Legislative Fiscal Bureau

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Family Care Enrollment Cap (DHS -- Medical Assistance -- Services)

[LFB 2011-13 Budget Summary: Page 215, #4]

CURRENT LAW

The Family Care program provides long-term care services to qualifying individuals under a capitated, risk-based payment system. The program has two primary components -- aging and disability resource centers (ADRCs) and managed care organizations (MCOs). ADRCs are meant to be a gateway for all individuals in the state in need of long-term care services, providing "one-stop shopping" for information, assessments, functional eligibility determinations, prevention, wellness, and other services relating to long-term care at no cost. MCOs provide long-term care services to Family Care enrollees, either through contracts with providers or by providing care directly through their employees. These services include many of the services provided under home- and community-based waiver programs (legacy waivers), long-term care standard medical assistance (MA) services (commonly referred to as "card services"), and nursing home services.

Currently, the Department of Health Services (DHS) pays each MCO one of two capitation rates for each individual enrolled in the MCO. One rate applies to Family Care enrollees who require a nursing home level of care, and the other applies to Family Care enrollees who meet the functional requirements of the program, but do not require a nursing level of care. Each rate represents an average cost calculated across all members of each respective MCO. Rates may differ between MCOs due to differences in each MCO's case mix, labor costs, and administrative costs. To protect MCOs, the state may provide phase-in payments to MCOs for the first three years of their operation. These payments are intended to provide additional financial support to MCOs as they train staff, adjust administrative procedures, and transition their provider networks from a fee-for-service and waiver delivery system to a managed care system. The financial solvency of all MCOs is monitored by both the DHS and the Office of the Commissioner of Insurance (OCI).

Participating counties are required to partially support the costs of Family Care benefits.

The formula DHS uses to calculate each county's contribution was established in 2007 Wisconsin Act 20. In the first year that Family Care is offered in a county, the county must contribute the same amount it spent in 2006 on long-term care services for clients who would have been eligible for Family Care at that time. If this first year amount is less than 22% of the county's basic community aids allocation (BCA), the county will continue to contribute this amount as long as it participates in Family Care. If the first year amount is more than 22% of the county's BCA, the county will lower its contribution by 25% of the difference, each year for four years, until its yearly contribution is 22% of its BCA. County contributions are credited to a program revenue appropriation that supports program benefit costs.

If the Family Care benefit is offered in a county, eligible individuals must also have the option to instead self-direct their long-term care services through the IRIS program (Include, Respect, I Self-Direct). IRIS participants receive a monthly budget allocation and choose which long-term care services they receive, and which providers will render these services. The budget allocation cannot be more or less than the amount that the person would have received if they had chosen to enroll in Family Care instead of IRIS. DHS operates both programs under waivers of federal MA laws granted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid (CMS).

Under these programs, individuals that meet both functional and financial eligibility standards are entitled to a full package of home- and community-based services designed to meet their needs. Family Care and IRIS benefits become an entitlement for all eligible individuals residing in a Family Care county 36 months after these benefits first become available. Family Care and IRIS benefits replace the legacy waiver services that were previously available in those counties. Consequently, while individuals who are eligible for Family Care and IRIS are not required to participate in these programs, eligible individuals who choose not to enroll in the programs do not have access to MA services that were previously provided under the legacy waiver programs.

MA recipients who are not enrolled in Family Care may still receive medically necessary, MA-funded long-term care services through the standard set of Medicaid benefits, subject to certain limitations. These services include personal care, home health care, therapies, some durable medical equipment and disposable supplies, and specialized medical vehicle services. In addition, MA recipients living in non-Family Care counties and eligible for institutional care may participate in the MA legacy waiver programs, such as the community integration program (CIP IA, CIP IB, CIP II), and the community options waiver program (COP-W). These programs fund certain long-term care services that are not available as standard MA card services.

Unlike MA card services, for which providers submit reimbursement claims to the MA program or to the MCOs in which the MA recipient is enrolled, MA legacy waiver services are funded from sum certain allocations to counties. Consequently, some counties maintain waiting lists for these services. Counties also provide their own funds, including community aids and tax levy revenue, to support these long-term care services. The state claims federal MA matching funds for MA-eligible services counties support with these funds.

The state offers two additional long-term care managed care programs in addition to Family Care. The program for all-inclusive care for the elderly (PACE) and the Family Care partnership (FCP) program are managed care programs that provide both acute health and long-term care services to elderly and disabled individuals who are eligible for nursing home care. Enrollment in the PACE program is limited to elderly individuals, ages 55 and older, while both elderly and disabled individuals may enroll in FCP. These voluntary programs are targeted to people that are eligible for both MA and Medicare (dual eligibles).

There are two primary differences between PACE and FCP. First, PACE requires enrollees to attend a day health center on a regular basis in order to receive many services. In contrast, FCP provides comprehensive services primarily in the participants' home, while offering voluntary enrollment in adult day care. Second, PACE requires that the client's primary physician be a physician who is a member of the PACE organization, while FCP attempts to retain the client's current primary physician by recruiting that physician to the FCP network. Finally, as noted above, PACE programs serve only elderly individuals, while the FCP also serves individuals with developmental and physical disabilities.

There are currently two PACE sites (Community Care Health Plan (CCHP) in Milwaukee and Waukesha), and eighteen counties with FCP services provided by four different providers: (a) CCHP in Kenosha, Milwaukee, Racine, Outagamie, Ozaukee, Washington, Waukesha, and Waupaca Counties; (b) Care Wisconsin in Columbia, Dane, Dodge, Jefferson, and Sauk Counties; (c) Independent Care, Inc. in Milwaukee County, and (d) Partnership Health Plan (PHP) in Chippewa, Dunn, Eau Claire, Pierce, and St. Croix Counties.

Similar to the Family Care program, the state's MA program makes capitation payments to PACE and Partnership MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on each individual's level of functional eligibility, labor costs and administrative costs. In addition to the MA capitation rate, these agencies also receive a Medicare capitation rate for acute care services.

As of March 2011, nine MCOs provided services in 57 counties and 35 ADRCs provided services in 59 counties. Based on data from the Department, Family Care, PACE, and Family Care Partnership served approximately 36,000 individuals at this time. Of these individuals, 49.5% were frail elders, 34.5% had developmental disabilities, and 15.6% had physical disabilities. In its monthly reports, DHS includes all individuals above age 65 in the elderly population, whether or not they have a disability.

GOVERNOR

Reduce funding by $67,442,100 (-$26,726,300 GPR and -$40,715,800 FED) in 2011-12 and by $223,361,500 (-$89,210,600 GPR and -$134,150,900 FED) in 2012-13 to reflect estimates of savings that would result by placing a cap on enrollment in Family Care and related programs in the 2011-13 biennium.

Prohibit DHS from enrolling, in a county, more persons into the Family Care, Family Care Partnership, PACE, or IRIS program than the number of persons participating in each of

those programs in that county on June 20, 2011, or the effective date of the provision, whichever is later. The enrollment cap would not apply after June 30, 2013.

Prohibit DHS from proposing to contract with entities to administer the Family Care benefit in a county in which the Family Care benefit is not available on July 1, 2011, unless DHS determines that administering the Family Care benefit in such a county would be more cost-effective than the county's current mechanism for delivering long-term care services. This prohibition would be in effect from July 1, 2011, through June 30, 2013.

Under the "MA Base Reestimate," which is discussed in a separate paper, the funding change for MA benefits costs is based on current law, which permits counties currently participating in Family Care to continue to increase enrollment in these programs throughout the 2011-13 biennium. In the "MA Base Reestimate" item, the administration estimates that approximately 52,100 would be enrolled in these long-term care programs as of June 30, 2013.

This provision would delete funding that would be provided as part of the MA Base Reestimate relating to projected enrollment increases. The funding reduction reflects the administration's estimates that approximately 42,300 individuals will be enrolled in these long-term care programs as of June 20, 2011, including 34,700 in Family Care; 4,700 in the Family Care Partnership and PACE programs; and 2,900 in IRIS; and that enrollment will remain constant throughout the 2011-13 biennium. Neither the MA Base Reestimate item nor this item assumes any expansion of Family Care beyond the counties in which it is currently offered. Attachment 1 shows the estimated effect of the proposed enrollment cap, by county.

Family Care Benefits. This provision includes decreased funding for Family Care benefits by $71,549,500 (-$28,306,800 GPR and -$43,242,700 FED) in 2011-12 and by $236,645,400 (-$93,900,300 GPR and -$142,745,100 FED) in 2012-13.

Adjustments to Other Appropriations. In addition, adjust funding for several appropriations that are related to the Family Care program, but which are not usually included in defining the Family Care budget. These adjustments include: (a) increases in MA program benefits ($6,157,500 GPR and $2,513,400 FED in 2011-12 and $19,843,900 GPR and $8,518,500 FED in 2012-13); (b) decreases in MA waiver benefits (-$4,582,100 GPR in 2011-12 and -$15,183,400 GPR in 2012-13); and (c) increases in health care for low-income families ($5,100 GPR and $13,500 FED in 2011-12 and $29,200 GPR and $75,700 FED in 2012-13).

DISCUSSION POINTS

Requested Modifications to the Bill

1. The administration has requested several modifications to the statutory changes in the bill. With these requested changes, the bill would prohibit DHS from enrolling, in the service region of each ADRC, more persons into the Family Care, Family Care Partnership, PACE, or IRIS programs than the total number of persons participating in all of those programs in that ADRC service region on June 30, 2011, or the effective date of the provision, whichever is later. DHS could only enroll persons into the long-term care programs that are offered in that person's county of

residence. The enrollment cap would not apply after June 30, 2013. Months during which this provision is in effect may not be counted toward the statutory requirement that the Department have sufficient capacity to offer the Family Care benefit to all entitled persons after the first 36 months the benefit is available in a county.

Notwithstanding the provision described above, under the administration's modifications, DHS could enroll any individual into the Family Care, Family Care Partnership, PACE, or IRIS programs who is relocated from a nursing home, intermediate care facility for the mentally retarded (ICF-MR), or State Center for People with Developmental Disabilities if the individual has resided in the facility for at least 90 days, the facility is not licensed, an emergency exists, or the facility is closing or downsizing.

DHS would still be prohibited from proposing to contract with entities to administer the Family Care benefit in a county in which the Family Care benefit is not available on July 1, 2011, unless DHS determines that administering the Family Care benefit in such a county would be more cost-effective than the county's current mechanism for delivering long-term care services. This prohibition would be in effect from July 1, 2011, through June 30, 2013.

2. The administration requested these changes for three reasons. First, CMS requires DHS to provide all eligible persons with the option to enroll in Family Care or IRIS. For this reason, the enrollment cap would need to be modified from a cap on enrollment in each program to a cap on total enrollment in all programs. Second, DHS requested that the enrollment cap be changed from a county-by-county cap, to a cap on enrollment in each ADRC region because some ADRCs serve multiple counties and manage one waitlist covering all of these counties. Third, DHS requested the ability to relocate individuals from an institutional setting to a community setting beyond what would be allowed under attrition in the Family Care-related programs. The Department indicates that this greater flexibility would be especially useful if a facility closes and that, since community-based care is no more expensive than institutional care, this modification to the bill should have no fiscal impact.

3. It is the administration's intent that any program openings created through natural attrition and disenrollment may be filled by new enrollees. In addition, any person relocated from an institution to a Family Care-related program would not be counted as a change in enrollment for the purposes of the cap.

Effects of the Enrollment Cap

4. The model that DHS uses to budget for Family Care, IRIS, PACE, and Family Care Partnership is based on the interaction between three components: (a) Family Care-related program enrollment and benefits; (b) legacy waiver savings and county contributions; and (c) fee-for-service card costs. The final cost of the Family Care program is the net effect of these three components. This interaction is described below.

First, DHS estimates Family Care benefit costs for each county. The Department begins with an estimate for the cumulative number of nursing home and legacy waiver participants that will be transitioned to the Family Care program. This transition takes between one and six months.

In addition, each month for the first 36 months, DHS increases enrollment by one thirty-sixth of the people on each county's initial waitlist. During this period, DHS prohibits counties from enrolling more individuals, excluding nursing home residents and legacy waiver participants, into Family Care per month than one thirty-sixth of the county's initial waitlist. After that time, the Department assumes that enrollment will increase by a trend factor calculated from enrollment growth in the original Family Care pilot counties. To estimate Family Care benefits costs, DHS multiplies total enrollment in each county by the county's projected capitation rate.

Second, DHS estimates both the amount of funding that the state provides to counties for legacy waiver programs and the total amount of county contributions. Since the legacy waiver programs are discontinued in Family Care counties, these funds are reallocated to fund Family Care benefits. County contributions are also used to fund Family Care benefits.

Third, based on projected enrollment in Family Care-related programs, the DHS model adjusts MA card spending by the amount of nursing home and other long-term care card costs that will be avoided as a result of individuals enrolling in Family Care. Under the model, DHS assumes that 5% of Family Care enrollees would receive care in a nursing home if Family Care services were not available. These people are then removed from the Department's estimate for fee-for-service nursing home costs. Similarly, for each Family Care enrollee, the Department reduces the number of elderly and developmentally disabled individuals that will receive MA long-term care card services.

5. The Department indicates that establishing an enrollment cap on Family Care-related programs will allow it to review current operations and evaluate potential policies for improving these programs. Under current law, the Department estimates that enrollment in Family Care-related programs would grow from approximately 42,200 enrollees in July, 2011, to approximately 52,100 in June, 2013, in the counties where Family Care currently is available. If the Department identifies program changes that would improve the Family Care-related programs, it may be easier to implement these changes with a smaller enrolled population.

6. Under the bill, as modified, enrollment in Family Care-related programs would be capped at the number of enrollees as of June 30, 2011. Relative to current law, the bill would reduce Family Care-related program benefits costs, increase nursing home costs, and increase MA long-term care card costs. The bill would not have any impact on savings associated with legacy waiver programs (since all legacy waiver participants in Family Care counties have transitioned to the program) or the amount counties would contribute to fund the program.

7. The Department has indicated that under the enrollment cap the number of total MA recipients should decrease relative to current law. The affected individuals have income above the standard financial MA eligibility limits, but below the special income limit for individuals receiving services in an institution or home- and community-based waivers. The special income limit is $2,022 per month. These individuals would be eligible for MA if they received waiver services, including Family Care, or care in an institution. However, since they would still be on the waitlist, they would not have access to waiver services, and would choose not to enroll in MA if it means moving to a nursing home. Instead, these people continue to live in their homes and rely on assistance from their friends and family. The number of people who meet this description is not

known.

8. DHS indicates that half of Family Care enrollees are not financially eligible for the program when they are placed on the waitlist, but only 5% are not eligible when they are scheduled to enroll in Family Care. This suggests that at least 45% of the waitlist is comprised of individuals that would successfully spend down their assets in order to enroll in Family Care.

9. With the administration's requested modifications to the bill, DHS could relocate individuals that have been in an institution for at least 90 days to a Family Care-related program. The Department indicates that this provision should not have a fiscal impact, since community-based services are no more expensive than institutional services. If the cost of providing community-based services is less than the cost of nursing home care, it is possible that this provision could reduce MA benefits costs. However, it is also conceivable that some individuals, especially those who would not otherwise be eligible for MA, may choose to move to an institution for 90 days as a means of qualifying for Family Care. Since some of these people would not receive any MA services under the Governor's original bill, this provision may lead to an increase in MA benefits costs. DHS believes that very few people would take this course of action.

10. Advocacy groups and MCOs have expressed concern that many of the individuals on the waitlist for Family Care services will be admitted to nursing homes as a result of the enrollment cap. The Aging and Disability Professionals Association of Wisconsin has suggested that many families will be unable to care for individuals who are on waitlists. They note that many families may not have the income or live in the same region to support these individuals. Several organizations have expressed the belief that a significant number of people on the waitlist will not receive any MA long-term care services, because they will either have income above the MA limit or there will not be a sufficient provider network for them to receive care.

11. Individuals on the waitlist, or in counties where Family Care is available, may have made financial and care decisions based on the expectation that they would have access to the Family Care benefit. For example, consider an individual that has their own home and meets the functional eligibility criteria for Family Care, but has income or assets above the MA limits. This person may choose to sell their home and enter an assisted living facility under the belief that once they spend down their assets, they will be able to continue to receive this service under Family Care. Under the bill, this person would be unable to enroll in the program, even though they no longer have a home and have spent down the money they could have used to live at home. Unless this person's family is able to take care of them, or the person has sufficient income to pay for their own rent and can live on their own, they may have no alternative but to seek admission to a nursing home.

12. The Department anticipates that approximately 272 more people in 2011-12 and 212 more in 2012-13 will enter a nursing home compared to current law. In comparison, 9,270 will enter or remain on the waitlist for Family Care-related services. The Department argues that any persons on the waitlist that do not receive services under Family Care will be taken care of by family members in conjunction with MA card services. In addition, the Department argues that in the 2009-11 budget it was assumed that 15% of people on the waitlist would be relocated or diverted from nursing homes as a result of the expansion of Family Care. However, far fewer relocations and

diversions took place in the current biennium, resulting in its underestimating MA-funded nursing home days. In its current model, DHS decreased the rate of nursing home relocations and diversions to 5% to reflect the actual experience in 2009-11. DHS also notes that occupied nursing home beds have decreased steadily for over a decade, even in years when there were no funding increases provided for the legacy waiver programs.

13. According to the Legislative Audit Bureau's April, 2011, evaluation of the Family Care program, DHS and OCI have identified three MCOs that are at risk for financial insolvency. Freezing enrollment at its current level may help these MCOs to stabilize their operations and allow DHS to evaluate the adequacy of the capitation payments it makes to MCOs.

However, it is also possible that freezing enrollment would prevent relatively low-cost individuals from enrolling in Family Care programs and, depending on how counties manage their waitlists, potentially increase the number of high-cost enrollees. If this were to occur, MCOs may experience more financial stress than they would without the enrollment freeze.

Program Enrollment and Service Plan Development

14. Beginning on the first day that the individual is in Family Care, the MCO must provide the services required to meet the person's immediate needs, as identified in the individual's functional screen. After the individual begins receiving services, the MCO does a full assessment of the person's needs, their informal friend and family supports, and their desired outcomes. Based on this information, the Family Care MCOs develop a person-centered care plan, through an interdisciplinary team (IDT) that includes a nurse, social worker, the member and family or friends the member wishes to include. The Partnership and PACE MCOs have an IDT with these same members, but also include a nurse practitioner and the member's doctor.

15. In 1999, DHS developed a resource allocation decision (RAD) method to help the IDT determine which services an individual should receive in order to meet their desired outcomes. The purpose of the RAD is to make the resource allocation process consistent across all long-term care managed care programs and to ensure that program participants receive the most cost-effective services that will help them meet their desired outcomes. The RAD requires the IDT to ask the following six questions:

- What is the need, goal, or problem?
- Does it relate to the person's assessment, service plan and desired outcomes?
- How could the need be met?
- Are there policy guidelines to guide the choice of option?
- Which option does the member (and/or family) prefer?
- Which options are the most effective and cost-effective in meeting the desired outcome(s)?

Finally, the RAD directs the IDT to explain its service decisions with the participant, have a dialogue with the participant about the decision, and negotiate to find a solution suitable to both the

MCO and the participant.

16. DHS and the MCOs have indicated that the Family Care program is based on a philosophy that emphasizes an individual's desired outcomes and that this can make it difficult for MCOs to determine what services a person should receive, especially if a participant's desired outcomes require expensive services. Currently, as noted in the RAD, MCOs are required by contract and administrative rule to develop service plans that help individuals meet their desired outcomes in the most cost-effective way possible. The most cost-effective way to help the participant meet their outcomes may not be the most cost-effective way to meet the needs of the individual. An argument could be made that cost should be given greater weight in the service plan development process. Both DHS and the MCOs agree that finding an appropriate balance between cost and an appropriate level of service can be difficult to maintain.

17. If an individual does not agree with an IDT's decision, they may file an appeal with DHS, the Department of Administration's Division of Hearings and Appeals, and the MCO's internal appeals committee. The composition of each MCO's internal appeals committee can vary, but many include community members, providers without conflicts of interest in the case, advocates, or family members of participants. The LAB indicates that 415 appeals were filed with either DHS or DOA during 2009-10.

18. The MCOs have expressed support for restructuring the appeals process. They cite two primary problems with the existing structure. First, participants can appeal to any of the three appeals agencies in any order, even if they lose an appeal in one. Second, if an MCO attempts to reduce a participant's service and the person appeals, the participant can postpone the appeal multiple times, during which the MCO remains responsible for providing the service. Since a participant can appeal to each agency separately, it is possible for an individual to appeal to all three agencies, with significant periods of postponement between each. The MCO would be required to provide the appealed service during the entire appeals process.

19. Currently, ADRCs manage one unified waitlist for all of the counties in their service region. Any person that is functionally eligible for Family Care and is expected to be financially eligible by the time their county has full entitlement may be placed on the waitlist. Individuals with assets above the MA limit must be in the process of spending down their assets in order to be on the waitlist. If people were not placed on the waitlist when they are not yet, but will be, financially eligible for Family Care, they would have to wait a significant period of time after they become eligible and require long-term care services.

DHS indicates that ADRCs are required to prioritize the waitlist on a first come, first served basis in their contract, but that each county may set some local priorities for how the waitlist is managed. For individuals that are scheduled to enroll in Family Care within a few months, ADRCs make some decisions as to which individuals should be given priority based on their acuity. For example, if an ADRC expects to have two openings based on program attrition and three openings due to allowable enrollment growth, the ADRC will review the next five participants on the waitlist and may prioritize those five individuals based on acuity or the presence of significant changes in health status. If the Committee adopts the Governor's proposal to cap enrollment but determines that ADRCs should be provided additional guidance with respect to the management of waitlists to

ensure fairness and uniformity throughout the state, the Committee could direct the Department to establish, in rule, the waitlist policy that all ADRCs would be required to follow (Alternative B2).

DHS Monitoring of MCO Effectiveness

20. The Department monitors the operation of the MCOs by setting the capitation rate, requiring regular business plan updates from the MCOs, and tracking MCO financial reports. These management practices are described in more detail below.

DHS believes that the pilot counties have achieved the managed care efficiencies that the Family Care program is modeled after, while many newer MCOs have not been able to do so. For this reason, DHS currently sets capitation rates paid to all of the MCOs based on the expenditure data of the original Family Care pilot counties. The Department indicates that using data from an efficient system results in capitation rates that require MCOs to structure their organizations and provider contracts in such a way so as to mimic the efficient practices of the pilot counties. Once DHS believes an MCO has met the level of cost-effectiveness demonstrated in the pilot counties, data from that MCO will be incorporated into the rate setting process.

In addition to setting the capitation rate, DHS also requests regular business plans from the MCOs to determine if they are making progress toward improving cost-effectiveness. For example, DHS indicates that, in general, provider contracts under the legacy waivers were more costly than is required in a managed care system, and that it expects MCOs to renegotiate these contracts. The Department studies the business plans to determine if the MCOs have renegotiated their contracts or taken other measures to achieve efficiency.

DHS uses monthly and quarterly financial reports to monitor whether MCOs are meeting the Department's benchmarks for administrative costs as well as any other service or program changes outlined in their business plan.

21. The Department indicates that it intends to create a comparative analysis of the cost-effectiveness of the Family Care-related programs and standard MA card services, based on completed analyses, and that this analysis should be available in the next couple of weeks. The Committee could direct DHS to conduct such an analysis and present its findings to the Committee (Alternative B1).

22. The LAB evaluation of Family Care found that 44.3 percent of the costs of the program are spent on residential services, such as community-based residential facilities, adult family homes, and residential care apartment complexes. Another 8.9 percent is spent on nursing homes and other institutional care. DHS acknowledges that more people currently living in residential and institutional settings may be able to live at home. The Department has expressed its intent to review the number of Family Care participants residing in these facilities, but also notes that multiple factors contribute to the program's high utilization of these services.

First, Family Care MCOs are absorbing the previous legacy waiver system, in which many participants became accustomed to living in a residential facility and are reluctant to move. Second, providers were also accustomed to higher rates under the legacy waivers and some MCOs have been reluctant to renegotiate these rates downward. Third, some elderly individuals have been

spending down their assets more rapidly than might be necessary, including possibly selling their homes. Spending down assets more quickly than is necessary increases the state's costs and limits the person's ability to receive services at home. Fourth, DHS notes a growing trend that parents of young adults with developmental disabilities often want their children to move out of the home and into a residential setting at age 18, like other young adults. Since parents are not legally required to take care of young adult children with developmental disabilities, there is often pressure to find a residential living situation for these individuals.

23. The Department indicates that it is continuing to explore other long-term care delivery systems, including self-directed services and integrated acute and long-term managed care. Freezing enrollment in existing Family Care-related programs may allow the Department to explore other, potentially more effective, programs that could be implemented going forward.

For example, in April, 2011, the Department was awarded a $1 million planning grant from CMS to develop a long-term care pilot program, which it calls Virtual PACE, to improve coordination of care for individuals eligible for both Medicare and Medicaid who would be eligible for care in a nursing home. According to the grant proposal, DHS intends to create a system in which it receives a capitated Medicare payment from the federal government and then provides a single capitated rate to another entity to provide all Medicare and Medicaid services required by the individual. DHS indicates the pilot program will begin in calendar year 2012 with three to four sites that will each enroll 2,000 members. Current Family Care and Partnership members would be converted to Virtual PACE, with an opportunity to return to their previous program after six months. In calendar year 2013 the Department indicates it may establish additional demonstration sites, based on the success of the pilot sites.

Other Arguments For and Against the Enrollment Cap

24. Perhaps the strongest argument for the Governor's proposal is that it significantly reduces costs in the MA program without changing eligibility standards or reducing services to current enrollees. Under the Governor's modified bill, all persons currently receiving services would continue to do so and individuals most at risk for prolonged stays in an institution would be allowed to transition to one of the Family Care-related programs.

25. As described above, counties with the Family Care benefit agreed to make contributions to the state in exchange for the state administering and providing the Family Care benefit to their residents. At the time that these counties joined the Family Care program, all of their eligible residents were expected to be entitled to the Family Care benefit after either 24 or 36 months, depending on when the county joined. An argument could be made that freezing enrollment would be counter to the state's original agreement with the counties.

26. The MCOs argue that, from the beginning, one of the key principles of the Family Care program design has been preventative care, both as a means for higher quality of life for participants and as a means for cost savings through lower utilization of urgent care. They emphasize that the MA card services are designed for acute care, in which individuals present a condition, the MA program provides treatment until the condition is resolved, and then treatment stops. In cases of recurring conditions, the MCOs would argue that once the acute treatment stops,

the condition often begins to worsen until it reaches such a severe level that acute care is needed again. They argue that the Family Care-related programs, allow participants to receive ongoing care that prevents conditions from worsening to the point of needing urgent acute care service. These concerns have also been raised by advocacy groups.

27. In addition, MCOs and advocacy groups argue that even if DHS is correct, and people on the waitlist are taken care of by their family members and friends, many of these individuals would still forego services they need. As a result, the health of these individuals would deteriorate more quickly, resulting in poorer quality of life, more nursing home admissions, and higher acuity for these individuals. MCOs are concerned how higher participant acuity will change the cost of the program in two years, when the enrollment cap is scheduled to end.

28. Finally, MCOs also note that significant time and money have been spent by the Department, ADRCs, and MCOs to establish the Family Care program in its current state. They and DHS program staff believe that there is evidence that the Family Care model does lead to eventual cost savings on a per person basis relative to the legacy waiver programs, but that it has taken longer than initially projected to achieve these efficiencies. For this reason, the MCOs do not think that it makes policy or financial sense to begin redesigning the program or creating a new program, especially since any changes may take as long to implement as the current system has.

29. The Committee could approve one of several alternatives that would add back some or all of the money that would be deleted to reflect projected savings from the enrollment cap. Each would decrease the number of individuals that would remain on the waitlist for Family Care-related programs or enter a nursing home. These alternatives are briefly described below.

One alternative is for the Committee to allow enrollment to continue in the 17 counties that have reached "entitlement status" as of July 1, 2011, but require an enrollment cap on all counties that have not reached "entitlement status" as of that date (Alternative 2). "Entitlement status" refers to counties in which all persons who meet Family Care eligibility requirements are entitled to receive services immediately, and cannot be placed on waiting lists. A number of arguments can be made for or against this alternative. An argument could be made that this alternative should not be enacted because it gives preference to counties that have already reached "entitlement status." Participants on the waitlist in other counties may argue that participants in the entitled counties have already had an opportunity to enroll in these programs, while they have yet to do so. A counter argument could be made that residents in entitled counties had more reason to believe that they would have access to the Family Care programs, and therefore, were more likely to make decisions based on this belief. This alternative also carries some risk that individuals in a waitlist county may move to an "entitlement status" county in order to access services provided under Family Care.

Another alternative is for the Committee to require that enrollment be frozen during 2011-12, but allowed to grow in 2012-13 (Alternative 3). This alternative would provide DHS one year to study these programs and develop program changes without enrollment in the program increasing. As under the Governor's bill, there is some risk that an enrollment cap in 2011-12 will increase the acuity of the participants that would enroll in 2012-13 under current law. However, this effect should be less than under the Governor's proposal.

The Committee could require that the entitlement period for all "non-entitlement status" counties be increased from 36 months to 48 months (Alternative 4). This would have no effect on counties that have reached "entitlement status" as of July 1, 2011. More individuals on the waitlist would be able to enroll in Family Care-related programs, but their enrollment date would be delayed, in some cases up to a year. This alternative would likely create a smaller backlog of enrollees than the enrollment cap alternatives.

A fourth alternative to the Governor's proposal would be for the Committee to require that enrollment continue during 2011-12, but be frozen in 2012-13 (Alternative 5). An argument could be made that waitlist and entitled individuals should be allowed to enroll in these programs while the Department studies potential changes to the programs, but that freezing enrollment might make it easier for the Department to implement any changes it identifies. As with the other alternatives that establish an enrollment cap, some enrollment backlog may be created.

Finally, the Committee could fully fund all Family Care-related programs and allow the Family Care program to expand to all counties under the same expansion schedule used in the DHS 2011-13 budget request. The Department's budget request assumed that all of the remaining counties would enroll in Family Care as of March 1, 2012, and the entitlement period would continue to be 36 months. This alternative would require adding back all of the funding that would be deleted in the Governor's bill, as well as increasing funding to the program above what is provided under current law. There would be some increase in PR from additional county contributions and in waiver funds that could be used to offset the costs in new counties. However, without a mandate requiring all counties to join the Family Care program, there is no guarantee that all counties would choose to participate.

The funding change to the bill for each of these alternatives is shown in the table in Attachment 2.

ALTERNATIVES

A. Funding Changes

1. Adopt the Governor's proposal, and the modifications requested by the administration, as described in Discussion Point 1.

2. Require that, for all counties that have not reached "entitlement status" as of July 1, 2011, total enrollment for all Family Care-related programs could not exceed, by ADRC service region, the number of enrollees that were in these programs as of June 30, 2011. Increase funding in the bill by $15,227,000 ($6,029,600 GPR and $9,197,400 FED) in 2011-12 and by $50,790,600 ($20,195,400 GPR and $30,595,200 FED) in 2012-13.

ALT A2	Change to Bill Funding
GPR	$26,225,000
FED	39,792,600
Total	$66,017,600

3. Require that in 2011-12, total enrollment for all Family Care-related programs cannot exceed, by ADRC service region, the number of enrollees that were in these programs as of June 30, 2011. Increase funding in the bill by $79,480,600 ($31,762,400 GPR and $47,718,200 FED) in 2012-13.

ALT A3	**Change to Bill** Funding
GPR	$31,762,400
FED	47,718,200
Total	$79,480,600

4. Require that for all counties that offer the Family Care benefit and have not reached "entitlement status" as of July 1, 2011, the entitlement period be transitioned from 36 months to 48 months. Increase funding in the bill by $37,956,200 ($15,040,100 GPR and $22,916,100 FED) in 2011-12 and by $144,947,200 ($57,886,000 GPR and $87,061,200 FED) in 2012-13.

ALT A4	**Change to Bill** Funding
GPR	$72,926,100
FED	109,977,300
Total	$182,903,400

5. Require that in 2012-13, total enrollment for all Family Care-related programs cannot exceed, by ADRC service region, the number of enrollees that were in these programs as of June 30, 2012. Increase funding in the bill by $67,442,100 ($26,726,400 GPR and $40,715,700 FED) in 2011-12 and by $173,413,300 ($69,277,000 GPR and $104,136,300 FED) in 2012-13.

ALT A5	**Change to Bill** Funding
GPR	$96,003,400
FED	144,852,000
Total	$240,855,400

6. Delete provision. Further, permit the Department of Health Services to continue to expand the Family Care benefit into new counties as initially proposed under the Department's agency request. Increase funding in the bill by $64,647,000 ($20,331,800 GPR, $3,735,700 PR, and $40,579,500 FED) in 2011-12 and by $252,220,600 ($76,756,500 GPR, $27,719,600 PR, and $147,744,500 FED) in 2012-13.

ALT A6	Change to Bill Funding
GPR	$97,088,300
FED	188,324,000
PR	31,455,300
Total	$316,867,600

B. Additional Statutory Changes -- Legislative Oversight

1. Require DHS to study the cost-effectiveness of Family Care, PACE, Family Care Partnership, and IRIS compared to one another and compared to standard MA card services, both before and after an individual enrolls in the programs. Further, require DHS to present its findings to the Joint Committee on Finance by March 1, 2012.

2. Require DHS to develop rules relating to the management of waitlists for the program, and to submit proposed rules to the Legislative Council staff by October 1, 2011.

3. Take no action on this item.

C. Eligibility Following Institutional Placement

1. Permit DHS notwithstanding any of the above alternatives, to enroll any individual into the Family Care, Family Care Partnership, PACE, or IRIS programs who is relocating from a nursing home, ICF-MR, or State Center for People with Developmental Disabilities if the individual has resided in the facility for at least 90 days, the facility is not licensed, an emergency exists, or the facility is closing or downsizing. Further, require that any person relocated under this provision would not be counted as a change in enrollment for the purposes of the cap.

2. Take no action on this item.

D. Exception to Enrollment Freeze

1. Approve the Governor's recommendation to prohibit DHS from proposing to contract with entities to administer the Family Care benefit in a county in which the Family Care benefit is not available on July 1, 2011, unless DHS determines that administering the Family Care benefit in such a county would be more cost-effective than the county's current mechanism for delivering long-term care services. This prohibition would be in effect from July 1, 2011, through June 30, 2013.

2. Delete the provision.

Prepared by: Grant Cummings
Attachments

ATTACHMENT 1

Enrollment and FC-Related Benefits Costs by County As of June of Each Fiscal Year
All Family Care-Related Programs

		Entitlement	SFY 11		SFY 12		SFY 13	
		Date Under	Current		Current		Current	
County	Start Date	Current Law	Law	Governor	Law	Governor	Law	Governor
Adams	N/A	N/A	-	-	-	-	-	-
Ashland	7/1/2009	7/1/2012	255	255	328	261	387	261
Barron	5/1/2009	5/1/2012	454	454	551	462	637	462
Bayfield	7/1/2009	7/1/2012	143	143	159	144	183	144
Brown	N/A	N/A	-	-	-	-	-	-
Buffalo	3/1/2009	3/1/2012	111	111	140	112	162	112
Burnett	6/1/2009	6/1/2012	112	112	130	113	154	113
Calumet	1/1/2010	1/1/2013	232	232	244	233	271	233
Chippewa	5/1/2008	5/1/2011	697	697	711	699	720	699
Clark	4/1/2009	4/1/2012	267	267	398	269	461	269
Columbia	3/1/2008	3/1/2011	566	566	659	574	728	574
Crawford	7/1/2009	7/1/2012	184	184	208	186	240	186
Dane	N/A	N/A	1,011	1,011	1,015	1,011	1,020	1,011
Dodge	8/1/2008	8/1/2011	447	447	521	452	579	452
Door	N/A	N/A	-	-	-	-	-	-
Douglas	5/1/2009	5/1/2012	496	496	591	504	698	504
Dunn	6/1/2008	6/1/2011	526	526	535	527	541	527
Eau Claire	11/1/2008	11/1/2011	1,586	1,586	1,616	1,590	1,631	1,590
Florence	N/A	N/A	-	-	-	-	-	-
Fond du Lac	2/1/2000	2/1/2002	1,151	1,151	1,177	1,153	1,202	1,153
Forest	N/A	N/A	-	-	-	-	-	-
Grant	4/1/2010	4/1/2013	293	293	338	296	399	296
Green	1/1/2009	1/1/2012	326	326	371	329	422	329
Green Lake	8/1/2008	8/1/2011	174	174	213	176	235	176
Iowa	4/1/2010	4/1/2013	90	90	102	91	116	91
Iron	8/1/2009	8/1/2012	73	73	90	75	102	75
Jackson	12/1/2008	12/1/2011	229	229	292	232	332	232
Jefferson	9/1/2008	9/1/2011	829	829	1,079	836	1,209	836
Juneau	7/1/2009	7/1/2012	190	190	244	195	282	195
Kenosha	2/1/2007	2/1/2009	1,119	1,119	1,119	1,119	1,119	1,119
Kewaunee	N/A	N/A	-	-	-	-	-	-
La Crosse	4/1/2000	4/1/2002	2,022	2,022	2,068	2,026	2,113	2,026
Lafayette	7/1/2009	7/1/2012	92	92	107	93	125	93
Langlade	1/1/2011	1/1/2014	167	167	172	167	191	167
Lincoln	4/1/2011	4/1/2014	206	206	220	208	234	208

County	Start Date	Entitlement Date Under Current Law	SFY 11 Current Law	SFY 11 Governor	SFY 12 Current Law	SFY 12 Governor	SFY 13 Current Law	SFY 13 Governor
Manitowoc	4/1/2010	4/1/2013	668	668	777	677	922	677
Marathon	11/1/2008	11/1/2011	1,154	1,154	1,479	1,165	1,687	1,165
Marinette	N/A	N/A	-	-	-	-	-	-
Marquette	7/1/2008	7/1/2011	171	171	199	174	218	174
Menominee	N/A	N/A	-	-	-	-	-	-
Milwaukee - Disabled	11/1/2009	11/1/2012	4,032	4,032	5,580	4,161	6,691	4,161
Milwaukee - Elderly	7/1/2000	7/1/2002	7,835	7,835	8,029	7,851	8,224	7,851
Monroe	1/1/2009	1/1/2012	391	391	593	395	678	395
Oconto	N/A	N/A	-	-	-	-	-	-
Oneida	N/A	N/A	-	-	-	-	-	-
Outagamie	4/1/2010	4/1/2013	796	796	947	809	1,147	809
Ozaukee	3/1/2008	3/1/2011	585	585	674	593	741	593
Pepin	3/1/2009	3/1/2012	87	87	112	88	130	88
Pierce	7/1/2008	7/1/2011	248	248	297	251	333	251
Polk	6/1/2009	6/1/2012	242	242	295	247	348	247
Portage	4/1/2000	4/1/2002	1,026	1,026	1,049	1,028	1,073	1,028
Price	8/1/2009	8/1/2012	181	181	198	182	235	182
Racine	1/1/2007	1/1/2009	1,183	1,183	1,206	1,185	1,230	1,185
Richland	1/1/2001	1/1/2003	416	416	425	416	434	416
Rock	N/A	N/A	-	-	-	-	-	-
Rusk	7/1/2009	7/1/2012	227	227	284	232	333	232
Sauk	9/1/2008	9/1/2011	520	520	622	525	710	525
Sawyer	8/1/2009	8/1/2012	174	174	217	178	265	178
Shawano	N/A	N/A	-	-	-	-	-	-
Sheboygan	2/1/2008	2/1/2011	913	913	1,051	926	1,156	926
St. Croix	9/1/2008	9/1/2011	481	481	679	486	752	486
Taylor	N/A	N/A	-	-	-	-	-	-
Trempealeau	2/1/2009	2/1/2012	321	321	364	324	420	324
Vernon	11/1/2008	11/1/2011	262	262	392	266	442	266
Vilas	N/A	N/A	-	-	-	-	-	-
Walworth	10/1/2009	10/1/2012	446	446	458	447	471	447
Washburn	6/1/2009	6/1/2012	249	249	296	253	343	253
Washington	4/1/2008	4/1/2011	872	872	1,003	884	1,100	884
Waukesha	7/1/2008	7/1/2011	1,879	1,879	2,221	1,907	2,470	1,907
Waupaca	7/1/2010	7/1/2013	301	301	307	302	313	302
Waushara	6/1/2008	6/1/2011	259	259	304	262	337	262
Winnebago	7/1/2010	7/1/2013	1,057	1,057	1,121	1,062	1,277	1,062
Wood	1/1/2009	1/1/2012	828	828	1,010	837	1,166	837
Total			41,854	41,854	47,590	42,245	52,141	42,245

ATTACHMENT 2

Family Care Funding Alternatives
Change to Bill

		2011-12				2012-13			
Alternative	Brief Description	GPR	FED	PR	Total	GPR	FED	PR	Total
1	Governor's Proposal -- Cap	$0	$0	$0	$0	$0	$0	$0	$0
2	Exempt "Entitlement Status" Counties from Enrollment Cap	6,029,600	9,197,400	0	15,227,000	20,195,400	30,595,200	0	50,790,600
3	Implement Cap in 2011-12 Only, Resume Enrollment in 2012-13	0	0	0	0	31,762,400	47,718,200	0	79,480,600
4	Delete Cap in All Counties. Extend Period Prior to Entitlement from 36 Months to 48 Months	15,040,100	22,916,100	0	37,956,200	57,886,000	87,061,200	0	144,947,200
5	Permit Expansion in 2011-12 Implement Cap in 2012-13	26,726,400	40,715,700	0	67,442,100	69,277,000	104,136,300		173,413,300
6	Delete Cap and Permit Expansion in Additional Counties in the 2011-13 Biennium	20,331,800	40,579,500	3,735,700	64,647,000	76,756,500	147,744,500	27,719,600	252,220,600

		2011-13 Biennium			
Alternative	Brief Description	GPR	FED	PR	Total
1	Governor's Proposal -- Cap	$0	$0	$0	$0
2	Exempt "Entitlement Status" Counties from Enrollment Cap	26,225,000	39,792,600	0	66,017,600
3	Implement Cap in 2011-12 Only, Resume Enrollment in 2012-13	31,762,400	47,718,200	0	79,480,600
4	Delete Cap in All Counties. Extend Period Prior to Entitlement from 36 Months to 48 Months	72,926,100	109,977,300	0	182,903,400
5	Permit Expansion in 2011-12 Implement Cap in 2012-13	96,003,400	144,852,000	0	240,855,400
6	Delete Cap and Permit Expansion in Additional Counties in the 2011-13 Biennium	97,088,300	188,324,000	31,455,300	316,867,600