
A Review of Wisconsin's Strategies for Long-Term Care Reform: Family Care and the Partnership Program

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Wisconsin is widely recognized as a leader for integrating long-term care services. To improve access and quality, the Wisconsin Partnership Program uses non-profit health plans to fully integrate acute and long-term care for clients dually eligible for Medicaid and Medicare. Family Care is a Medicaid-only program administered by county care management organizations. The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for the aged and disabled, because it allows full integration of all primary, acute, sub acute, and long-term care dollars. Yet Medicare is still a difficult partner, and evaluations of Family Care suggest that significant improvements can be made with partial integration.

Long-term care reform is difficult for many reasons. Perhaps this is because long-term care is not one thing, but many things—things we take for granted when we are young and healthy. For example, long-term care includes things not obviously related to the health care system like family support, transportation, and housing. There is also confusion on what health services are really meant to be for long-term care. Those services that we might think of as directly related to long-term care like nursing home and home health care are not long-term care from Medicare's perspective. But if you are poor and eligible for Medicaid, those same services are indeed major long-term care expenditures that states must help pay for. The key difference is whether these services are skilled-care oriented versus custodial or maintenance services. Medicare only pays for skilled care nursing home and home care, and only for relatively short periods of time where recovery or rehabilitation is likely.

States have been the leaders in the reform of long-term care. The fact that much of long-term care is related to daily living needs rather than health care needs tends to make the approach to care more the concern of individuals and their communities. Perhaps even more important, financing and administration of long-term care under the Medicaid program has been an increasing burden for states. Their desire to find home and community-based alternatives to nursing home care has provided most of the experience with program innovation.

States are hungry for workable models to help deal with their long-term care responsibilities. This interest complements the emerging national recognition of the need to improve the health care delivery system for those with chronic care needs. A commonly accepted premise is that to make progress, we must improve

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the integration and coordination of acute and long-term care. To do this, state governments along with the Federal Centers for Medicare and Medicaid Services (CMS), health plans, and providers have begun to experiment with new systems of care and financing.

Wisconsin is widely recognized as being among the leaders in creating workable strategies for integrating long-term care services. In this report, Wisconsin's Family Care program and Partnership Program are reviewed in the broader context of the lessons learned from the Robert Wood Johnson Foundation's Medicare/Medicaid Integration Program.

Why this Interest in Medicare/Medicaid Integration and What can it Accomplish?

According to one school of thought, form follows finance. That is, in the absence of appropriate financing mechanisms and incentives, long-term care reform will be nearly impossible to accomplish. Several factors have prompted renewed interest in how to best integrate Medicaid and Medicare through managed care: (a) the current Medicaid crisis; (b) the new Medicare prescription drug benefit; and (c) the increased recognition of the high cost and unique care needs of many special needs populations, including those eligible for both these programs who are referred to as dual eligibles.

The Medicare/Medicaid Integration Program, with the support of the Robert Wood Johnson Foundation, has been working with states to help end the fragmentation of financing, case management, and service delivery that currently exists with our two main public financing programs (see: chpre.gmu.edu). Wisconsin, along with Arizona, Florida, Massachusetts, Minnesota, Texas, and New York have made considerable progress in developing integrated care programs with the help of the Centers for Medicare and Medicaid Services. Other states (CA, GA, NJ, MD, and WA) have been working at it and are interested in doing more. The initial focus is on public pay clients, although the ultimate potential of these efforts is to provide an effective and efficient care for all populations in need of or at risk for the full array of acute and long-term care services.

One of the lessons from the Medicare/Medicaid Integration Program is that full integration of Medicare and Medicaid is not easy. However, progress toward the goals of integrated care can be made through coordinating Medicaid managed care benefits with traditional Medicare benefits. This raises the question as to whether there is one best approach. Wisconsin's experience with the Partnership Program and Family Care has helped to clarify and inform what can be accomplished with each.

How Do Wisconsin's Partnership Program and Family Care Work?

The Wisconsin Partnership Program (WPP) began in 1996 and currently operates through four non-profit health plans in selected locations in the State. It is a fully integrated program of acute and long-term care designed to improve access and quality, while achieving cost savings for clients "dually eligible"

for Medicare and Medicaid. It uses special waivers to combine the benefits of each program into one system of care. Doing so helps avoid fragmentation and duplication of services—challenges dual eligibles face in the traditional fee-for-service system. Wisconsin's Partnership Program serves elders and adults with disabilities. Acute and long term support services are coordinated across care settings using an inter-disciplinary team comprised of a physician, nurse practitioner, and social worker or independent living coordinator.

Drawing on the early Wisconsin Partnership experiences and with similar goals, Family Care (FC) began in 2000 in five pilot counties. It is a partially integrated (Medicaid only) program that uses special waivers to serve elders, adults with disabilities, and adults with developmental disabilities. The counties provide a flexible benefit package of long-term care services, along with preventive services coordinated by nurse and social worker care managers. Primary and acute services are coordinated with these services, but offered through traditional fee-for-service arrangements. The county care management organization receives a capitated payment for each enrollee's Medicaid long-term care services, and bears the risk for cost-effective service use.

The motivation behind these programs was a desire to address Wisconsin's significant bias toward providing care in institutions by increasing access to long-term supports in the community. The Wisconsin Partnership Program framework was built off a model of integrated Medicare and Medicaid currently known as PACE (Program of All-Inclusive Care for the Elderly), which is now a permanent option under Medicare. Wisconsin's Partnership Program offers important flexibilities that limit the growth in the number and census of PACE programs. PACE requires the use of staff physicians and frequent attendance at an adult day care. Wisconsin's Partnership Program allows patients to keep their own physician and emphasizes care in the home setting.

Family Care was designed to follow the Partnership Program's lead. However it avoids the difficulty and complexity of integrating Medicare with Medicaid and is administered by counties, which have agreed to operate as the care management organization, rather than non-profit health plans. A special selling point of Family Care is that it set out to eliminate the waiting lists that exist with the home and community-based care waiver programs (e.g., COP and CIP) operating in the counties. Family Care encourages the introduction of a broader array of long-term care services operating through managed care and capitated rate-setting strategies.

Both the Wisconsin Partnership Program and Family Care take a broad view of the long-term care needs of the patient. Importantly, both recognize the interrelationships of acute with long-term care, institutional with community care, and medical with social services. Each of these interrelationships represent trade-offs in the daily struggle of those who are eligible and need Medicare and Medicaid benefits. Learning how to better integrate these components of our health care system has prompted the national interest in the experiences of Wisconsin and the other states that have participated in Robert Wood Johnson's Medicare/Medicaid Integration Program.

The Partnership Program fully integrates acute and long-term care services for clients dually eligible for Medicare and Medicaid.

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What Challenges Have Evaluators Faced?

As is typical with new program ideas, the devil is in the details. It takes time to sort out the key issues that need to be addressed, figure out how to address them, and then correct the mistakes made in each of these steps as you learn along the way. Generally, this all takes place in a context where some who are tracking the process are not supportive, whereas others are sure the ideas are so good that they want to move further and faster. In both cases, it makes even believers nervous about the learning process.

States often are frustrated by evaluation expectations that require programs to be evaluated too early in the program development process. Because the know-how related to implementing long-term care integration programs is still emerging, the programs may be evaluated before they reach a steady state, from which outcomes can best be measured.

In Wisconsin and other states, the bulk of time and resources early on have been focused on just getting the programs to some level of steady state; typically, little time and energy remain for system improvements to ensure the original program goals are met. Fortunately with both Family Care and the Partnership Program, recent evaluation studies occurred beyond the start up stage. They offer some encouragement that the program goals are being accomplished.

How Effective has the Wisconsin Partnership Program Been?

In August 2005, program administrators reported outcomes for Wisconsin's Partnership Program (WPP) to the Wisconsin Assembly Committee on Medicaid Reform. Program sites were paid 5% less than comparable groups outside the program, yet were able to achieve the following results:

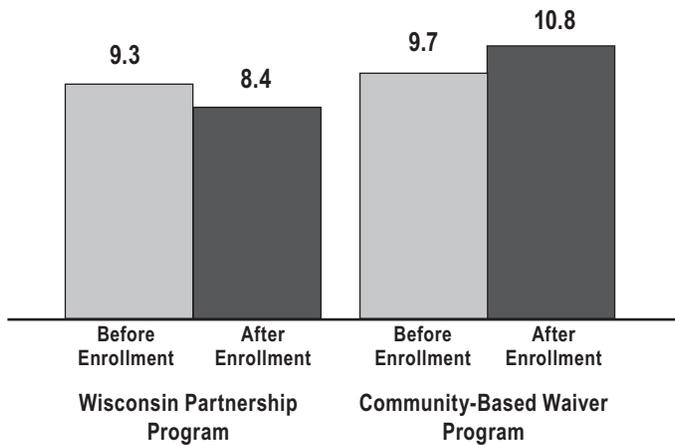
After one year in the Partnership Program, the number of nursing home days decreased 25% for the elderly.

- The number of inpatient hospital days decreased 52% for physically disabled members in the first year after enrollment in WPP.
- The number of nursing home days decreased 25% for elderly in the first year after enrollment in WPP. Only about 6% of WPP members are in nursing homes compared to 26% of Medicaid recipients age 65+ across the state.
- By close coordination and monitoring, the WPP has been able to keep prescription drug increases in the range of 9% to 12%, well below the national average of 18% to 21%.
- The vast majority (95%) rated the services excellent or very good. Only 5% of members disenrolled for reasons other than death or relocation.

Another recent study compared the WPP to a matched sample of frail and disabled persons in a community-based waiver program.¹ For WPP, hospital admissions for 100 members served for one month (i.e., member months) fell from 9.3 before enrollment to 8.4 after enrollment (see Figure 1). In contrast, for those in the community-based waiver program, hospital admissions per 100 member months rose from 9.7 before enrollment to 10.8 after enrollment.

Figure 1. Hospital Admissions Declined Among the Frail and Disabled Enrolled in the Wisconsin Partnership Program

(Number of hospital admissions for 100 members served for one month)

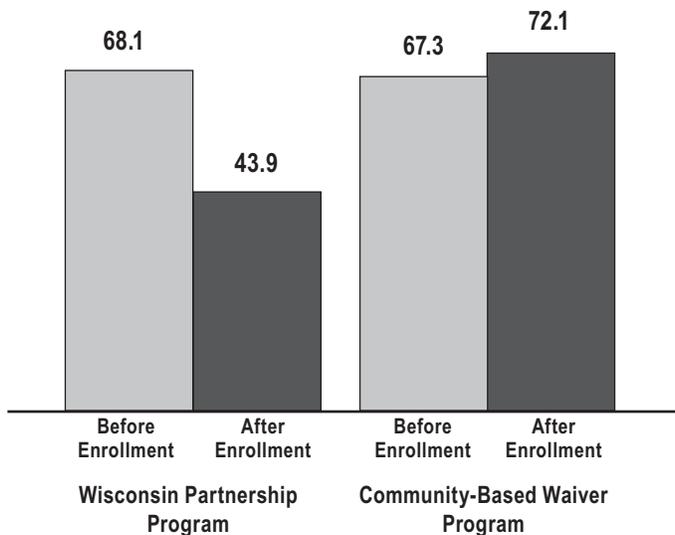


Note: Based on comparisons of the Wisconsin Partnership Program and a matched sample of frail and disabled persons enrolled in a community-based waiver program (Wiggins, et al., 2005).

Hospital days per 100 member months showed a similar pattern (see Figure 2). For the Wisconsin Partnership Program (WPP), hospital days per 100 member months fell from 68.1 before enrollment to 43.9 after enrollment. For those in the community-based waiver program, hospital days per 100 member months rose from 67.3 before enrollment to 72.1 after enrollment ($p < .0001$).

Figure 2. Hospital Days Declined among the Frail and Disabled Enrolled in the Wisconsin Partnership Program

(Number of hospital days for 100 members served for one month)



Note: Based on comparisons of the Wisconsin Partnership Program and a matched sample of frail and disabled persons enrolled in a community-based waiver program, $p < .001$. (Wiggins, et al., 2005).

The Partnership Program decreased hospital use for the elderly and disabled.

These statistically significant results held for both the 65 to 85 and the over 85 age groups. Compared to a community-based waiver program, WPP is an effective intervention for decreasing hospital use for the elderly and disabled populations.

How Effective has the Wisconsin Family Care Program Been?

Family Care has also recently undergone a rigorous independent review conducted by APS Healthcare.² The study focused on the fourth (2003) and fifth (2004) years of operation. Evaluators examined Family Care members' health status, health care costs, and long-term care costs compared to similar individuals receiving fee-for-service Medicaid services in the rest of the state.

Medicaid costs for Family Care members outside Milwaukee were \$452 less per month than for the comparison group.

The report found that Family Care's Care Management Organizations (CMOs) continued to improve the quality of long-term care services for their members. Waiting list elimination—a key selling point of Family Care—has been achieved for over three years now. Individual health outcomes remain good and the cost savings appear encouraging. Over the two-year study period, Medicaid costs for Family Care members outside Milwaukee were, on average, \$452 less per month than costs for the comparison group. Costs for members in Milwaukee were \$55 lower per month than for the comparison group. The source of these savings was two-fold: (1) a direct effect of a more cost-effective mix of service purchases; and (2) an indirect effect of improving member's health and ability to function independently.

One particularly interesting finding was that Family Care members visit their primary care physician more regularly than the comparison group. This benefit accrued across all counties and target groups. For example, Family Care members outside Milwaukee visited a physician's office 20.6 times on average during the two-year study period, compared to 14.7 visits in the comparison group. This additional attention to primary health care is thought to be related to the work of the Family Care nurse care managers; these nurse care managers may also contribute to reduced institutionalization and less illness burden and functional impairment. More frequent primary care physician visits appeared to provide opportunities to increase prevention and early intervention health care services that, in turn, reduced the need for more acute and costly services.

Summary

Long-term care reform in Wisconsin has the benefit of years of experience with innovative programs. Wisconsin is one of the few states that we can look to for insights on how best to proceed with long-term care integration. The programs are now mature enough to be generating the positive results originally hoped for and this has prompted interest in going statewide. However, the best way to proceed is still a question. Family Care and the Wisconsin Partnership Program each have taken on this challenge quite differently.

Family Care limits its integration efforts to Medicaid-only services that fall under its capitation payments. Family Care relies on nurses and social workers to *coordinate* with primary and acute care services (physician, hospital, prescription drug, dental care, podiatry, vision, and mental health related

services), but does not *provide* those services. The Wisconsin Partnership Program integrates all Medicaid with Medicare benefits through non-profit health plans that blend capitation payments from both these programs. The Partnership Program relies on a broader interdisciplinary team that includes the patient and their physician, along with a nurse practitioner, nurse, social worker, and others as needed.

The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for aged and disabled beneficiaries, because it allows flexible use of all primary, acute, sub acute, and long-term care dollars. This is important to states because it is often the Medicaid-supported care coordination of home- and community-based services that creates savings to Medicare. For example, an evaluation of the PACE program has suggested that savings accrue to Medicare, but Medicaid costs are actually higher in the first year of enrollment than in fee-for-service approaches.³ States generally feel there needs to be a long-range view in such evaluations. In any case, states would like to share in any Medicare savings or at least protect themselves against Medicaid cost increases that can happen when Medicare's primary and acute care services are not managed well.

Unfortunately, the integration of Medicare with Medicaid is not straightforward. Medicare and Medicaid remain quite different programs. The new Medicare "special needs plan" allows Medicare plans to selectively market to the populations of interest to Wisconsin's Partnership Program and Family Care. Yet, there are still significant programmatic barriers to seamless systems for plans and their members that need to be worked out. Enrollment into Medicare managed care must be voluntary, whereas either mandatory or optional enrollment can be considered for Medicaid. Also, there is no guarantee that the higher Medicare "frailty" payments received by programs like the Wisconsin Partnership Program and PACE will be available when these programs are replicated.

The bottom line is that no clear consensus has emerged about how best to proceed on long-term care integration, especially when best is defined to mean expedient. Because Medicare is still a difficult partner, Wisconsin and other states will look to models like Family Care and the Wisconsin Partnership Program as alternative ways to improve the systems of care to their beneficiaries. The results of the recent Family Care evaluation suggest that significant improvements can be made with partial integration. However, it remains to be determined which approach is more replicable and ultimately best for each of the various vested interests. The good news is that both approaches have demonstrated merit and can inform the next steps for Wisconsin and other states.

Family Care evaluations suggest that partial integration can improve care and avoid the difficulty of partnering with Medicare.

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