Wisconsin Partnership Program Fact Sheet

The State of Wisconsin submitted an application to the Centers for Medicare and Medicaid Services (then HCFA) in February 1996 for Medicare 402/222 and Medicaid 1115 demonstration waivers to establish a "Partnership" model of care for dually-entitled nursing home-certifiable beneficiaries who are either elderly or under age 65 with physical disabilities. Waivers were approved for this demonstration on October 16, 1998 and all four sites called for in the demonstration - Elder Care and Community Living Alliance (CLA) in Madison, Community Care for the Elderly (CCE) in Milwaukee, and Community Health Partnership (CHP) in Eau Claire - became operational between 1/1/99 and 5/1/99. A total of 1616 beneficiaries were enrolled as of 1/31/04. In Milwaukee, the Partnership site is co-located with a pre-existing PACE (Program of All-inclusive Care for the Elderly) site and serves an elderly population. ElderCare, also serves only elderly participants. CLA serves only people under 65 with disabilities, and CHP serves both populations. The CLA and CHP were the first plans in the nation to provide fully capitated Medicare and Medicaid services for people with physical disabilities. Roughly a quarter of Partnership enrollees are persons with disabilities and about 85% of the total enrollment is dually eligible. The proportion of dual eligibles varies from 60% among persons with disabilities to 95% among the elderly.

The Partnership model is similar to the PACE model in the use of multidisciplinary care teams, combined Medicare and Medicaid capitation payments, and sponsorship by community-based service providers. The programs differ in two important ways. The Partnership treatment team consists of a community-based primary care physician (PCP) plus a nurse practitioner, nurse and social worker that are employed by the health plan. The plan-based team members provide in-home services and facilitate continuity and coordination of care with the PCP and other health providers. The Partnership team is smaller than the PACE team since it does not include occupational, physical, or speech therapists. Partnership plans also do not require direct participation of primary care physicians in team meetings as does PACE. In the Partnership model, the nurse practitioner has primary responsibility for coordinating the activities of the plan-based team with those of the community-based physician. A second important difference between the two programs is that PACE sites have traditionally established day treatment programs where participants receive their primary care along with a variety of therapies and supportive services.

While most participants in the Partnership program are able to chose their PCP, there is not complete freedom of choice because plans must place some limits on the number of participating physicians in order to maintain efficient communication and coordination between the plan-based team members and the community-based physicians. Plans have also found that physicians are more likely to "buy into" the Partnership model when more of their patients are program participants.

An independent contractor is conducting a formal evaluation of the Partnership Program. The contractor has completed a survey in which the satisfaction of Partnership members with their care is compared to satisfaction of participants in both PACE and regular HCBS waiver program. The preliminary results indicate few differences among the three programs. An analysis of expenditures, utilization, and quality is scheduled for delivery in March, 2004.

More information on the Wisconsin Partnership Program is available on the Internet at:
http://www.dhfs.state.wi.us/WIpartnership/

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