# ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

OCTOBER 5-7, 2009 / LONG BEACH, CALIFORNIA

NATIONAL ACADEMY *for* STATE HEALTH POLICY

## Wisconsin's Family Care Partnership Program

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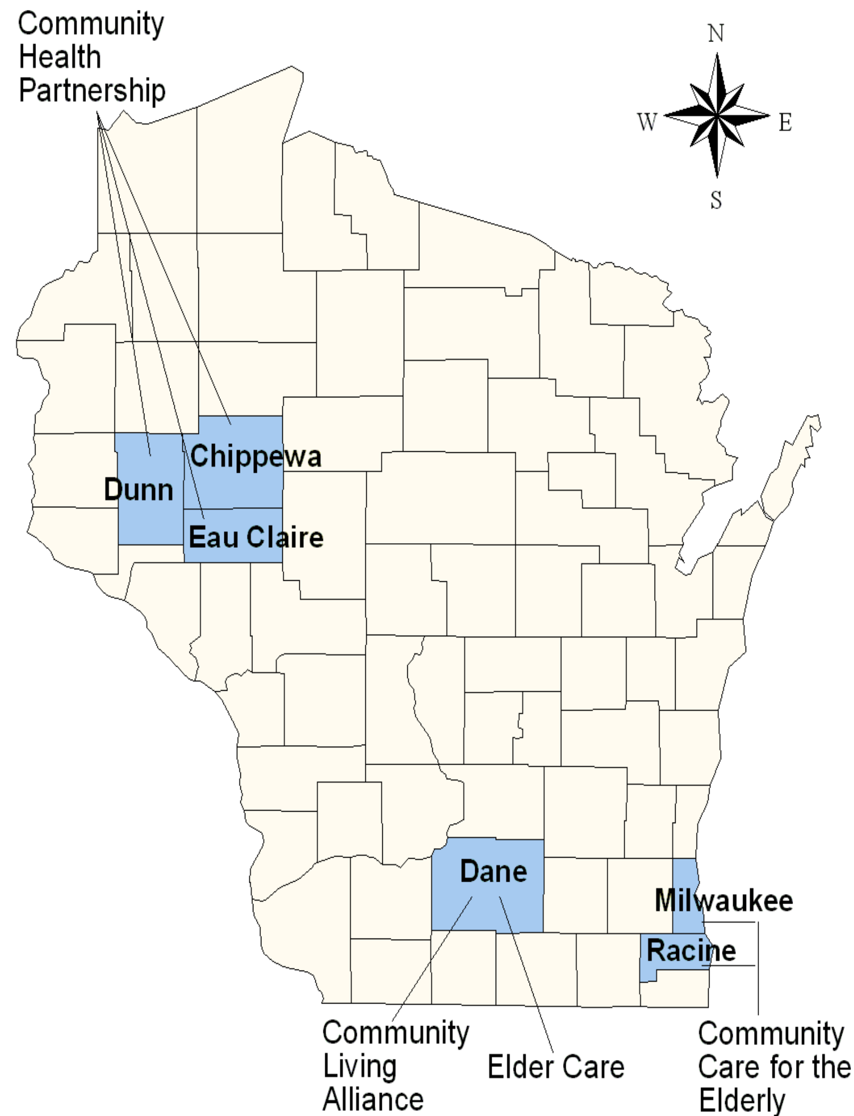
# WI Partnership Program

- Fully integrated Medicaid – Medicare health and long term care program
  - Evolution of the PACE model
  - Services delivered in physician office or home
  - Contracts with community physicians
- Risk based
- Care management model

# History

- Development funding from RWJ Grant
- 4 community-based non-profit organizations
- Began 1996-97
- Five Wisconsin counties

# Wisconsin Partnership Program Counties and Organizations



# Who benefits from Family Care?

- Target groups
  - Adults with physical and/or developmental disabilities
  - Elderly people
  - People with disabilities and people who are elderly who also have mental health, alcohol or drug abuse problems
- Nursing home level of care
  - Chronic medical conditions
  - Cognitive challenges
  - Decreased functioning and ability to live at home

# LTC Functional Screen

- Automated tool for assessing level of care
- Screeners, certified by DHS, verify and input:
  - Diagnoses / health conditions
  - ADL/IADL deficits
  - Behavioral challenges
  - Other risk factors
  - Current level of informal supports
- The screen determines Nursing home/ICF-MR level of care

http://dhs.wisconsin.gov/ltcare/FunctionalScreen

# Goals - Reduced Fragmentation

- Integrate funding streams to eliminate cost shifting, avoid unnecessary spending.
- Increase quality by coordinated care across providers, focused on the whole person.
- Focus on quality from the individual's perspective, not on each service or provider across an uncoordinated system.
- Program managers are responsible for quality across the whole system, not just individual parts of the system.

# Goals for People

- Foster independence and help keep the person at home or in the community for as long as possible
- Apply preventive healthcare measures, by anticipating problems and concerns in advance
- Provide direct assistance, advice, and respite for family and other caregivers
- Emphasize "Member's Choice" in planning his/her own care
- Promote "one-stop-shopping" for services
- Reduce costs by providing outpatient health care interventions
- Improve and maintain quality of life

# Benefit Package

| MA Waiver Services | MA LTC Card Services | Acute & Primary Medicare or MA |
| --- | --- | --- |
| Assisted Living | Home Health | MD Visits |
| Home Care | Nursing Home | Lab Tests |
| Home Mods | Med Transportation | Hospital |
| Day Services | Med Equipment | Therapy |
| Lifeline | | Rx (Part D) |

# Program Design

- Use of interdisciplinary teams to address health, LTC and social needs
  - Physician, Nurse Practitioner, RN, Social Worker, Personal Care Worker, Others
- Person-centered: identify and support consumer-defined outcomes
  - Clinical, functional and personal experience outcomes
- Risk – based, managed care approach

# Managing Risk

- If members' overall health and well being deteriorates, the cost of their care will increase
- The IDT works to:
  - Improve or maintain best possible health, including mental health, quality of life
  - Balance benefits and costs in the short and long term
  - Prevent high-cost NH and hospital stays

***Bad outcomes for members = bad $ outcomes for MCO***

***Good outcomes for members = good $ outcomes for MCO***

# Care Management

- One-stop approach helps members with chronic conditions and/or frailty maneuver through the complex health and long term care system, live independently and maintain their quality of life
- Holistic approach
- Care team coordinates all health, medical and long-term care services.
  - Many services provided in member’s home
  - Member no longer need to worry about getting to doctor, setting up appointments and dealing with confusing medical bills.

# Care Management

- Care team arranges care within the contracted provider network.
- Staff may attend appointments with members to relay important information about any changes in condition to all team members.
- Nurse Practitioner on care team can prescribe medications, perform general physical exams and help in communicating with doctors.

# Federal Authority

- Initially a demonstration waiver
  - 1115 waiver for Medicaid
  - 222 waiver for Medicare
- Currently (since 2007)
  - Medicare Special Needs Plan
  - Medicaid
    - 1915 c waiver for HCBS services
    - State Plan amendment for managed care

# Personal Experience Outcomes

- I decide with whom and where I live
- I make decisions about my supports and services
- I decide how I spend my day, including work if I want
- I have relationships with family & friends I care about
- I work or do other things that are important to me
- I am involved in my community
- My life is stable
- I am respected and treated fairly
- I have privacy
- I have the best possible health
- I feel safe
- I am free from abuse and neglect

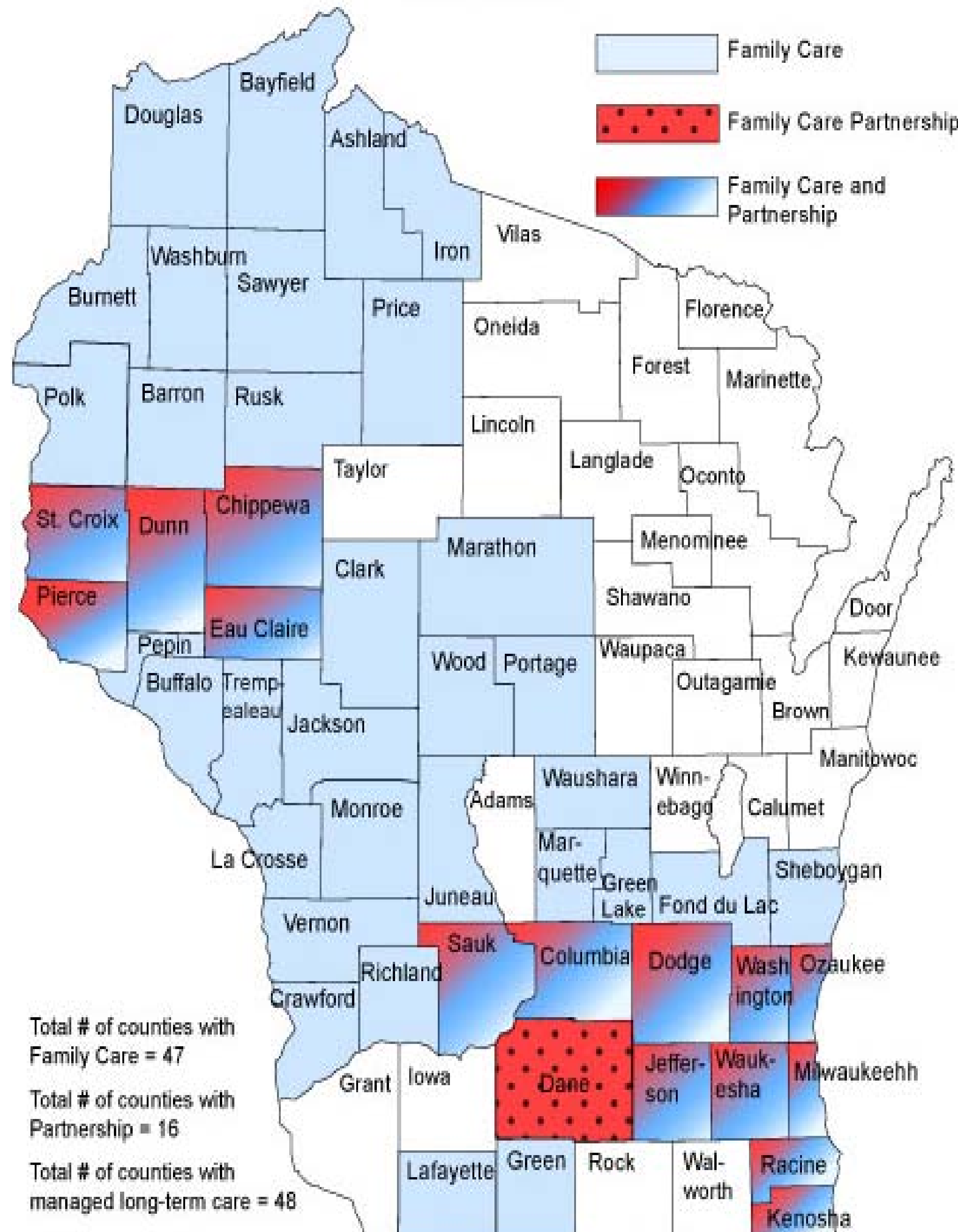
# Partnership Results

Results for both costs and members:

- Improved access to dental care
- Reduced hospital admissions, lengths of stays, and days
- Reduced long-term nursing home stays

# Family Care Partnership Service Areas

September 1, 2009



# Census on August 1, 2009

- Care Wisconsin First – 1,116
- Community Health Plan – 1,896
- Community Care
  - Partnership – 288
  - PACE - 907

# Challenges

- Elimination of frailty factor for Medicare Special Needs Plans
- Decreased funding to Medicare Advantage Plans generally
- Implications:
  - Sustainable Medicaid funding
  - Further work w/ CMS on Medicare funding

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