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March 22, 2011

Recommendations for Efficiencies and Improved Outcomes in Wisconsin's Medicaid Programs

The Survival Coalition of Wisconsin Disability Organizations is comprised of over 30 groups representing people with disabilities, their family members, advocates and providers of disability services. For over 20 years Survival has been at the forefront of promoting cost effective, community-based services and supports for people with disabilities. We have a strong track record of working collaboratively with the Department of Health Services, the Legislature and Governors of both parties on solutions that are in the best interest of individuals with disabilities and the State of Wisconsin. Given this history, our commitment to work with DHS on a new round of efficiencies in Medicaid is really a continuation of past efforts.

This paper identifies a variety of ideas that we believe can support the provision of the right service at the right time to each individual based on their needs and abilities to participate in their care. Some of these are more than ideas; they represent programmatic and policy approaches that have been piloted in Wisconsin or elsewhere and have clear evidence of achieving cost effectiveness. Others are promising ideas in need of further exploration. Finally, there are some items in this paper that represent cautions about proposals that are currently or may be under consideration by the Legislature that could actually increase costs to Medicaid or to the State overall.

It is worth noting that one of the most important things that DHS can do is to continue to support substantial and meaningful involvement of people with disabilities and family members throughout this process. Ensuring that services and supports respond to their needs and wishes will increase the likelihood of designing a system that will achieve positive outcomes.

This paper also identifies some of the specific investments that Survival members or collaborating partners have made or are willing to make to support development and implementation of these proposals. In addition, Survival is ready to identify individuals with the necessary experience and expertise to assist DHS in the development of any of these initiatives.

1. Cost-Efficiencies in Long Term Care

A. Increase Integrated Employment Services in Long Term Care

Incentivize and increase the proportion of spending in Family Care, Partnership and IRIS on employment services which focus on integrated employment experiences and reduce spending on

sheltered employment. Savings are realized as supported employment costs less than sheltered work on average, and will simultaneously improve outcomes regarding community integration and wages. (See Summary of Wisconsin's Vocational Service Costs in Long Term Care for savings estimates.) The 2010 report "An Evaluation of the Long-Term Service Costs and Vocational Outcomes of Supported and Center-Based Employees in Wisconsin" showed that for 171 matched pairs of individuals, those in Supported Employment averaged $300 per month in costs for this service while those in center-based employment averaged $458.82 over the same period. This is also an area where Wisconsin could develop pay-for-performance incentives for providers who provide integrated employment rather than sheltered work, or rate reductions for providers who do not.

B. Reduce Administrative Costs in Family Care, IRIS and Partnership

1) Conduct a comparison of Family Care/IRIS/Partnership vs. the COP and CIP programs regarding a) the proportion of total funding that is spent on direct services to the client/member, and b) the cost of the multiple MCO infrastructures which have been created vs. the cost of the former county LTC infrastructures.

2) Evaluate mandatory interdisciplinary team composition and the degree of disability expertise available in the team structure to identify potential cost efficiencies. For instance, not all teams would require a nurse or a social worker. Team composition should be based upon the needs of the member.

3) Consider the benefits of setting up uniform procedures for service authorization, claiming, and payment mechanisms in MCOs, either by having a third party manage these functions or by setting up a DHS office of long term care financing to manage processes.

4) Reduce spending on congregate care for Family Care members with mental illness by improving assessments and service plans and increasing the use of other proven service models which lower overall costs (e.g. CSP, CCS, crisis intervention services, certified peer specialists.)

C. Increase Utilization of Self-Directed Supports in Long Term Care (LTC)

Incentivize the expansion of Self-Directed Supports (SDS) in Family Care and IRIS. Self-directed supports hold promise for simultaneously improving outcomes and producing cost efficiencies; however, quality concerns around implementation of Wisconsin's current self-directed options continue to exist.

Various Survival Coalition members are willing to partner with DHS on this initiative and commit resources to improving the service quality and outcomes in self-directed programs. Examples of this include:

- Work and investment by the state's Independent Living Centers to provide training to consumers on self-direction;
- Partnership with Disability Rights Wisconsin's Family Care and IRIS Ombudsman Program to help DHS identify and address systemic concerns;
- New investments by the Board for People with Developmental Disabilities (BPDD) identified in their five year state plan to increase the numbers of LTC recipients who participate in SDS. One BPDD initiative for 2012 will be to develop pilots for youth in transition and their families, and in counties not yet enrolled in Family Care, to provide training and support in

choosing the SDS option. BPDD can conduct and evaluate a pilot program to train and support individuals and their families choosing SDS in a county in a targeted region of the state.

D. Implement the Recommendations of the Wisconsin Council on Children with Long-Term Support Needs to Streamline Services

Recommendations include streamlining and consolidating eligibility determination for the Katie Beckett, Family Support and Children's waivers using the CompassWisconsin Threshold model which has shown a significant reduction in duplication of services. The model is currently being used in Racine and Walworth Counties; other counties have expressed interest in participating.

E. Implement a Standardized Set of Performance and Outcome Indicators for LTC Services to Improve Outcomes and Generate Cost Efficiencies

No consistent method currently exists in Wisconsin to measure outcomes for individuals within our LTC programs, so resources are being allocated with very little measurement of efficacy or impact. Because of the critical need for comprehensive and reliable data and questions about the implementation feasibility of DHS' piloted PEONIES evaluation instrument, we recommend that DHS partner with the Wisconsin Disability Policy Partnership (which includes the Board for People with Developmental Disabilities, Disability Rights Wisconsin, and the Waisman Center) on the **National Core Indicators** (NCI) project to implement a nationally recognized set of performance and outcome measures for our LTC system.

NCI began in 1997 as a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) to develop a standard set of performance measures for states to manage quality. NCI is an evidence-based system that provides baseline data, measures impacts, and provides data-driven analysis and recommendations for improvement.

Partnering with NCI would align with Wisconsin's objective of increasing pay for performance outcomes; intensify the commitment to ensure that LTC services and supports are accountable to people with disabilities, their families, and taxpayers; and provide specific recommendations for targeted efficiencies and improvements based on data.

By partnering with NCI, Wisconsin would be provided with the tools and technical assistance to implement the core indicators, as well as data analysis, management and reporting. As a partner with DHS on this effort, the Wisconsin Disability Policy Partnership would commit to initial participation costs and could devote staff time toward gathering data.

F. Reduce the use of Institutions

- Close/downsize Southern Wisconsin Center
- Strengthen incentives for closing/downsizing county and private ICF/MRs

Potential savings are evidenced in the range of rates in institutional and community-based care. The average cost of care in an ICF-MR is approximately $198 per day; the care rate is $830 per day at Central Wisconsin Center; $634 per day at Southern Wisconsin Center; monthly capitation rates for MCOs in Family care range from approximately $100 per day.

In order to realize savings and move forward with downsizing in a way which addresses previous concerns, DHS must planfully redirect resources to the community as well as:

1) Establish guardian support networks which guarantee successful transition to the community;
2) Build community capacity;
3) Collect data on community outcomes and individual safety;
4) Address the need for training of MCOs and the IRIS program to understand how to transition individuals successfully. The Waisman Center, a Survival Coalition member, has demonstrated experience in supporting people with disabilities in transition to the community and could serve as a significant resource.

G. Strengthen Partnerships with the Department of Public Instruction (DPI) and Improve Accountability and Supports for Appropriate Transition Programs

Public schools are federally mandated (and funded) through the Individuals with Disabilities Education Act with preparing students with disabilities for adult life, including employment. Research has shown that early work experiences while still in high school are a strong predictor of post-school employment and independent living success, yet few schools provide these opportunities to students with disabilities. Transition programming in Wisconsin high schools is an area for significant improvement. DHS should partner with DPI to ensure all students with long-term support needs are receiving appropriate transition services with work experiences while in high school.

DHS should also play a lead role in ensuring that the new MOU between DHS, DPI and DVR maximizes employment outcomes for transition age youth.

2. Cost Efficiencies in Acute and Primary Care

A. Improve Integrated Care Coordination

DHS data shows that 12-15% of Family Care participants have fifteen or more diagnoses. Care coordination has been well documented as an effective strategy to identify the most appropriate resources to fit identified needs. Unlike many models of care management, those that manage health care benefits and costs, care coordination and integration focus on assisting individuals with disabilities to coordinate care in both the primary and long-term care realms with a focus on optimum health and quality of life outcomes. Evidence shows that well-designed and implemented care coordination can help persons with disabilities live independently longer, and with added years of quality life. According to the Center of Excellence in Research on Disability Services, Care Coordination and Integration, care coordination may be even more vital for certain populations, such as individuals with multiple chronic conditions and those with higher levels of disability (HHS 2010).

Efficacy and cost effectiveness should be measured in large part by outcomes such as improved quality of life, independence, or a slowed decline in functioning, that is, outcomes that must be assessed through participant experience data and are not included in administrative databases. Effective community-based services and supports are also dependent on the unique preferences, as well as the social, cultural, and functional circumstances of a person, in addition to strictly clinical criteria. Therefore, evaluating care coordination services must also take into account the highly variable nature of long-term care needs.

B. Take Advantage of Savings in Health Care Reform

1) The Kaiser Commission on Medicaid and the Uninsured estimates states will realize some Medicaid savings by taking advantage of select provisions in the Affordable Care Act. Wisconsin is one of a number of states that may be able to transition some higher-income individuals from Medicaid to coverage in the new exchanges. Wisconsin may be able to recoup a higher federal match for coverage of childless adults by taking advantage of the "expansion state match rate" which scales up to 90% by 2019 from the current Medicaid match rate. The Kaiser Commission reports that Wisconsin could count these individuals as "new eligibles" and realize a savings relative to the costs incurred to cover these populations in current programs.

2) Once Wisconsin establishes a simple, market-oriented exchange, DHS should immediately plan to move all BadgerCare Plus enrollees who are at or above 133% of the federal poverty line into the Wisconsin exchange. This will not only save (future) GPR, but increasing the number of participants in the exchange (without having any significant effect on adverse selection) will increase the exchange's capacity to lower costs for all its enrollees.

3) DHS should actively pursue federal funding through the Affordable Care Act to develop an RFP to pilot medical homes that would work with hospitals, pharmacies, physical therapists and occupational therapists, among others, to deliver comprehensive, coordinated, integrated care to Medicaid beneficiaries. Medicaid health homes will include comprehensive care management; care coordination and health promotion; comprehensive transitional care; referral to community and support services; and the use of health information technology to link services.

C. Explore Arrangements with Federally Qualified Health Centers (FQHCs)

The Survival Coalition believes FQHCs can play a role in providing quality, cost-effective health care to individuals, but we would like to support FQHCs in improving how people with disabilities are served in these settings. Specifically, DHS should:

1) Explore Sole Source Contracts

Potential savings can be realized by making changes to the way the entire BadgerCare Plus population is served. Suggestion: in Milwaukee and many regions of the state, enter into long-term (e.g., 5 year) contracts with Federally Qualified Health Centers (FQHCs) to serve the region's BadgerCare Plus population at 90% (or a smaller percent if possible) of the lowest capitation rate currently negotiated with HMOs from the region. Adjust payment after Year 1 only for CPI.

The FQHCs could be required to: provide (or create, if need be) multiple clinics conveniently distributed throughout their service areas; to offer BadgerCare Plus enrollees a wide choice of primary care providers; and guarantee high minimum percentages of pre-natal visits, well-baby visits, immunizations, SBIRT procedures, etc., but also dental check-ups, including application of coatings and sealants. FQHCs should also provide access to key specialists including dental, mental health care, and neurology. Enrollees could be permitted to choose one of the current HMOs if the HMO agreed to charge the same risk-adjusted per-person rate as the FQHC.

2) Explore Care Management to People with Complex Needs

There is potential for FQHCs to do care management for people with complex needs. Survival Coalition could identify appropriate members who can serve as resources to increase the capacity of FQHCs to adequately serve individuals with disabilities.

D. Study Cost-Benefits of Referring Wisconsin Veterans to Federally-Funded VA Benefits
The Survival Coalition agrees that veterans are entitled to high quality, appropriate health care services. Prior studies have found that anywhere from 2/3 to 3/4 of veterans were eligible for, but did not use Veteran Administration services. While there may be many reasons for this, including inaccessible or inadequate care, we simply do not know what they are. Under federal law all honorably- and generally-discharged veterans with a certain level of active service and income level are eligible for drugs and other VA medical care at a cost of only $8 per prescription. Those with incomes under about 110% FPL have no co-pays. An estimated 40% of men over age 65 are eligible for this benefit. Again, it is unclear how Wisconsin veterans are informed about or are maximizing these benefits which could reduce state-funded payment for this population. Wisconsin should study the risks and benefits of encouraging medical and pharmacy assistance eligibles who are veterans to access VA health care.

E. Explore Expanded Access to Private Insurance Benefits
Wisconsin should consider the potential for savings by additional inquiry of Medicaid recipients about their ability to access dependent coverage in employer health plans. In keeping with the provision that Medicaid is the payer of last resort, DHS should take steps to ensure that all available private insurance resources are utilized. Two strategies to address this issue include:

1) Subsidizing premiums (which are often cost prohibitive and the reason why coverage is not sought) for private coverage which is currently not utilized in the plans available through a working spouse, domestic partner or parent of a Medicaid recipient who has a disability. Examples of successful efforts in Iowa are summarized under "Premium support" at www.IHPS.org ; information about Pennsylvania's effective program is at http://statecoverage.net/pennsylvaniaprofile.htm and other information on *Purchasing Private Health Insurance Through Government Health Care Programs* is also at www.IHPS.org;

2) Penalizing employers who have disproportionate numbers of employees who utilize Medicaid as their primary health care coverage.

F. Explore the Capacity of Private Health Plans to Continue Coverage Past Childhood
An informal survey by the Blue Cross Association estimated that about 50% of private employer plans may have little-known clauses which enable adult children of employees to remain as covered dependents of the employer if the family can demonstrate the onset of a medical impairment during childhood. Again, as stated above, DHS should ensure that Medicaid is the payer of last resort.

G. Improve Continuity of Care and Access to Eligible Benefits for Released Inmates
Coordinate with the Department of Corrections (DOC) to require that, once DOC knows an inmate will be released from prison, the inmate's eligibility for all publicly funded benefits and BadgerCare Plus is determined well in advance of release; a primary care physician is chosen and medical treatment information is shared; and the inmate is enrolled in the program on the first day of his or her release. This will improve continuity of care (especially for treatment of addiction and mental illness), lower health care costs, and reduce recidivism.

H. Explore Strategies to Keep Medicaid Recipients from Going on and Off the Program
Examine successful strategies to prevent and reduce the rate at which individuals come on and off the Medicaid program and any correlated savings associated with supporting recipients who regularly cycle back through eligibility. Maintaining eligibility for truly qualifying individuals will reduce emergency room visits and uncompensated care as well as help persons with chronic disease manage their care so they do not become sicker during unnecessary gaps in eligibility.

I. Improve the Prior Authorization Process
1) Medicaid Prior Authorization (PA) has been used rigorously to assess the appropriateness of services for children with disabilities. A previous legislative audit of PA found that PA was used disproportionally with children and is characterized by frequent review, short approval times, and frequent requests for additional information leading to long delays, interruption in services and unwillingness of providers to participate in Medicaid. That audit also showed that 97% of requests that needed prior authorization were eventually approved. Without early intervention it seems costs would increase as children become older and conditions may worsen without appropriate therapies, requiring more and longer treatments. Once medical necessity for a requested service has been met and a PA approved, only an annual review is necessary, eliminating repeated reviews for the same service, as well as administrative costs and time.

2) There have been corresponding concerns about how PA is used for outpatient mental health services. The PA form is currently trying to serve many purposes, which has made it burdensome for providers to complete. There may be duplication in DHS efforts to assess quality of care through the Medicaid PA process and the Division of Quality Assurance certification process. In addition, mental health providers experience some of the same concerns as those noted above, with the need for resubmission more frequently than might be required to ensure appropriateness of care. Providers, consumers and advocates are working with Medicaid staff to explore this further with the goal of recommending changes. We encourage DHS to accelerate this process. The current process discourages providers from serving Medicaid recipients. Reduced access to appropriate outpatient services can increase Medicaid costs if more costly emergency department and inpatient services are used.

J. Allow Direct Purchase of Durable Medical Supplies and Equipment (DMS/DME)
Many times purchasing DMS/DME through Medicaid is characterized by excessive administrative overhead, delays in obtaining equipment or supplies and high costs. Examples include over the counter medication, off the shelf splints or mobility equipment and incontinent supplies. Medicaid recipients should be allowed to purchase some DME and DMS supplies from local providers or through the internet when these items can be purchased less expensively than through a certified Medicaid provider.

K. Re-Examine the Medicaid Hotline
Many consumers have reported on the lack of assistance, poor customer service, and inaccurate information received through the Medicaid Hotline. This service should be improved.

L. Keep the Door Open for Consideration of Provider Assessments
We believe some providers are open to this idea; assessments can be part of a balanced approach in dealing with the Medicaid deficit. A 2% all-provider assessment is estimated to generate $1.3 billion on an annual basis for the Medicaid program. There has not been adequate discussion with providers about this issue.

3. Cost Efficiencies in Community-Based Mental Health Services

There are a wide variety of opportunities to utilize emerging approaches to recovery-oriented mental health services to achieve efficiencies in mental health services. While some of these will produce short-term savings to Medicaid, others may actually increase Medicaid costs but reduce overall State GPR and county spending. Because counties play such a critical role in the provision of mental health services and pay the state match for many Medicaid mental health services, savings to counties must be considered as equivalent to savings to the State.

A. Provide Alternatives to Existing Inpatient and Emergency Department Services

1) Experience with the Milwaukee Crisis Resource Center (CRC) which is a recovery oriented alternative to the emergency room and hospitalization shows tangible savings. In 2010, there were 340 individual admissions to the CRC and 54% were diverted from a hospital ER or inpatient hospitalization; an additional 22% were a step-down from inpatient hospitalizations. Milwaukee County and advocates are supportive of opening a second CRC on the north side of Milwaukee, which could provide significant additional diversion, but Medicaid reimbursement issues are currently a barrier to moving forward.

The CRC model has proven far more cost-efficient when compared to emergency room and hospitalization:

- CRC: $425 per day
- WI Average Psychiatric Inpatient: $1,424 per day (Wisconsin Hospital Association)
- WI Average ER Visit: $950 per day

DHS should consider:

- Increasing the Medicaid rate for the crisis stabilization per diem code S9485 to a level capable of sustaining residential care in an environment that is less restrictive and less costly than inpatient care and inappropriate emergency room care;
- Identify a new Medicaid code for acute residential care that would allow the T19 HMOs to include clients served under this code in the T19 HMO contract encounter data.

2) Consumer run respite centers are safe houses where people learn new skills for managing emotional crises. They reduce the stigma associated with involuntary treatment. A California study showed significantly greater improvement and dramatically higher satisfaction with a peer-run residential program than with a locked psychiatric ward. Peer-run respite costs about $250/day. Wisconsin should pilot this model as a way of gathering additional data on its cost effectiveness and understanding the barriers to implementing it more broadly in Wisconsin.

3) The State is waiting for approval of a change to our BadgerCare Core plan waiver to include other mental health services provided by non-psychiatrist providers (e.g. psychologists, psychiatric nurse practitioners, clinical social workers). DHS should continue to pursue implementation of this change to ensure cost-effective and timely care, beyond expensive and often limited psychiatrist visits. DHS should also hold HMOs accountable for having a sufficient provider network, in particular in the areas of mental and dental health and neurology.

B. Increase the use of Certified Peer Specialists
Peer specialists are people with mental illnesses who use their personal recovery experience as a unique tool to aid others. They can be used anywhere other mental health professionals are used. They facilitate self-direction and goal-setting, assist in identifying resources for consumers and both present and model recovery concepts. A study of 25 New York consumers found that those randomly assigned to inpatient peer support had costs averaging $4,831 less per year for their set of services than those receiving standard care. The PeerLINK Project in Wisconsin found a 46% reduction in hospitalizations when certified peer specialists worked with people who had a history of inpatient hospitalization. In order to promote use of certified peer specialists DHS should fund additional training to support people in their effort to become certified. This skill development is critical in order to ensure that peer specialists realize their full potential within the human service system.

C. Increase the use of Wraparound Services for Youth and Parent Peer Specialists
Wraparound services, also known as coordinated service teams or integrated service projects ensure coordination of services through multiple systems (e.g. mental health, child welfare, juvenile justice, schools) for youth who have serious emotional disturbances and their families.

National data from the Federal Substance Abuse and Mental Health Administration (SAMHSA) found that after 18 months in systems of care programs, the percentage of youth who used inpatient facilities decreased 54%, school attendance increased 54%, and school achievement (grade C or better) improved 21%. Emotional and behavioral problems were reduced significantly or remained stable and did not worsen for nearly 90% of children. Locally, Manitowoc County reduced use of out-of-home placement from 16 youths in 2001 at a cost of just under $1,000,000 to 2 youths at a cost of about $75,000 in 2006 through implementation of wraparound.

Use of parent peer specialists, similar to use of peer support for adults with mental illnesses, assists families in identifying and utilizing existing resources and provides support from someone who has “been there.”

D. Expand Consumer Run Recovery Centers
DHS should expand the number of funded Consumer Run Recovery Centers as an alternative to traditional mental health services and a form of prevention through the provision of peer support. Currently only 12 centers exist in Wisconsin. Last year they:

- Provided 2,390 mental health consumers/survivors direct Peer Support services
- Provided Peer Support through non-crisis telephone calls (warmline) to 8,444 callers
- Provided 24,803 hours of direct Peer Support services to consumers/survivors throughout Wisconsin
- Utilized 375 consumer/survivor volunteers, who volunteered 26,549 hours

E. Implement County System Changes
In 2009 and 2010 DHS, in collaboration with a wide range of stakeholders, conducted a study of the public mental health system and made a number of recommendations on potential changes to enhance overall access to quality, recovery-oriented care and to reduce geographical disparities in services that can contribute to increased costs by a lack of access to community-based care when needed. The Division of Mental Health and Substance Abuse Services is prepared to issue Request for Proposals to pilot some of these ideas. They include:

- Changes to statutes or rules to enhance the ability of counties to share service delivery with other counties. Small counties currently cannot achieve adequate economies of scale to provide a wide range of services for people with mental illnesses. But if counties could more effectively and efficiently work together they could make these services available regionally. Over the past few years many counties have been developing these types of relationships through regional crisis grants. This experience will form the foundation for development of additional sharing.
- Because of the degree to which counties fund mental health services, the local investment of property tax levy—which funds about 35% of public mental health services overall---can vary greatly from one county to the next. This means that the services available can differ. DHS and stakeholders identified a potential set of core services that should be available in every county.
- People with serious mental illness die an average of 25 years younger than the general population. There are a variety of reasons, but if individuals could be provided better access to health care some of this disparity could be reduced. There are models for better integration of mental health and primary care that have been developed in other states that are very promising. A number or counties have proposed partnering with Federally Qualified Health Centers to achieve this. We encourage DHS to try out these models in Wisconsin.

4. Cautionary Proposals Which May Increase Medicaid Costs

A. Oppose any Reduction of Important Private Insurance Mandates (e.g. mental health parity; autism services, hearing aid and cochlear implant coverage)

By taking healthy people out of the risk pool for any of these mandates (as proposed in two recent legislative initiatives - LRB-0373 and LRB-1529), the cost of insurance which includes cost-effective coverage like community mental health services, hearing supports and autism services for children, will become too high and unaffordable. Eventually private insurance coverage for many services will be eliminated and people in need of these services will require public supports. Changes to the insurance mandate related to intensive autism services for children though private insurance plans will result in an increase in use of the Medicaid waivers to cover this cost shifting.

B. Reconsider the Proposal in the Governor's Budget to Eliminate Certain Earned Release Provisions in the Prison System

The care for Wisconsin prisoners with disabilities who also have terminal illness or other costly conditions can be shifted and savings realized through certain earned release provisions which are now proposed to be eliminated in the Governor's budget. Wisconsin should analyze the cost-benefits of maintaining certain previously successful release provisions for state prison inmates with terminal illnesses, serious physical disabilities, advanced geriatric conditions and kidney failure which result in shifting cost from 100% state funding to full Medicare or federally matched Medicaid funding. Nationwide estimates put state correctional health costs at $3.7 billion with a substantial portion of such costs going to the care of inmates with serious and incapacitating conditions.

C. Consider the Unintended Costs of Freezing Family Care

Counties are already estimating how an indefinite freeze on Family Care will affect their budgets and their ability to adequately serve people. In Outagamie County officials estimate that without the ability to enroll clients in Family Care, the county will be required to place individuals in nursing homes and could face additional uncovered costs of up to $1 million per year – drawn entirely from the tax levy. In Milwaukee County, they expect to be forced to start a waiting list for older people for the first time since 2002 and estimate they will now be adding a total of 262 people, including individuals with disabilities, to the list every month.