconsin residents who meet these criteria will eventually use publicly-funded long-term care services. Broader access to home- and community-based services does not change this population which relies on Medicaid programs; rather managed long-term care eligibility changes the manner in which Medicaid programs meets the needs of this group of people.

The Department's analysis suggests any impact Family Care may have on Medicaid enrollment does not affect the cost-effective management of the program. The proportion of county residents who are EBD Medicaid eligible members may also change as a result of demographic changes in the county or other factors independent

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of the Family Care program. To account for these independent factors, the Department compared the annual growth in the proportion of county residents who were EBD Medicaid eligible to identify any change in the growth rate that could be attributed to Family Care expansion into the county. The differences in annual growth are shown in Table 10 below.

In the initial years of Family Care expansion, the annual growth rate in the proportion of county residents who were EBD Medicaid members was a fraction of a percent greater than it had been in the year prior to Family Care expansion. However, by the second year of entitlement, the fifth year of expansion, the annual growth rate in EBD Medicaid eligibility had returned to the pre-Family Care level. In the year before Family Care expansion, counties experienced an average increase in the proportion of county residents who were EBD Medicaid members of 0.04 percent over the prior year. The first year of Family Care expansion, counties saw an average increase of 0.06 percent in the growth in the proportion of county residents who were EBD Medicaid members. The growth rate peaked in year two of expansion at 0.16 percent and began to decline in each year until it returned to the pre-Family Care level of 0.04 percent. The reduced rate of growth in the entitlement years attests to the limited impact Family Care has on Medicaid enrollment.

Initial Family Care enrollment, during the first three years in a new area, is limited to the number of individuals in a county’s waiver program or on its waitlist prior to Family Care expansion. In year four, entitlement to home- and community-based services begins and enrollment is no longer capped. If broader access to long-term care services led to a substantive increase in Medicaid enrollment, then the rate of Medicaid enrollment growth should increase. This analysis demonstrates that this does not occur. The Department’s analysis suggests that more individuals may enroll in Medicaid due to Family Care. However, the analysis shows that that any impact on Medicaid enrollment growth diminishes over time and that this impact is too small to endanger the cost-effectiveness of the program.

| Year before Family Care Expansion | Family Care Expansion Year 1 | Expansion Year 2 | Expansion Year 3 | Expansion Year 4, Entitlement Year 1 | Expansion Year 5, Entitlement Year 2 |
|-----------------------------------|------------------------------|------------------|------------------|--------------------------------------|--------------------------------------|
| 0.04% | 0.06% | 0.16% | 0.10% | 0.06% | 0.04% |

The Department also compared the adult EBD Medicaid member growth trends in the 15 counties remaining in the waiver/FFS system to the growth trends in counties currently participating in Family Care to gauge the potential impact of Family Care expansion. This is shown in Table 11 below. The annual rate of growth in the proportion of county population that was an adult EBD Medicaid member was identified for the years between 2008 – the year that significant Family Care expansion began as

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authorized by the 2007-09 biennial budget – and 2012. This analysis showed that 2.51 percent of the total population in the 15 waiver/FFS counties was an adult EBD Medicaid member in 2008. This proportion grew to 2.74 percent by 2012, resulting in a four year average annual growth trend of 0.06 percent. In Family Care counties, the proportion of the population that was an adult EBD Medicaid member was 2.90 percent in 2008 and increased to 3.40 percent by CY2012 resulting in a four year average annual growth trend of 0.13 percent. The differences in the average annual growth trend suggest that Family Care has some impact on Medicaid enrollment. However, the magnitude of this impact is very small: the average annual increase in the adult EBD Medicaid enrollment in the Family Care counties was 0.07 percent higher than that in waiver/FFS counties. Some of this difference in the proportion of may result from factors independent of Family Care participation, such as variation in the proportion of residents over the age of 65, with a disability, or with limited income. Even if all of this difference could be attributed to the expansion of Family Care, this is less than one percent and does not endanger the cost-effectiveness of the long-term care system.

| Table 11: Growth in Elderly, Blind, Disabled Adult Medicaid Population | | | | | | |
|---|-------------|----------------|----------------|----------------|----------------|----------------------|
| <i>EBD % of total population*</i> | | | | | | |
| | 2008 | 2009 | 2010 | 2011 | 2012 | |
| 15 Waiver/FFS Counties | 2.51% | 2.57% | 2.67% | 2.74% | 2.74% | |
| Family Care Counties | 2.90% | 3.23% | 3.24% | 3.34% | 3.40% | |
| <i>Year-to-Year Change</i> | | | | | | |
| | | '08-'09 | '09-'10 | '10-'11 | '11-'12 | 4-Yr. Average |
| 15 Waiver/FFS Counties | | 0.06% | 0.10% | 0.07% | 0.00% | 0.06% |
| Family Care Counties | | 0.33% | 0.01% | 0.11% | 0.06% | 0.13% |

* Dec. 1 of year

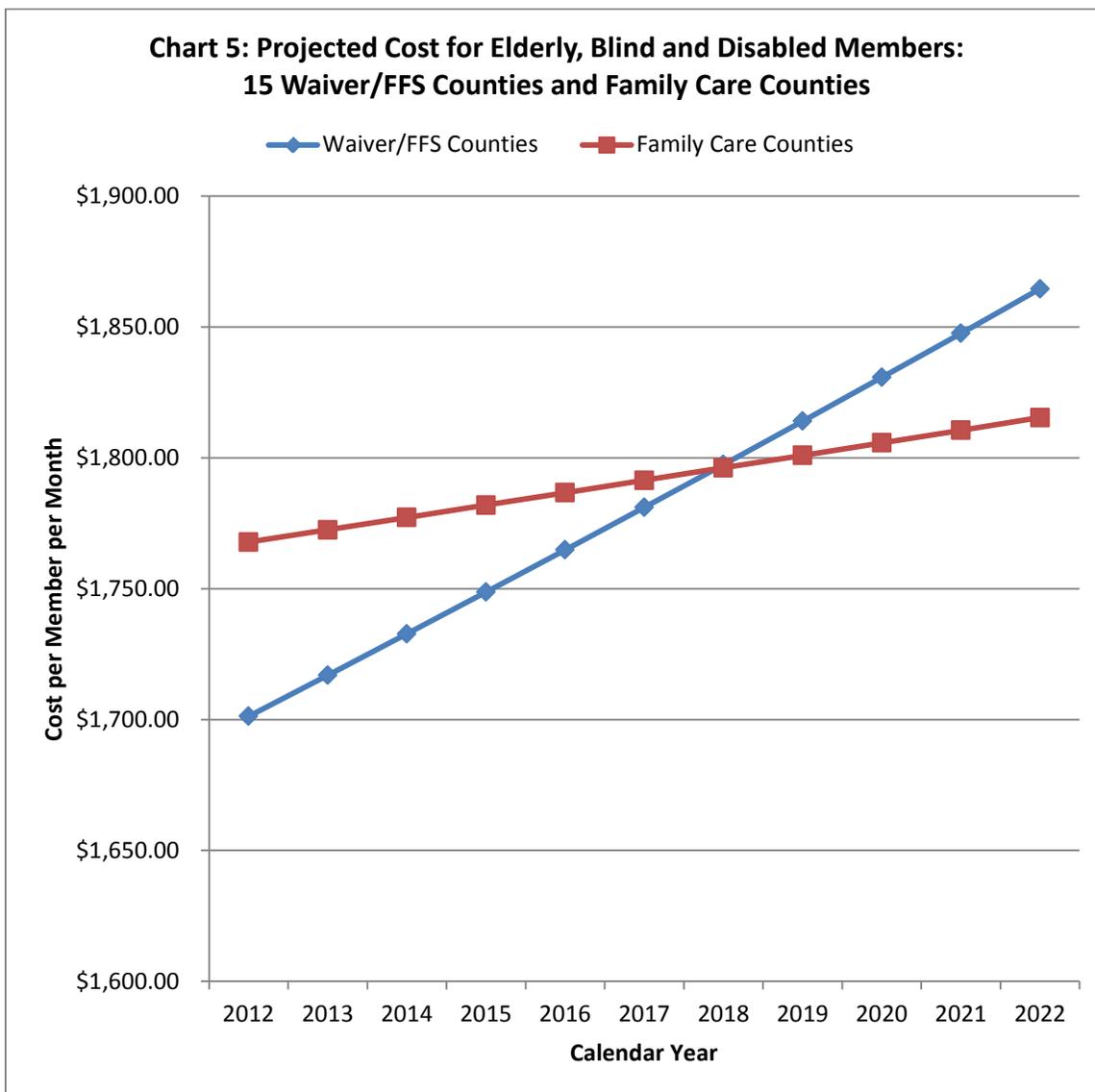
MANAGED LONG-TERM CARE IMPACT ON MEDICAID COSTS ANALYSIS

Although Family Care increases the number of Medicaid members receiving long-term care services and may lead to a slight rise in the number of adults enrolled in EBD Medicaid, the expansion of Family Care into the remaining 15 counties will reduce long-term care costs. The broadened access to home- and community-based long-term care services and the capabilities of managed long-term care establish to a long-term care system that has the tools necessary to control costs.

A projection of average per member per month Medicaid costs for adult EBD Medicaid members shows the impact of Family Care on reducing long-term care costs. The Department compared the projected average per member per month Medicaid costs for adult EBD Medicaid members in the 15 remaining counties and in Family Care counties through 2022. The projection used the 2012 average monthly Medicaid expenditures for adult EBD Medicaid members in 2012 for the 15 remaining counties and for Family Care counties. Projected growth in costs were based on the average annual increase in Medicaid costs over the prior year for 2008 through 2012 for adult EBD Medicaid members in the 15 counties and in counties operating the Family Care program.

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This projection, shown in Chart 5, illustrates that initially the Family Care counties' average monthly Medicaid expenditure for adult EBD Medicaid members was higher than the 15 waiver/FFS counties in 2012 (\$1,768 versus \$1,701), however, Family Care counties experienced a slower growth in costs for this population. The average annual growth trend from 2008-2012 for counties operating Family Care was 0.3 percent per year compared to a 0.9 percent per year cost growth for the 15 waiver/FFS counties. The cost difference between the two groups of counties decreases each year until 2018, when the per member per month cost in Family Care counties becomes lower than the waiver/FFS counties. By 2022, the Family Care counties costs are \$49.24 per member per month lower than the 15 remaining waiver/FFS counties. After an initial investment to expand Family Care into a county, the cost trends in managed long-term care are sufficiently lower relative to the waiver/FFS system that, over time, the managed long-term care system becomes the less costly system to operate.



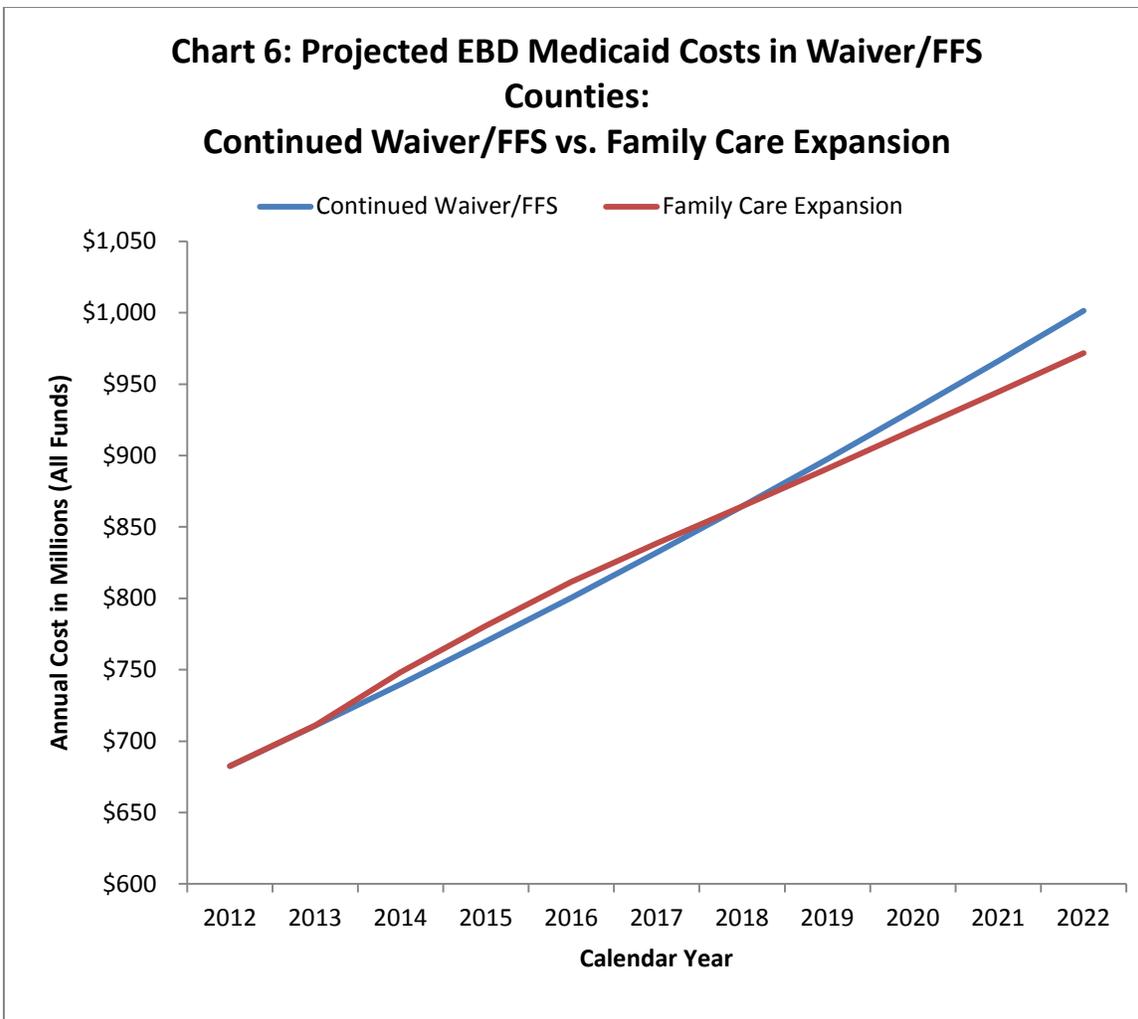
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PROJECTED IMPACT OF FAMILY CARE EXPANSION

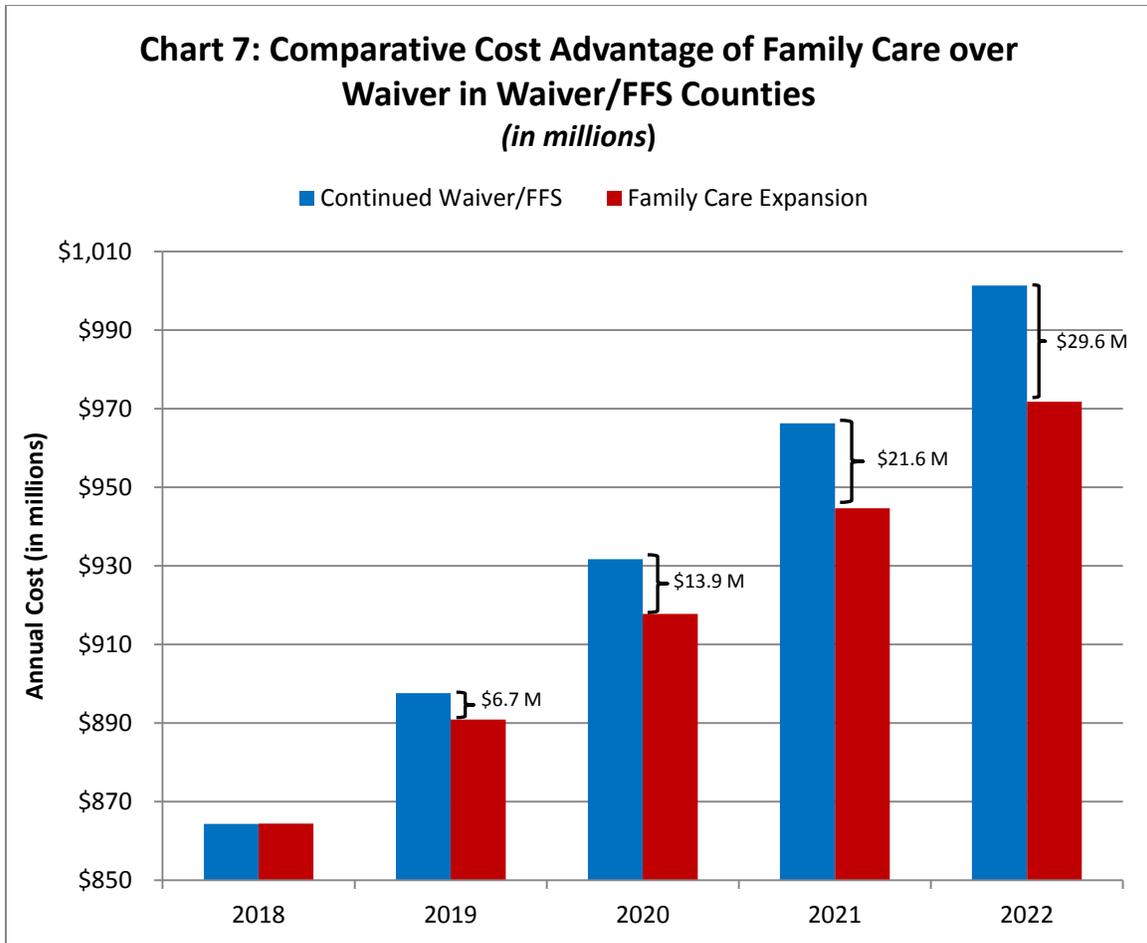
The Department’s projected impact of Family Care expansion to the 15 remaining waiver/FFS counties is a reduction of publicly-funded long-term care costs by \$34.7 million, all funds (AF) over the first 10 years of implementation. The savings from managed care compared to the waiver/FFS system will increase in future years as managed long-term care controls the growth of long-term care costs. A managed long-term care system generates cost savings over the current waiver system by reducing the per member per month cost, even though the cost for long term-care services will continue to increase due to inflation and increasing demands. Cost savings are generated by ensuring that services are delivered in right amount, at the right time, and in the right setting. A long-term care managed care system facilitates these goals by aligning reimbursement incentives and integrating accountability.

The initial phase of expansion may increase Medicaid expenditures for elderly, blind, and disabled adults. However, within seven years, the managed care system will have slowed cost growth to the extent that expenditures under Family Care will be less than they would be under the current waiver/FFS system. Table 12 and Chart 6, below, show the projected expenditures for 2013 to 2022 for Medicaid elderly, blind, and disabled adults in the 15 remaining counties under the current waiver/FFS system and under a scenario where Family Care has expanded to all 15 counties as of 2013. Although Family Care has not begun operations in any of these counties in 2013, the Department has used this method because it allows the most comprehensive comparison of the 10-year impact of Family Care expansion on these counties.

| Table 12: Projected EBD Medicaid Costs in Waiver/FFS Counties: Continued Waiver/FFS vs. Family Care Expansion <i>(figures in Millions)</i> | | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|----------------------------|
| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| Continued Waiver/FFS | \$682.5 | \$710.8 | \$739.9 | \$769.8 | \$800.5 | \$832.0 |
| Family Care Expansion | \$682.5 | \$711.1 | \$748.2 | \$780.7 | \$811.5 | \$838.5 |
| Family Care Cost/(Savings) | \$0.0 | \$0.3 | \$8.3 | \$11.0 | \$11.0 | \$6.4 |
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2013-2022 Total |
| Continued Waiver/FFS | \$864.4 | \$897.6 | \$931.7 | \$966.3 | \$1,001.4 | \$8,514.3 |
| Family Care Expansion | \$864.4 | \$890.9 | \$917.8 | \$944.7 | \$971.8 | \$8,479.6 |
| Family Care Cost/(Savings) | \$0.1 | (\$6.7) | (\$13.9) | (\$21.6) | (\$29.6) | (\$34.7) |



The cost advantages of Family Care compared to the waiver/Fee-For-Service system continue to grow in the future. Chart 7, below, shows the projected avoided costs associated with Family Care expansion into the 15 remaining waiver/Fee-For-Service counties for expansion years six through ten (2018 through 2022). The additional annual savings compared to the waiver/FFS system grow in each year. Whereas the annual avoided costs in year seven (2019) are \$6.7 million, they increase to \$29.6 million in year ten (2022). The difference will expand due to the lower per member per month expenditures under managed care.



The Department’s projection begins with the average 2012 monthly per member per month Medicaid expenditures for elderly, blind, and disabled members in the 15 remaining waiver/FFS counties, and applies trends for the impacts of Family Care on both Medicaid enrollment and average monthly EBD Medicaid costs in these counties.

Starting Per Member Per Month Costs

The starting per member per month amount for adults who are EBD Medicaid members, \$1,701 was chosen as it is the most recent actual expenditure data available for the population of people potentially impacted by Family Care expansion in the 15 remaining counties. This figure may over-estimate the expenditures associated with individuals enrolling in Family Care. An actuarial analysis of the 15 counties found that Family Care would reduce Medicaid long-term care program expenditures in those counties by 21.5 percent. The actuarial analysis compared the expected Medicaid long-term care expenditures under the legacy waiver programs and under managed long-term care for individuals in those counties’ waiver programs or on their waitlists. Appendix E includes further details of this actuarial analysis. The Department did not use the more substantial actuarial projection of cost savings as experience with Family Care expansion has shown that reductions in long-term care costs are not realized immediately. The

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Department assumed that it will take time for managed care organizations to work with members to develop a care plan consistent with the Family Care model. For that reason, the Department's projection assumes that initially the Family Care managed care organizations will inherit the long-term care costs experienced under the waiver program and uses this figure as its starting point.

Enrollment Trend

The Department assumed an annual growth trend in the adult EBD Medicaid Population for the 15 counties based on the four year average annual growth experiences between 2008 and 2012 (0.06% annually). The projection for Family Care expansion adds to this trend based on the assumption that the expansion of Family Care will increase Medicaid enrollment during the first four years of expansion and that by year five of expansion Medicaid enrollment growth will return to pre-expansion trends. The projection assumes that 1,600 people will enroll in Medicaid over the first four years of expansion (2013-2016) who would not have enrolled under the waiver/FFS system. This figure is based on the number of individuals on the 15 counties' waitlists as of October 2013. In reality, some individuals currently on county waitlists are already receiving Medicaid services through Medicaid FFS. The Department believes that the waitlist figure provides the best representation of the portion of waitlist individuals not receiving Medicaid and the number of individuals unknown to the Department who will enroll in Medicaid during the initial years of Family Care expansion. The experience of the Family Care program indicates that the impact of Family Care on Medicaid enrollment subsides once the program is fully implemented in a county.

Medicaid Cost Trend

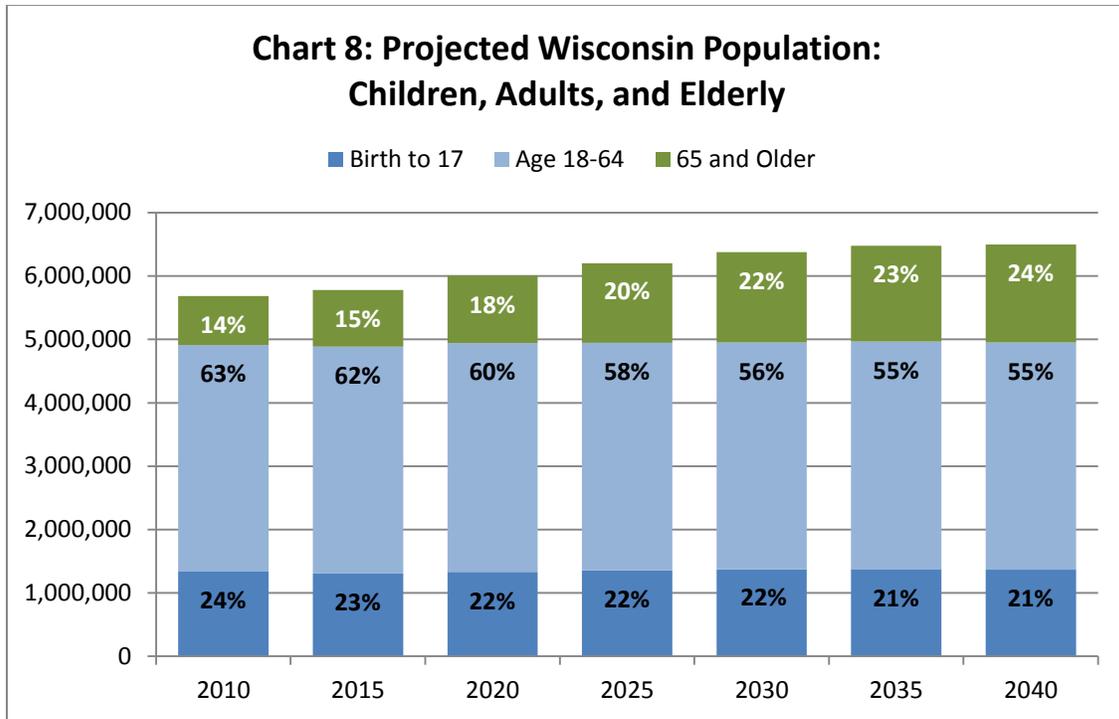
The increased number of people able to access home- and community-based long-term care services is offset by the Family Care program's ability to slow the growth in costs compared to the legacy waiver and Fee-For-Service programs. The Department used the average annual growth trend from 2008-2012 for Family Care (0.3 percent) and the 15 waiver/FFS counties (0.9 percent) to model the managed long-term care impact on cost growth. The experience of Family Care expansion into new counties suggests that the full implementation of the managed care model does not occur immediately. The Department's projection delays the full impact of Family Care on annual Medicaid cost growth until the third year of expansion (2015) or year. In expansion years one (2013) and two (2014), Medicaid costs are assumed to grow at 0.7 percent and 0.5 percent, respectively, accounting for the phase-in of managed care impacts on costs. Based on these trends, the Department finds that the slowing of long-term care cost growth generates sufficient savings over the waiver/FFS system to offset the additional costs incurred by serving more Wisconsin elders and people with disabilities by year seven (2019) of expansion. After that point, the savings associated with Family Care grow annually. Table 13 shows the projected per member per month costs in the 15 remaining counties under the current waiver/FFS system and under a scenario where Family Care has expanded to all 15 counties as of 2013.

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| Table 13: Projected EBD Medicaid Per Member Per Month Costs in Waiver/FFS Counties: Continued Waiver/FFS vs. Family Care Expansion | | | | | | |
|--|------------|------------|------------|------------|------------|------------|
| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| Continued Waiver/FFS | \$1,701.27 | \$1,716.94 | \$1,732.75 | \$1,748.71 | \$1,764.82 | \$1,781.07 |
| Family Care Expansion | \$1,701.27 | \$1,713.18 | \$1,721.75 | \$1,714.88 | \$1,719.44 | \$1,724.01 |
| Difference | \$0.00 | (\$3.76) | (\$11.01) | (\$33.83) | (\$45.38) | (\$57.06) |
| | 2018 | 2019 | 2020 | 2021 | 2022 | |
| 15 Waiver/FFS Counties | \$1,797.48 | \$1,814.03 | \$1,830.74 | \$1,847.60 | \$1,864.62 | |
| Family Care Counties | \$1,728.60 | \$1,733.19 | \$1,737.80 | \$1,742.42 | \$1,747.06 | |
| Difference | (\$68.88) | (\$80.84) | (\$92.94) | (\$105.18) | (\$117.56) | |

CHALLENGES OF AN AGING POPULATION

Wisconsin is on the cusp of a demographic change as a growing proportion of the state’s population becomes elderly. Chart 8 shows that in 2010, 14 percent of Wisconsin residents were age 65 or older; in 2040, this proportion is projected to be 24 percent.¹⁷ A rise in the average age of Wisconsin residents will increase the number of people who will require long-term care assistance. The Department of Health Services’ current initiatives, and the further expansion of the managed long-term care system, provide the foundation to ensure that frail elders and people with disabilities have access to needed care while managing costs and maintaining quality even with this increased demand.



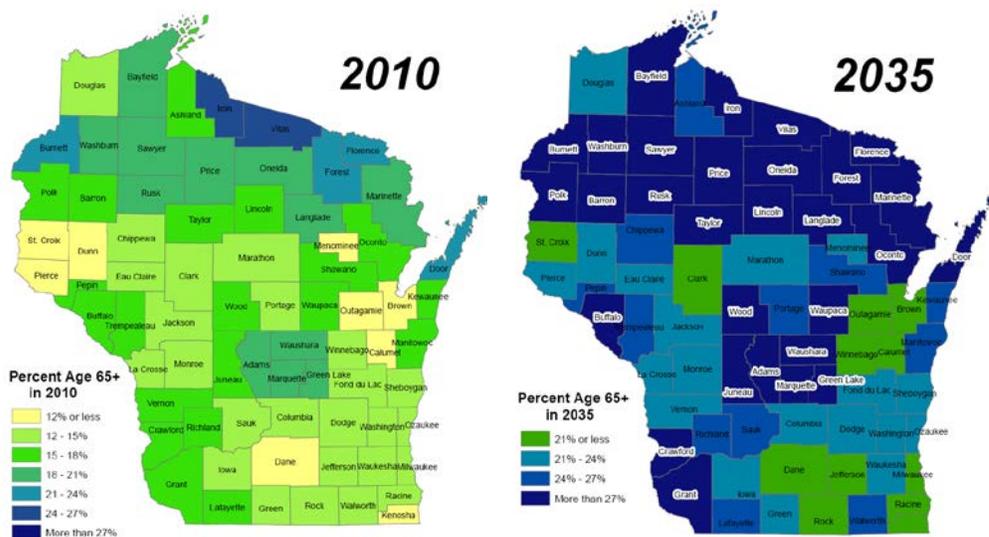
¹⁷ Population projections from Wisconsin Department of Administration.
<http://www.doa.state.wi.us/subcategory.asp?linksubcatid=105&linkcatid=11&linkid=64&locid=9>

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The legacy waiver programs are not set up to effectively manage this increased demand and the related cost impact. The aging population in many counties may reduce the funding available to legacy waiver programs as the demand for their services rises. As the proportion of county residents who retire and leave the work force increases, the county tax base will shrink. This may result in funding for these programs shrinking unless counties are able to move resources from other priorities, or the State can provide additional funding. This makes it likely that more county residents will need to wait for access to long-term care service in their own homes or a community-integrated setting as access to home- and community-based long term care services is limited by the available funding in legacy waiver counties. People’s health often deteriorates while waiting for services. This results in a need for more intensive services upon entry into publicly-funded long-term care programs, or results in an admission into a nursing home, that could have been avoided or delayed by access to preventative and early intervention services. Limiting access to home- and community-based services in the near-term risks increasing care costs in the long-term.

The impact of Wisconsin’s aging population will be significant in northeast Wisconsin, which includes the majority of the remaining waiver/FFS counties. As shown in Chart 9, the Department’s analysis indicates that in many of these northeast counties, over 27 percent of the population will be age 65 or greater in 2035.

Chart 9: Percent of the Population Age 65 and Older¹⁸



¹⁸ Source: WI DOA Demographic Services, Population Projections Vintage 2008
Prepared by Cindy Ofstead, DHS Bureau of Aging and Disability Resource

CONCLUSION

Family Care is the foundation of a manageable long-term care system that can control the cost of publicly-funded long-term care and ensure that elderly residents and people with severe disabilities receive the care they need.

The State of Wisconsin has built a reformed long-term care system that begins at the Aging and Disability Resource Centers (ADRC). Wisconsin residents seeking long-term care support can access the ADRC for information and assistance to better manage their health needs and connect with community resources. This ensures wise use of personal resources and can delay, or prevent, the need for publicly-funded long-term care programs. Over the last three decades, the Department of Health Services has worked to transform the long-term care system from one dominated by institutional care in nursing homes to one where people with long-term care needs receive less intensive and less expensive services in their homes and community-integrated settings. The Family Care program's service model combines with the Department's efforts to relocate individuals from nursing homes and to address the needs of individuals before they enter a nursing home to promote residents' ability to remain in their own homes and receive cost-effective long-term care supports.

The Department has implemented a number of initiatives that, along with the expansion of managed long-term care, will control the growth in Medicaid costs and maintain a cost-effective long-term care system. The Department has focused on areas such as medication compliance, dementia care, mental health and challenging behaviors, and chronic disease self-management that can reduce the need for high cost services and admissions into hospitals, emergency rooms, and nursing homes. The Family Care program incorporates these efforts along with the capability of managing costs. The managed care model encourages managed care organizations to develop diversified and flexible provider networks that can fit the level of service to a member's level of care need. The funding model promotes managed care organizations to purchase the right care at the right price by making managed care organizations responsible for the full spectrum of long-term care services, from less expensive preventative care to more intensive nursing home services. The Department's capitated rate-setting model is then based on the cost-experience of members with similar health and care needs.

The Family Care program has shown that it can control the cost of publicly-funded long-term care. In the absence of home- and community-based services, elderly residents and people with severe disabilities requiring long-term care support must enter a nursing home or rely on acute and primary care services such as physician, hospital, and personal care services to meet their needs. Care in the community is less expensive than care in a nursing home and enables people to access preventative and early intervention services that delay the need for more intensive and expensive care. The Family Care program's managed care model provides quality care for less cost than the Fee-For-Service system and legacy waiver programs. Family Care members also have lower Medicaid expenditures than members of legacy waiver programs. Further, the average

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Medicaid costs for Family Care members have been declining annually. The impact of Family Care's service and funding models reach beyond the services that managed care organizations manage directly: the average cost of physician, hospital, personal care, and other acute and primary care services for Family Care members have also declined over the last three years.

The statewide expansion of Family Care is the culmination of a transformation of Wisconsin's long-term care system that began in the 1980s. Three decades ago, elderly individuals and people with severe disabilities who lacked the financial resources to purchase the supports and services to meet their long-term care needs had to enter a nursing home, or rely on acute and primary care services such as physician, hospital, and personal care to manage their health. Wisconsin took the lead as one of the first states to provide access to long-term care in peoples' homes and community-integrated settings when it developed the county-administered Medicaid home- and community-based services waivers for long term care. However, waiting lists for the county-administered waivers has limited the capacity and the availability of care outside of an institutional setting. Wisconsin's piloting of managed care models for long-term care, starting in the late 1990s, demonstrated that access to home- and community-based services can be assured by the use of the tools to better control the cost of publicly-funded long-term care. These efforts keep the promise of timely, community-based care.

The State embarked on a significant expansion of the Family Care managed care program throughout the state in 2008. However, this expansion was put on hold in 2011 as critical questions about the long-term fiscal impact of this new model of care needed to be addressed. This has resulted in the Department of Health Services operating parallel long-term care systems with differing administrative structures and unequal access to long-term care services. The success of continued system reform efforts and programmatic efficiencies, as well as the analysis of the benefits of managed long-term care, as presented in this report, establish that it is time to finish the statewide expansion of managed long-term care. This will ensure that Wisconsin residents who qualify for publicly-funded long-term care services will have equal access to care regardless of setting. People can remain in their own homes, move into a community-integrated residential setting, or be admitted into a nursing home based upon their care needs. People's ability to receive long-term care outside of an institution setting should not be dependent on where they live in Wisconsin.

The experience of Family Care shows that this managed-care program controls the growth of long-term care costs better than the legacy waiver programs. Expansion of managed care into the remaining 15 counties in Wisconsin will strengthen Wisconsin's long-term care system. Broader access to less intensive and less expensive services, as well as the Family Care service and funding models will make publicly-funded long-term care in Wisconsin manageable despite a growing population of people in need.

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APPENDIX A: BENEFIT PACKAGES: MEDICARE AND MEDICAID

| Family Care Partnership & PACE (Program of All Inclusive Care for the Elderly) | | | |
|---|---|---|--|
| Family Care | | | |
| IRIS | | | |
| Home and Community Based Waiver Services | Medicaid Card Services - LTC Services | Acute/Primary Medicaid Services | Medicare Services |
| <ul style="list-style-type: none"> • Adaptive Aids (general and vehicle) • Adult Day Care • Care/Case Management (Family Care only) • Communication Aids/Interpreter Services • Consumer Education and Training • Counseling and Therapeutic Resources • Customized Goods and Services (IRIS only) • Daily Living Skills Training • Day Services/Treatment • Financial Management Services (Family Care only) • Fiscal Employer Payroll Services (IRIS only) • Home Modifications • Housing Counseling • Self-Directed Personal Care (IRIS only) • Meals: home delivered • Personal Emergency Response System Services • Prevocational Services • Relocation Services • Residential Services: <ul style="list-style-type: none"> – Adult Family Home – Community-Based Residential Facility (CBRF) – Certified Residential Care Apartment Complex (RCAC) • Respite Care • Skilled Nursing (amounts above what's available with Medicaid card) • Specialized Medical Equipment and Supplies • Specialized Transportation • Support Broker • Supported Employment • Supportive Home Care • Vocational Futures Planning | <ul style="list-style-type: none"> • Alcohol and Other Drug Abuse Day Treatment Services (in all settings except hospital-based) • Community Support Program • Durable Medical Equipment, except for hearing aids and prosthetics • 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 Individuals with Intellectual Disabilities (ICF/IID) and Institution for Mental Disease. IMD not covered between ages 21-64) • Nursing Services (including respiratory care, intermittent and private duty nursing) • Occupational Therapy (in all settings except for inpatient hospital) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Speech and Language Pathology Services (in all settings except for inpatient hospital) • Transportation to receive non-emergency medical care (except Ambulance) | <ul style="list-style-type: none"> • 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 • Prescribed drugs (very limited if Medicare eligible. Medicare Part D would cover most outpatient drugs) • Diagnostic, screening, preventive and rehabilitation services • Clinic services • Primary care case management services • Dental services, dentures • Dialysis service • Hospice care • Prosthetic devices, eyeglasses • TB-related services • Other specific medical and remedial care • Inpatient mental health • Chiropractic services • Podiatry services • Outpatient mental health provided by a physician • Outpatient substance abuse provided by a physician • Outpatient surgery • Ambulance services • Emergency care • Urgent care • Diagnostic services • Hearing services • Vision services | <p>Medicare Part A (Hospital), Part B (Medical), and Part D (Prescription Drugs)</p> <ul style="list-style-type: none"> • Ambulance services • Ambulatory surgical centers • Blood • Durable Medical Equipment, Prosthetics, Orthotics and Supplies • Cardiac rehab • Chiropractic services - extremely limited (Only service covered is manipulation of the spine to correct a minor dislocation, called "subluxation") • Diabetes supplies • Diagnostic tests, x-rays and lab services • Physician services • Emergency and urgent care services • Home health care if homebound and need skilled nursing or therapy services • Hospice care • Inpatient hospital care • Inpatient mental health care • Outpatient mental health care • Outpatient hospital services, including outpatient surgery • Limited post-hospital skilled nursing facility if daily skilled nursing and/or rehabilitation services needed • Physical/speech/occupational therapy • Podiatry services, limited to treatment of injuries or diseases of the foot, no routine care • Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D • Very limited dental, hearing and vision services, excluding all dental services except where necessary to the provision of other, covered medical services, also excluding routine eye care and hearing exams and hearing aids. Eyeglasses and contacts limited to one pair after cataract surgery, • Substance abuse treatment (outpatient) • Various preventive services, screenings, vaccinations, and yearly wellness visit. |
| <p>IRIS participants access Medicaid LTC card services and acute/primary services with their Medicaid card. Family Care members access acute/primary services with their Medicaid card. Individuals enrolled in IRIS or Family Care may also be eligible for Medicare.</p> | | | |

APPENDIX B: ELIGIBILITY CRITERIA FOR MEDICAID LONG-TERM CARE PROGRAMS

Functional Eligibility

Information collected through the Long-Term Functional Screen (LTCFS) is used to determine an individual's functional eligibility for a Medicaid program that provides Home- and Community-Based Waiver (HCBW) services. The instructions for the screen explain functional eligibility criteria in the following manner¹⁹:

For people age 18 or older, the LTC FS determines functional eligibility for HCBW programs. Wisconsin has five waiver programs for persons who are a frail elder, have a physical disability, or have an intellectual/developmental disability. These waivers are COP-W, CIP II, IRIS, Family Care and PACE/Partnership programs.

Once an applicant's LTC FS is complete, the eligibility logic built into the application is able to determine that person's Nursing Home Level of Care (NH LOC), Developmental Disability Level of Care (DD LOC), and Family Care Level of eligibility (Family Care Nursing Home LOC and Family Care Non-Nursing Home LOC) as well as eligibility for the other waiver programs. NH Level of Care or DD Level of Care is absolutely necessary to be eligible for COP-W, CIP II, IRIS, PACE/Partnership because those programs can only serve NH eligible people.

Wisconsin has the following four **nursing home levels of care**:

1. Intermediate Care Facility, Level 2 (ICF-2)- people with the lowest needs;
2. ICF Level 1(ICF-1)- people with moderate needs;
3. Skilled Nursing Facility (SNF)- people with high needs; and
4. Intensive Skilled Nursing (ISN)-people with highest needs.

Wisconsin has five waiver programs for people with developmental disabilities. They are CIP 1A, CIP 1B, IRIS, Family Care and PACE/Partnership.

Wisconsin has four institutional **levels of care for people with developmental disabilities**:

1. DD1A- person with DD with significant medical problems;
2. DD1B- person with DD with significant behavioral problems;
3. DD2- person with DD who does not meet DD1A or DD1B and who need help with all or most activities of daily living (ADLs) and instrumental activities of daily living (IADLs); and
4. DD3- person with DD who is more independent with most ADLs and IADLs.

For Family Care there are two levels of eligibility:

1. Family Care Nursing Home Level of Care; and
2. Family Care Non-Nursing Home Level of Care.

¹⁹ This information is available at <http://www.dhs.wisconsin.gov/LTCare/FunctionalScreen/instructions.htm>

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Level of Care in Medicaid Home and Community-Based Services Waiver Programs:

In general, Wisconsin's federally approved Medicaid home and community-based services long-term care programs require that the applicant achieve a qualifying nursing home (NH) or developmental disability (DD) level of care on the Long Term Care Functional Screen as described above. People who do not meet a qualifying level of care on the Functional Screen may still be eligible for COP Level 3 or for a more limited Family Care benefit.

In addition to meeting level of care, the applicant must meet related non-financial eligibility criteria. The applicant must meet residency requirements and his/her physical or medical condition must be expected to last more than one year or result in death within one year and, for applicants who are less than 65 years of age, a disability determination is required.

It is important to remember that level of care and non-financial program criteria do interact as eligibility is determined. For example, applicants who have shorter-term needs (90 days or longer) may still receive a nursing home level of care. However, they will not be eligible for the CIP 1A/1B, CIP II, COP-Waiver, PACE, Partnership and the Family Care home and community-based waiver programs because they have not met the requirement that the physical/medical condition last one year or longer. These applicants may be eligible for reduced benefits under the Family Care program.

The remainder of this section describes NH and DD LOC and how these interact with Family Care eligibility.

NH or DD Level of Care and Family Care:

NH or DD level of care is very important in Family Care as well.

To qualify for NH or DD level of care, a person must have a long-term care condition likely to last more than one year.

Screeners must understand the ways in which NH and DD levels of care interact with the two levels of Family Care eligibility. The two levels of Family Care eligibility are "Family Care Nursing Home LOC" and "Family Care Non-Nursing Home LOC." (A third level would be "Not Eligible for Family Care").

Family Care Nursing Home LOC: Family Care Nursing Home LOC level includes all NH eligible people. If someone receives a NH or DD level of care, they are eligible at the Family Care Nursing Home LOC.

Family Care Non-Nursing Home LOC: People at the Family Care Non-Nursing Home LOC level usually need help with only one or a few particular ADLs or IADLs and do not have a nursing home LOC or DD LOC. Only those people at the Family Care Non-Nursing Home LOC who have a Medicaid card are entitled to the program.

People at the Non-Nursing Home LOC not eligible for Family Care should be helped by the Resource Center with options counseling.

Screeners should always confirm that the NH or DD level of care seems appropriate for the person. If it seems someone should be nursing home eligible, then the LTC FS should assign them a NH level of care. Be sure you confirm all health-related services with a

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nurse or other health professional familiar with the consumer. Consult with your Screen Liaison, who can contact the Department if necessary.

A nursing home level of care requires that the individuals need assistance with minimum number activities of daily living (ADLs) and be at imminent risk of institutionalization or have a sufficient acuity level based on the individual's health care needs as identified in the Health Related Services portion of the LTCFS.

Financial Eligibility

Enrollees in Medicaid long-term care programs will qualify for Medicaid under financial eligibility criteria for elderly, blind, and disabled (EBD). The 2013 financial criteria for this eligibility group are the following²⁰:

39.4.1 EBD Assets and Income Table Effective January 1, 2013

| Group Size | | | | |
|-----------------------------------|--------|--|--------|---|
| Category | | 1 | | 2 |
| EBD Categorically Needy Limits | Assets | \$2,000 | Assets | \$3,000 |
| | Income | \$557.11 (+ actual shelter up to \$236.67) | Income | \$842.72 (+ actual shelter up to \$355.33) |
| EBD Medically Needy Limits | Assets | \$2,000 | Assets | \$3,000 |
| | Income | \$591.67 | Income | \$591.67 |
| SSI Payment Level | | | | |

²⁰ This information is available at <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>

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| | | | | |
|--|--------|------------|--------|------------|
| Federal SSI Payment Level | Income | \$710.00 | Income | \$1,066.00 |
| State Supplementary Payment (SSP) | Income | \$ 83.78 | Income | \$132.05 |
| Total | Income | \$793.78 | Income | \$1,198.05 |
| SSI Payment Level + E Supplement | Income | \$889.77 | | |
| SSI E Supplement | Income | \$95.99 | | |
| Community Waivers Special Income Limit | Income | \$2,130.00 | Income | |
| Institutions Categorically Needy Income Limit | Income | \$2,130.00 | | |
| Substantial Gainful Activity limit (non-blind individuals) | Income | \$1,040 | | |
| Substantial Gainful Activity limit (blind individuals) | Income | \$1740 | | |

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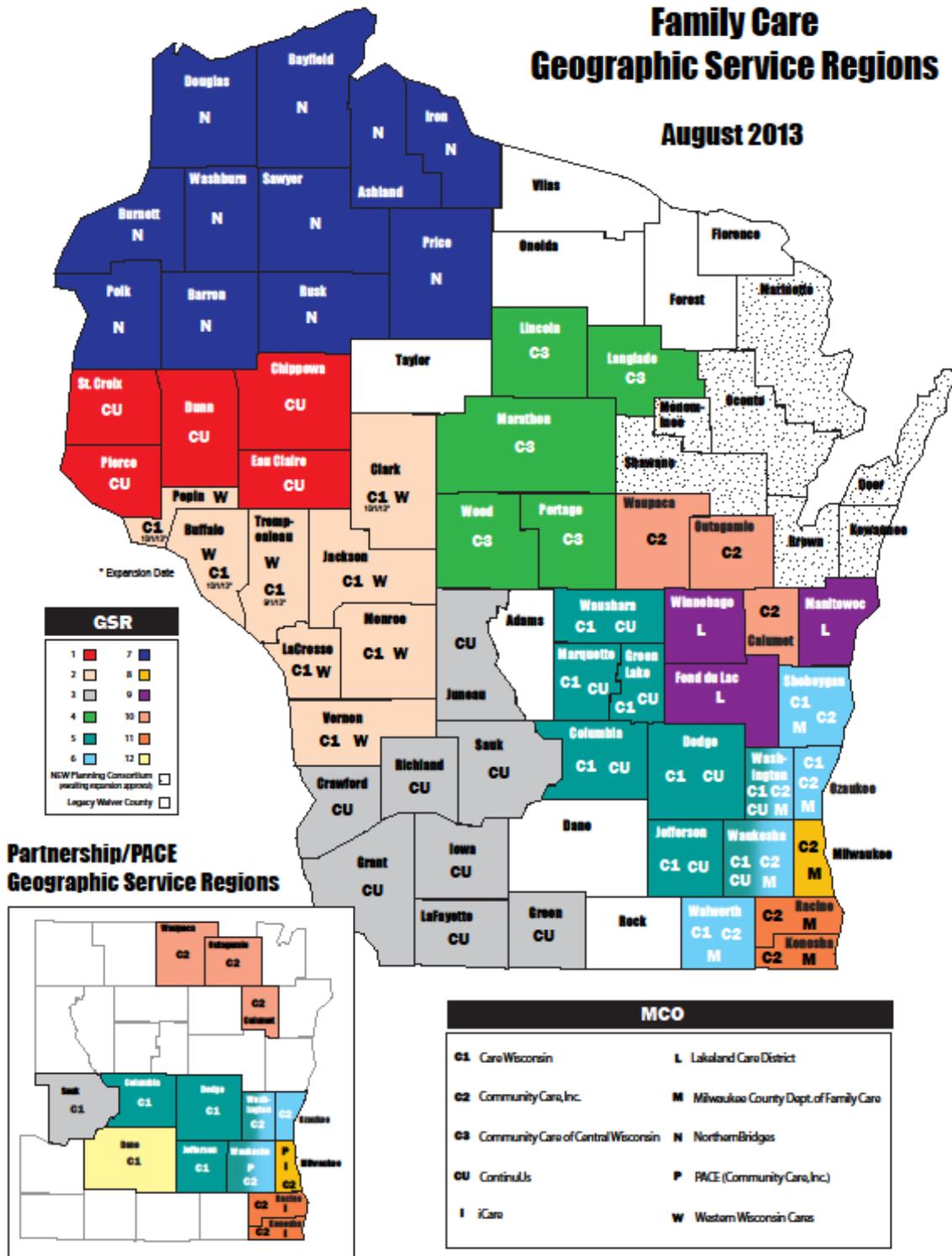
39.4.2 EBD Deductions and Allowances

Rows 1- 6 effective January 1, 2013

Rows 7 - 9 effective July 1, 2013

| | Description | Amount |
|---|---|------------------------|
| 1 | Personal Needs Allowance (effective 7/1/01) | \$45.00 |
| 2 | EBD Maximum Personal Maintenance Allowance | \$2,130.00 |
| 3 | EBD Deeming Amount to an Ineligible Minor | \$356.00 |
| 4 | Community Waivers Basic Needs Allowance | \$890.00 |
| 5 | Parental Living Allowance for Disabled Minors | \$710.00 \$1,066.00 |
| | 1 Parent 2 Parent | |
| 6 | MAPP Standard Living Allowance (SLA) SLA = SSI + State Supplement + \$20 | \$813.00 |
| 7 | Community Spouse Lower Income Allocation Limit | \$2,585.00 |
| 8 | Community Spouse Excess Shelter Cost Limit | \$775.50 |
| 9 | Family Member Income Allowance | \$646.42 |

APPENDIX C: MANAGED LONG-TERM CARE PROGRAMS IN WISCONSIN



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APPENDIX D: AVERAGE MEDICAID EXPENDITURES: FAMILY CARE AND IRIS

| Average Monthly Service Expenditures (Program and Fee-For-Service) for Long-Term Care Population, Per Member, by Calendar Year | | | |
|---|-------------|-------------|-------------|
| | <i>2010</i> | <i>2011</i> | <i>2012</i> |
| <i>Member Months</i> | | | |
| Family Care | 335,853 | 381,223 | 399,110 |
| IRIS | 23,829 | 50,253 | 75,242 |
| <i>Average Expenditure</i> | | | |
| Family Care | \$3,188 | \$3,183 | \$3,128 |
| IRIS | \$4,159 | \$3,692 | \$3,433 |

| Table 3: 2012 Average Monthly Service Costs (Program and FFS) - Risk-adjusted to be a Comparable Population Across Program Type | | | |
|--|---------------|---------------|--------------|
| | DD | PD | FE |
| Waiver Programs | \$4,878 | \$3,379 | \$2,465 |
| <i>Dec 2012 Members</i> | <i>3,334</i> | <i>1,302</i> | <i>1,515</i> |
| Family Care Program | \$3,690 | \$2,873 | \$2,502 |
| Difference from Waiver | \$(1,188) | \$(506) | \$37 |
| Difference as % of Waiver | -24% | -15% | 2% |
| <i>Dec 2012 Members</i> | <i>14,658</i> | <i>10,806</i> | <i>9,100</i> |
| IRIS Program | \$3,951 | \$2,891 | \$2,521 |
| Difference from Waiver | \$(928) | \$(488) | \$56 |
| Difference as % of Waiver | -19% | -14% | 2% |
| <i>Dec 2012 Members</i> | <i>3,359</i> | <i>3,110</i> | <i>1,043</i> |

DD: Developmental Disability
 PD: Physical Disability
 FE: Frail Elderly

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APPENDIX E: ACTUARIAL ANALYSIS OF 15 REMAINING WAIVER/FEE-FOR-SERVICE COUNTIES

Comparison of Imputed Managed Care and FFSE Rates

with \$150 PMPM admin

| Non-Family Care Counties Rate Comparison | | | | |
|---|----------|----------|-------|------------|
| | MC | FFS | Lives | Difference |
| Adams | 3,177.48 | 3,098.39 | 117 | -2.5% |
| Florence | 2,000.22 | 1,492.41 | 34 | -25.4% |
| Forest | 2,855.24 | 2,825.45 | 73 | -1.0% |
| Oneida | 2,846.36 | 2,876.30 | 236 | 1.1% |
| Taylor | 2,133.46 | 1,974.37 | 168 | -7.5% |
| Vilas | 2,570.88 | 2,439.27 | 183 | -5.1% |
| Dane | 3,503.72 | 4,678.04 | 1,866 | 33.5% |
| Rock | 3,099.26 | 3,743.58 | 780 | 20.8% |
| Brown | 3,035.41 | 3,686.22 | 1,348 | 21.4% |
| Door | 3,021.80 | 3,150.14 | 177 | 4.2% |
| Kewaunee | 2,739.80 | 2,603.85 | 194 | -5.0% |
| Marinette | 3,003.14 | 3,082.81 | 263 | 2.7% |
| Menominee | 3,083.46 | 3,976.52 | 31 | 29.0% |
| Oconto | 3,275.10 | 6,346.40 | 130 | 93.8% |
| Shawano | 2,791.98 | 2,848.57 | 291 | 2.0% |
| Total | 3,121.03 | 3,793.14 | 5,891 | 21.5% |