2003 Joint Committee on Audit

Family Care

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4/24/03

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Sen Mueller
Called

Carol Roessler
STATE SENATOR • 18TH SENATE DISTRICT

703-269-5560

Bob Atlas Pres Lewin Group
Report on Family Care
everyone knows is good
fulfill promise
~~be there~~
~~midday~~
~~tomorrow!~~
at desk 30 mins
(Conner

OFFICE: State Capitol, P.O. Box 7882, Madison, WI 53707-7882
PHONE: 608-266-5300 **FAX:** 608-266-0423 **TOLL-FREE:** 1-888-736-8720
HOME: 1506 Jackson Street, Oshkosh, WI 54901

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

22 E. MIFFLIN ST., STE. 500
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

May 1, 2003

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

As required by 1999 Wisconsin Act 9, the Legislative Audit Bureau contracted with The Lewin Group, Inc., to conduct an evaluation of the Family Care Pilot program. The program is a restructuring of Wisconsin's long-term care system for the elderly, the physically disabled, and the developmentally disabled. This draft report is the fourth in a series prepared under the terms of the contract. The first three Lewin reports, issued in 2000, 2001, and 2002, focused on state and county-level implementation of the statutory provisions of the program, including the operation of Resource Centers (which operate in nine counties) and Care Management Organizations (which operate in five of the counties with Resource Centers). This draft report examines the early outcomes and cost-effectiveness of the program.

To ensure the Legislature's timely consideration of this report as the Joint Committee on Finance deliberates the 2003-05 biennial budget, we are adopting a report release schedule that varies from our standard protocol. The first three reports were reviewed by the Department of Health and Family Services before release, as is typical of our standard audit process. The Lewin Group did not, however, complete its final report within the time frame required by our contract. As a result, this draft report has not been fully reviewed by this office or the Department of Health and Family Services. We intend to work with the Department and the contractor and expect to release the final Lewin report within the next several weeks, following the Department's review and discussion of this draft. The findings in this draft report are subject to change depending on the outcome of the exit process.

We note that the data that were analyzed reflect activity in the Family Care program for the period December 2000 through June 2001. This time period was selected to ensure that at least 90 percent of claims for the most critical services provided under Family Care had been recognized in the Department's data systems, thereby allowing a more complete identification of the costs. During this time period, the counties of Fond du Lac, La Crosse, Portage, and Milwaukee were operating both Resource Centers and Care Management Organizations; the later start date for the Richland County Care Management Organization precluded its inclusion in this study.

A summary of the key findings developed by The Lewin Group in the draft report is enclosed.

I hope you find this information useful. Please contact me with your questions.

Sincerely,

Janice Mueller
State Auditor

JM/KW/bm

cc: Members, Joint Committee on Audit
Members, Joint Committee on Finance

Enclosure

FAMILY CARE PILOT PROGRAM

Family Care was created in 1999 Wisconsin Act 9 as a redesign of the State's long-term care system. The program, which is administered by the Department of Health and Family Services, is currently operating as a pilot program in nine counties. Its goals include eliminating problems related to long-term care, such as a perceived bias toward institutional care, and streamlining a fragmented array of funding streams for services. The Family Care model creates two new community organizations: Resource Centers to provide "one-stop shopping" for information and assistance for the elderly and the physically and developmentally disabled, and Care Management Organizations (CMOs) to help arrange and manage services for those determined eligible for program services. The program also uses managed care principles, including capitated payments, in an effort to help control costs.

In fiscal year 2001-02, payments to CMOs totaled $100.2 million and the cost of operating the Resource Centers totaled $4.8 million; Family Care enrollment in August 2002 was 6,500. Services covered by the Family Care capitated payment include residential services, personal care, home health and therapy services, adult day care, and supportive employment services; hospital care and physician care are not provided in the Family Care benefit, but are received on a fee-for-service basis under Medicaid. The capitated payments that are made to the CMO for each participant reflect actual expenditures and vary by county. For the most recent period in the Lewin analysis, monthly capitation payments ranged from $1,610 in Milwaukee County to $2,407 in Portage County; the average across the four counties in the analysis was $1,885.

Access to Services

Wait lists were eliminated in the five CMO counties by the end of 2002. The report notes that the wait lists in the remainder of the state continued to grow. The CMO counties first enrolled Community Options Program (COP) and other waiver program participants, then enrolled individuals on the wait lists for those programs.

The level of Resource Center information and outreach services in the counties can be measured in terms of contacts per 1,000 county population. From 2001 to 2002, the average number of monthly contacts increased for all nine Resource Centers. With the exception of Portage County, which has more than twice the contact rate of any of the counties, the Resource Centers in all five CMO counties experienced growth in contacts for information and assistance.

Enrollment in Family Care's five CMOs exceeded budgeted levels by 12 percent in December 2002, and the demographics for program participants changed between December 2000 and December 2002, showing slight percentage increases in enrollees who were elderly, and in younger individuals with physical disabilities. As the CMOs direct their outreach efforts to nursing facilities, and as the general population ages, Lewin suggests that the elderly may constitute an even larger proportion of Family Care enrollment than the 76 percent in December 2002.

Lewin examined how the use of and expenditures for services changed with the implementation of Family Care in the CMO counties, as well as how service use and expenditures changed in the remainder of the state, where COP and the other waiver programs serving the target populations continued to operate. In the CMO counties, average monthly expenditures per person increased from $2,002 to $2,510, or 25.0 percent. In the remainder of the state, expenditures increased

from $2,160 to $2,396, or 11.0 percent. Of the three services for which average monthly expenditures are highest statewide—personal care, residential services, and drugs—only expenditures for drugs increased at a slower rate in the CMO counties than in the remainder of the state: the increase was 10.6 percent in the CMO counties, compared to 16.9 percent elsewhere.

Quality of Life and Quality of Care

The Department has developed an interview tool to assess program participants' perceptions of the program. The Department has conducted interviews with care managers and randomly selected Family Care program participants, and with participants in other waiver programs, addressing quality of life issues affected by the programs. In a comparison of the interview results from Family Care with those from the other waiver programs, Lewin notes that the Family Care results are higher than those for the other waiver programs in three broad areas:

- choice and self-determination, including fairness, privacy, choice in one's daily routine, and satisfaction with services;
- community integration, including choosing where and with whom to live, participating in the life of the community, and remaining connected to informal support networks; and
- health and safety, including freedom from abuse and neglect, attainment of the best possible health, and continuity and security in one's life.

Lewin also compared the incidence of five traditional indicators of quality of care for CMO enrollees with the incidence of those indicators in the remainder of the state. There was no significant difference between the two groups in the use of hospitals or emergency rooms, the diagnosis of decubitis ulcers, or the incidence of death. However, Family Care enrollees entered nursing facilities at about one-half the rate of individuals in the remainder of the state.

Expenditures

Lewin compared spending levels before and during the Family Care pilot program period in the Family Care counties, in a matched "comparison" county for each Family Care county, and in the remainder of the state. It found increases in all three areas, but total spending increased more in the CMO counties than in their comparison counties. For example, in Portage County, total spending for Family Care enrollees increased 19 percent, compared to 16 percent in Pierce County. Expenditures in La Crosse County increased 31 percent, compared to 24 percent in Manitowoc County. However, Lewin notes that the difference in the rates of increase is statistically significant only when the expenditure increase for all CMO members is compared with the expenditure increase for the remainder of the state.

Lewin also used capitated payments to the CMOs as a measure of the cost of Family Care and examined the difference between pre-Family Care expenditures and the capitated payments. Spending increases were significantly smaller for individuals who moved from a waiver program to Family Care than for individuals in comparison counties or the remainder of the state who

received traditional waiver services. It should be noted, however, that the capitated payments were less than total spending in three of the CMO counties. For example, while total average monthly spending in La Crosse County was $2,412 under Family Care, the capitated payment to La Crosse was $1,744. The average monthly capitation to the five CMOs was $1,885, while Lewin identified $2,510 in average monthly expenditures.

In developing its comparison of expenditures under Family Care to expenditures associated with care in nursing facilities, Lewin noted a number of caveats. In particular, more data on the costs of services provided to each enrollee are available for Family Care participants than for individuals in nursing facilities, and data on the functional status of individuals are collected using a different methodology in Family Care—the functional screen—than in a nursing facility. Lewin, however, selected comparable functional measures for the Family Care participants and nursing facility residents and used the Medicaid per diem payment for nursing facilities to calculate a monthly payment for nursing facility care.

Lewin also adjusted the nursing facility Medicaid per diem payment to reflect the average number of days that an individual receives services in a nursing home and the Medicaid spend-down provisions that result in nursing facility residents paying for a portion of their care. When this adjusted per diem rate was compared with the monthly capitation rate under Family Care, Lewin found the nursing facility payment was 2 percent higher than the CMO capitation. The average Medicaid per diem payment in the nursing facility was $1,929, and the CMO capitated payment was $1,885 for the period Lewin reviewed.

These findings are contained in a draft report from The Lewin Group dated May 1, 2003. The Legislative Audit Bureau intends to work with the Department and Lewin to review and discuss the draft. The findings in this report are subject to change depending on the outcome of that exit process. We expect to release the final Lewin report in the next several weeks.

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Wisconsin Family Care Outcome and Cost-Effectiveness Report

DRAFT REPORT

Prepared for:

Wisconsin Legislative Audit Bureau

Prepared by:

The Lewin Group

Lisa Maria B. Alecxih
BrieAnne Olearczyk

May 1, 2003

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PART ONE:
INTRODUCTION

I. PROGRAM OVERVIEW

Family Care is an innovative experiment designed to improve Wisconsin's long-term care system. The redesign is being watched closely both within Wisconsin and across the nation. Though viewed as having a model long-term care system prior to the institution of Family Care, the state wished to further address a structural bias towards institutional care and a fragmented and often confusing array of funding streams for services. Family Care creates two new community organizations a Resource Center (RC) to provide one-stop shopping for information and assistance in obtaining services, and a Care Management Organization (CMO) to help arrange and manage services. It also introduces managed care principles in an attempt to control escalating costs.

The Governor and Legislature authorized the Department of Health and Family Services (DHFS) in 1998 to pilot the Family Care Program in a limited number of counties. Fond du Lac, Portage, La Crosse and Milwaukee Counties (age 60 and over) began operating RCs in 1998 and implementing Family Care CMOs during CY 2000, while Richland began its CMO in 2001. Jackson, Kenosha, Marathon and Trempealeau are currently piloting the RCs. The goals of Family Care include:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

If the program achieves its goals, the new long-term care system will provide elderly and adult individuals with physical or developmental disabilities with greater access to flexible services that promote independence and facilitate a higher quality of life.

II. OVERVIEW OF THE EVALUATION

This is the second to the last report in The Lewin Group's evaluation of Family Care. This evaluation involved three distinct parts: 1) an **implementation process** evaluation, which focused on documenting how the Family Care Program was implemented in the five full model pilot counties; 2) an **outcome analysis** that assesses the system and individual level outcomes of Family Care; and 3) a **cost-effectiveness study** that serves the interests of the State and may provide an initial basis for the Center for Medicare and Medicaid Services' (CMS) independent review requirements.

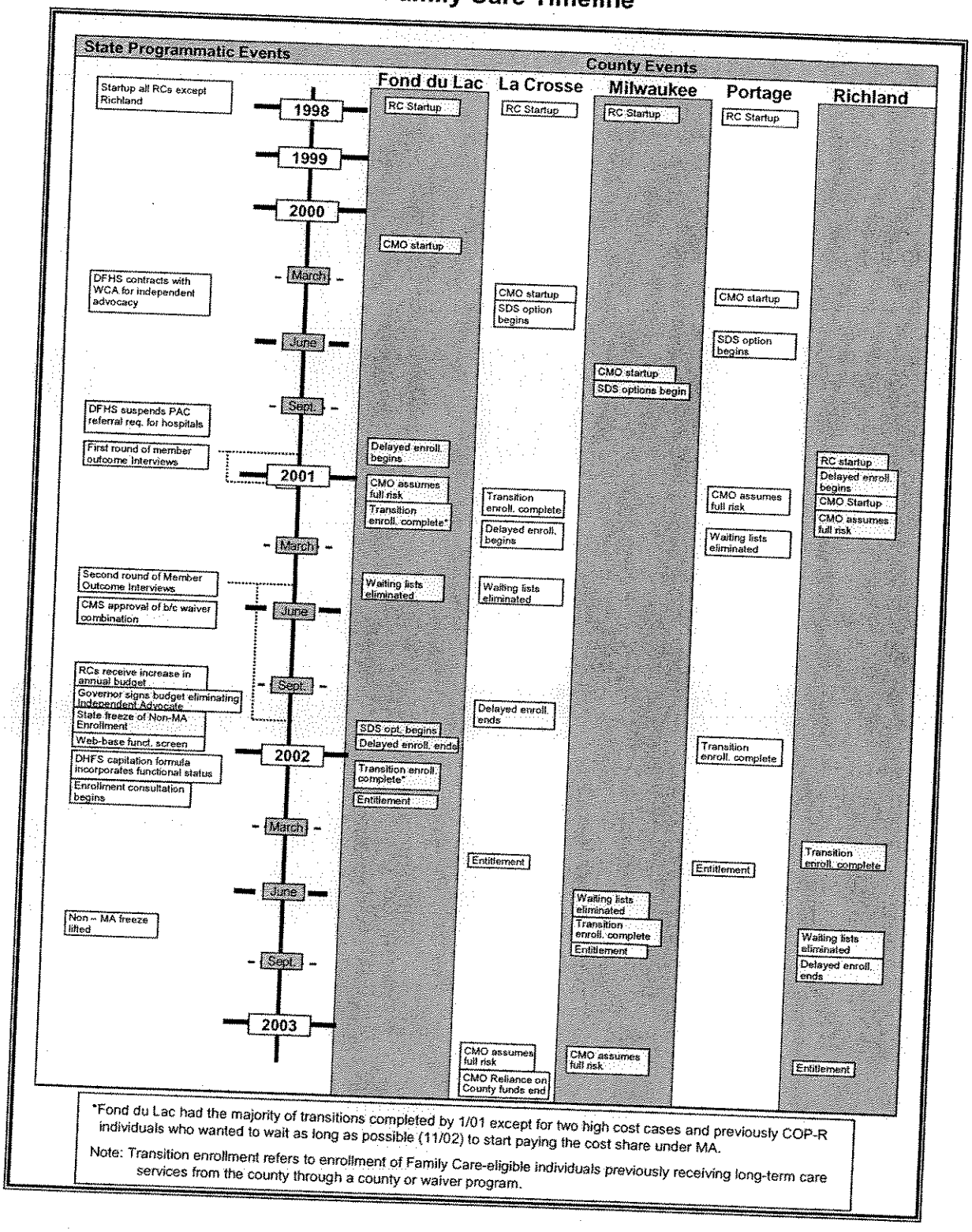
Lewin Evaluation Reports
Implementation Evaluation Process Update Report I -November 2000
Implementation Evaluation Process Update Report II - August 2001
Implementation Evaluation Process Update Report III - December 2002
Outcomes and Cost-Effectiveness Evaluation Report
Combined Implementation Process, Outcomes and Cost-Effectiveness Evaluation Report – May 2003

This report constitutes the *Outcome and Cost-Effectiveness Evaluation Report*. The information in this report provides some preliminary indications of the results of the Family Care program. It is important to note that the data available for the pre- post- comparison for this report generally reflect only the first year of the program's implementation, and as a result does not capture the ultimate impact of the program. ***Exhibit II-1*** indicates that several milestones have occurred following the primary period of analysis for this report, including full entitlement. In addition, our prior implementation reports indicated that the CMOs were focused on start-up issues and were not yet able to fully realize the potential advantages of the new care management structures and other aspects of the program during this period. Impacts of the program would not be expected to be realized until three to four years following start-up, and the data for an analysis of this timeframe would be available four to five years after start-up, or 2004-05. In addition, ultimate impacts, particularly on nursing home use, may not be realized for some time to come. The final report in May 2003 will provide an update on implementation progress.

A. Phase I

The primary activity during Phase I of the evaluation was to monitor and assess the process of implementation of the Family Care Program in the five counties that implemented both components of the Family Care model – Resource Centers (RCs) and Care Management Organizations (CMOs). The process evaluation of implementation examined program organization, service delivery, context, and other key data elements to assess the effectiveness of implementation and identify lessons that can assist in replicating the program in other parts of Wisconsin, as well as in other states. The process evaluation also provides contextual basis for this report.

Exhibit II-1
Family Care Timeline



*Fond du Lac had the majority of transitions completed by 1/01 except for two high cost cases and previously COP-R individuals who wanted to wait as long as possible (11/02) to start paying the cost share under MA.

Note: Transition enrollment refers to enrollment of Family Care-eligible individuals previously receiving long-term care services from the county through a county or waiver program.

The Lewin Group began conducting Phase I of the evaluation in February 2000. The first Implementation Process Report submitted to the Governor and the Legislature on November 1, 2000 (found at http://www.legis.state.wi.us/lab/Reports/00-0FamCaretear.htm) involved the establishment of baseline information on the major structural features of the program, as well as a preliminary assessment of procedural and structural program information. The second Implementation Process Report provided an update (found at http://www.legis.state.wi.us/ lab/Reports/01-0FamilyCare.htm). The third report offered a bridge to the outcomes and cost-effectiveness evaluation phase (Phase II) as we began to assess implications related to program outcomes while continuing to monitor program implementation, and primarily reflected progress as of May 2002.

B. Phase II

A fidelity measure was developed to assess the level of program stability and formed the outcome and cost-effectiveness evaluation phase. We expect the measure to evolve as implementation continues to mature and the pilot counties reach greater program stability. The outcome phase documented in this report examines the extent to which the program met overall goals of Family Care. These goals, referenced on the Family Care web-site[1], include:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

In addition to the program outcome assessment, Phase II involved a cost-effectiveness study to assess the extent to which program benefits justify program costs. This cost assessment includes both quantitative and qualitative data and incorporates, to the extent possible, the viewpoints of all the major stakeholders involved in Family Care, including program participants, the State, the CMOs and RCs, as well as the general public not involved directly in Family Care. Analyses include both present and future estimates of costs and benefits. Additionally, in accordance with the legislative requirements for the evaluation, the cost-effectiveness portion of this study includes a comparison between Family Care and nursing facilities. This assessment yielded aggregated comparisons at the program and facility levels, controlling for the case mix of consumers served.

[1] Available at http://www.dhfs.state.wi.us/LTCare/Generalinfo/WhatisFC.htm. Accessed November 20, 2002.

III. METHODOLOGY

This report focuses on the outcome and cost-effectiveness analyses which required selection of comparison groups, development of analysis files, and measurement of selected program outcomes and costs.

A. Comparison Groups for Family Care CMO Members

A critical component in the analysis is the use of a comparison group for Family Care. Determining the effect of Family Care requires a counter-factual, i.e. what would have happened in the absence of the program? This requires outcomes for a period or group of individuals not enrolled in a CMO to compare to the outcomes for individuals enrolled in a CMO.

Family Care was implemented county-wide in those counties that developed a CMO. In Wisconsin, the counties manage the home and community-based care system. While the state requires some aspects of the process to be standard (e.g., level of care determinations use uniform assessments), to the extent that counties wish to invest their own funds, they have broad latitude regarding the number of recipients and the amount of spending per recipient. This variation makes comparisons to non-Family Care counties challenging.

To assess whether the Family Care CMOs had an effect on outcomes and costs, we examined changes in selected outcomes and costs for CMO members from prior to implementation of the CMOs to a period following implementation. We then compared these changes to changes among comparison groups. This combined pre-post and comparison group non-experimental design is called a difference-in-difference (DID) analysis. The simple difference-in-difference estimator is represented by the following formula:

$$DID = (Post^{demo} - Pre^{demo}) - (Post^{comp} - Pre^{comp})$$

where $Post^{demo}$ and Pre^{demo} are the outcomes and costs for Family Care CMO, and $Post^{comp}$ and Pre^{comp} are the corresponding outcomes and costs in the comparison areas. The DID technique provides simple, consistent, non-parametric estimates of the relationship between demonstration and comparison sites. Using information for the comparison group in both the pre-and post-periods, as well as for the pre-period demonstration group allows us to effectively deal with the selectivity issue (i.e., by using a DID approach and focusing on change over time rather than absolute levels, we control for bias generated by the sites included in the Family Care versus the comparison sites).

The research team, in collaboration with The Legislative Audit Bureau and DHFS, pursued two comparison groups.

1. **Matched Non-Family Care Counties** – For each of the four CMO counties included in the analysis, we identified comparison counties that have similar community long-term care systems characteristics to the CMO counties (***Exhibit III-1***). Data availability dictated an analysis timeframe that required most analyses to focus on the initial four CMO counties and therefore many of the analyses exclude Richland. The matched county approach strives to measure the incremental effect of the system and reimbursement changes as a result of Family Care, holding constant the "generosity" of the county prior to the program. The matched counties were chosen based on similarity for four main criteria related to the combination of COP-W, CIP II and COP-R. These criteria focus on the elderly and non-elderly adults with physical disabilities which constitute two-thirds of the CMO enrollment in Fond du Lac, La Crosse, and Portage. The criteria included:

- Service spending per capita for the county;
- Service recipient per 1,000 county residents;
- Service spending per recipient; and
- The percent of spending for alternative residential care.

There are no counties comparable to Milwaukee in terms of size, urban area, and minority population. Rock County was selected as the closest in terms of long-term care system measures. For the Milwaukee specific analyses, we compared to the population age 60 and older in Rock County. Similar information for MR/DD services by county was not available for our analysis.

Exhibit III-1
Matched Comparison Counties and Selected Characteristics of County Matches for Medicaid Home and Community-Based Waivers (COP-W/CIP II/COP-R)

County	2000 Population (in 1,000s)	1997 Service Spending per Capita	1997 Service Recipients per 1,000 County Residents	1997 Service Spending per Recipient	1997 Percent of Spending for Alternative Residential Care
Fond du Lac	97.3	$13.61	2.4	$5,707	29.9%
Waupaca	51.7	$15.68	2.0	$7,651	35.9%
Portage	67.2	$17.82	2.8	$6,435	31.6%
Pierce	36.8	$17.91	3.0	$5,939	29.2%
La Crosse	107.1	$19.53	3.6	$5,406	32.9%
Manitowoc	82.9	$19.99	3.6	$5,579	35.3%
Milwaukee	940.2	$28.29	3.5	$8,114	19.3%
Rock	152.3	$30.45	3.4	$8,952	24.7%
Entire State	**5,363.7**	**$22.54**	**2.9**	**$7,685**	**25.1%**

Source: 1999 Legislative Audit Bureau report entitled "An Evaluation: Community Options Programs" and Wisconsin Medicaid statistics webpage.

DHFS raised concerns that outcomes would be driven in part by the selection of the comparison county. Specifically, if the criteria for matching did not capture what makes one long-term care system similar to another, then the results would not capture the incremental effect of Family Care. As a result, a sample of the remainder of the state was also pursued.

2. **A Sample of the Remainder of the State** – A random sample of individuals receiving Medicaid home and community-based waiver services in counties other than Fond du Lac, La Crosse, Milwaukee, Portage and Richland was drawn.[2] The random sample approach has the advantage of diversifying the comparison area and precluding the possibility of selecting a county that looks well-matched on paper but a poor match for other reasons. The random sample approach, however, does not account for any fundamental differences between the CMO counties and the rest of the state in the number of potentially eligible individuals served, the funding level per recipient, and the range of services available.

[2] Richland was excluded because it began operating its CMO during the post-period for the analysis.

We note that the use of a difference-in-difference approach mitigates some of the concern about the random sample versus the matched county approach and that by examining both of these comparisons, we were able to determine whether the chosen comparison site made a difference in the analysis.

In addition to the DID analyses, the authorizing legislation for this evaluation specified comparing Family Care recipients with comparable individuals being served in nursing facilities. To fulfill this requirement, we examined Medicaid-funded nursing facility residents in the Family Care counties during December 2000. ***Exhibit III-2*** provides information about nursing facilities in the CMO counties.

Exhibit III-2
Nursing Facility Information for CMO Counties

County	Medicaid Certified Residents	Medicaid-certified Nursing Facilities		
		Number of Nursing Facilities	Number of Beds	Total Number of Residents
Fond du Lac	563	9	935	809
La Crosse	540	7	1,050	884
Milwaukee	4,921	55	8,236	6,532
Portage	220	2	309	257
Total	6,244	73	10,530	8,482

Source: Medicaid residents as of December 2000 from Wisconsin Department of Health and Family Services, website accessed June 11, 2001, http://www.dhfs.state.wi.us/Medicaid1/caseload/intro.htm. Nursing home characteristics from www.Medicare.gov Nursing Home Compare database.

The analyses of those in institutions exclude individuals who qualify for Family Care based on a developmental disability because: 1) we did not have access to a similar electronic functional status measure for this population (the MDS is not required among residents of ICF-MRs); and 2) the CMO counties that serve the DD population have limited numbers of, or no, individuals in ICF-MRs within their county (***Exhibit III-3***).

Exhibit III-3
ICF-MRs in CMO Counties Serving Individuals with Developmental Disabilities

County	Number of ICF-MRs	Staffed Beds	Average Daily Census
Fond du Lac	2	79	79
La Crosse	1	52	47
Portage	0	0	0

Source: Wisconsin Nursing Home Directory, 2000. Data based on a survey of facilities.

B. Data Analysis

The data for the outcome and cost-effectiveness analyses included a number of sources to capture the range of outcomes and relevant individual characteristics. Most of the data sources constitute administrative data systems used for payment and reporting purposes. In working with administrative data, it is important to be cognizant that data are only as complete and reliable as the incentives to enter it. This means that fields that affect payment tend to be the most reliable. Required fields not used for payment determination that include intelligent edits to prevent poor data entry would be the next most

reliable. Required fields without edits would be expected to be completed but may not include reliable data. Optional fields would be expected to have the most missing data.

Exhibit III-4 summarizes the key characteristics of the data sources used in the analyses for this report. The analyses primarily focused on the change from just prior to the implementation of Family Care (October 1999 to March 2000) compared to the first half of the first full calendar year of operation (January 2001 to June 2001) for:

- The first four CMO counties (Fond du Lac, La Crosse, Milwaukee, and Portage);
- Matched comparison counties (Waupaca, Manitowoc, Rock, and Pierce); and
- A sample of the remainder of the state.
- In addition, individuals residing in a nursing home in CMO counties in December 2000 were also examined.

Data availability dictated the analysis timeframe. A request for data was made in January 2002 for data through the end of June 2001. This time period was necessary due to the time lag between service provision and when a claim is entered and recognized into the data systems (particularly MMIS). DHFS provided information regarding lag factors associated with different types of services in the MMIS. We used a goal of capturing 90 percent of claims for the most critical services (inpatient, prescription drugs, home health, personal care, and therapies). Among these services, inpatient hospital had the longest time period to capture close to 90 percent -- 89.16 percent at eight months following the service date. Working eight months backwards from February 2002, established June 2001 as the last month for the analysis and requiring six months of experience in the CMO brought us to December 2000 for the analysis samples. This also limited the analyses to the four initial CMO counties.

Exhibit III-4
Key Characteristics of Outcome and Cost-Effectiveness Data Sources

	System Maintenance	Key Information Used	Timeframe	Comments
Medicaid Management Information System (MMIS)	Claims submitted by providers and processed by EDS; Eligibility entered manually based on Client Assistance for Reemployment and Economic Support (CARES) system data submitted by Economic Support Units and Social Security offices	Demographics, Medicaid coverage, diagnoses, and use & spending for Medicaid acute care services and LTC services not part of HCBS waivers	7/99 to 6/01	Payment based system with edits
Human Services Reporting System (HSRS) Long-term Support (LTS) Module	Information entered monthly by County Agencies and maintained by the Division of Supportive Living (DSL); CMOs also enter service use & payment information	Demographics, services, and cost data for Wisconsin's COP and MA Waiver clients, as well as CMO members	7/99 to 6/01	Used for reporting & reconciliation purposes, not direct payment for services; no audits performed; demographic data likely reflects first enrollment
Nursing Facility Minimum Data Set (MDS)	Information entered by nursing facility at entry & specified intervals	Demographics, functional impairment, behavioral	Closest to 12/00	Used for reporting and Medicare RUGS classification for payment
Long-term Care (LTC) Functional Screen	Information entered by certified county screeners for initial eligibility and at least annual renewal	Demographics, functional impairment, behavioral, disability category (elderly, physical disability, DD) diagnoses	Closest to 12/00	Initially batch entered and now web-based direct entry; different versions of the screen prior to web-based in 10/01 limit comparability across time
Community Options Program (COP) and DD Functional Screens	Paper-based screens at least annually for elderly and physically disabled; at least every three years for DD; samples abstracted by The Management Group for analysis	Demographics, functional impairment, behavioral, disability category, diagnoses	Closest to 12/99 and 12/00	No information recorded beyond that necessary for eligibility determination so often incomplete functional impairment
Member Outcome Tool	Interviews with members and COP & CIP participants and their care managers to determine whether 14 outcomes met from consumer perspective	Outcomes met or not and supports in place or not	Rnd 1: 11/00-1/01 Rnd 2: 5/01-11/01 Waiver: 2001	No established standard for comparison; differences in methods between 2 rounds

1. Samples and Analysis Files

The need to abstract level of care screens for the pre-period in the Family Care CMO counties, the pre- and post-period for the comparison areas, and the resources available for the abstracting, precluded using the universe of individuals for the analyses. DHFS contracted with The Management Group (TMG) to abstract nearly 4,000 screens for approximately 2,800 individuals. The Lewin Group developed two Access input forms – one for the COP screens for the elderly and those with physical disabilities, and one for the screens for those with developmental disabilities. ***Exhibit III-5*** outlines the sampling strategy, including:

- A stratified random sample of 600 HCBS waiver recipients based on the proportion who were elderly, non-elderly adults who had physical disabilities and adults who had MR/DD in the CMO counties as of December 2000. To be able to capture a subset of new enrollees rolled over from the waiver, one-half received Medicaid personal care option, waiver, nursing facility or ICF-MR services during 1999. In addition to the 300 with data in both December 1999 and December 2000, an additional 300 in December 1999 were included. This meant that one-half were also new enrollees. The 600 individuals represent about four percent of all target group waiver participants in the remainder of the state during December 2000.
- For Fond du Lac, La Crosse and Portage, all target group waiver recipients from December 1999.
- For Milwaukee, a target of 400 waiver recipients age 60 and over in December 1999 were sampled, half of which enrolled in the CMO in December 2000. The 400 individuals represent approximately 16 percent of elderly waiver participants in Milwaukee during December 2000.
- For the matched comparison counties of Waupaca, Manitowoc, Rock, and Pierce, all target group waiver recipients in both time periods.

Those screens completed closest to December 1999 and December 2000 were sought for the elderly and the physically disabled because these groups are supposed to be screened at least annually. Only one screen was sought for individuals with developmental disabilities because screens are required only every fourth year. TMG successfully abstracted screens and we were able to match MMIS and HSRS data for approximately 80 percent of the sample. The remaining 20 percent represent either: 1) elderly or those with physical disabilities who were missing one or both screens, 2) individuals with DD who did not have a screen available, or 3) anyone lacking spending data. Because only one screen was sought for those with DD, a higher percentage of the sample was obtained for this group (95 percent) compared to the elderly and those with physical disabilities (75 percent). The differences in the final sample proportion by target group was adjusted for in the analyses by developing weights based on the original proportions.

Exhibit III-5
Samples for Level of Care Abstracting Among those in Pre- and Post-Period

	Participants Who Were Elderly or Physically Disabled		Participants with Developmental Disabilities			
	1999	2000	1999	2000	Individuals	Number of Screens to Abstract
Fond du Lac	199		110		309	309
La Crosse	302		151		453	453
Manitowoc	174	174		79	253	426
Milwaukee (elderly only)	392	198			392	590
Pierce	48	49		76	125	174
Portage	142		103		245	245
Rock	252	252		38	290	542
Waupaca	82	82		77	159	238
Family Care CMO Co.	1,035	198	364		1,399	1,597
Statewide Sample	433	438	162	162	600	1,195
Total	1,985	1,154	364	432	2,787	3,932

Note: Family Care CMO counties are the subtotal for Fond du lac, La Crosse, Milwaukee, and Portage. The Statewide sample for the elderly and physically disabled include 39 individuals also in the matched comparison counties. The totals for elderly and physically disabled do not double count the 39 individuals included in both the statewide and comparison county samples.

C. Caveats and Limitations

The analyses presented in this report are subject to a number of caveats and limitations.

- **Time period for analysis** – As noted earlier, the period for analyses was early in the implementation of the CMOs and as a result reflect only initial outcomes of the program. Given the major start-up activities that had to be accomplished, impacts of the program would not be expected to be realized until three to four years following start-up, and the data for an analysis of this timeframe would be four to five years after start-up, or 2004-05. In addition, ultimate impacts, particularly on nursing home use, may not be realized for some time to come.
- **Data reliability** – Also, as noted earlier, the primary data sources for the analyses were administrative files that can be subject to data entry error and misreporting, particularly if payment is not dependent upon the reported data. However, we focused on those items that would be considered more highly reliable and well reported for our measures (e.g., based on cautions made by DHFS, we did not examine units from the HSRS data).
- **Lack of Medicare claims data** – The analyses do not include Medicare data for individuals who were eligible for both Medicare and Medicaid. This group represents approximately 70 percent of the analysis sample. This means that measures that relied upon the availability of acute care claims (e.g., hospitalization and emergency room visits) are captured only to the extent that Medicaid paid a portion of the bill (i.e., deductibles and copayments) and may not fully capture use and certainly does not reflect total spending for dual eligibles. Although, to the extent that readers are interested only in the state's liability, the spending information does capture state benefit payments. In order to obtain the Medicare data, a special request to the Centers for

Medicare and Medicaid Services (CMS) would have had to been submitted and the timeframe for completion the analysis did not permit submission of such a request.

- **Comparability of measures for institutional and community settings** – In the cost-effectiveness analyses of CMO members and nursing facility residents, both the functional impairment measures and the cost measures were not fully comparable. The MDS impairment measures for nursing facility residents are subject to some degree of setting bias (i.e., staff are more likely to indicate impairment because individuals are more likely to receive assistance with some activities of daily living simply because they are in the nursing facility) which increases the proportion of individuals with more severe disabilities. Also, the per diem payment system for nursing facility care means that costs cannot be associated with individuals based on their reported level of functioning. Therefore, we were only able to compare the level of functioning in the community relative to the nursing facility and focus on individuals in the community with a comparable level of impairment to compare average spending.

PART TWO:
PRELIMINARY OUTCOMES AND COSTS

IV. OVERVIEW OF OUTCOMES AND COST ANALYSES

As we noted in our conclusions of the previous report, defining cost-effectiveness and measuring outcomes can be difficult. Issues related to "how to measure costs?", "cost to whom?", "how to quantify outcomes or benefits", and "compared to what?" emerge. Cost-effectiveness analysis (CEA) is one of the techniques of economic evaluation designed to compare the costs and benefits of a healthcare intervention.[3] The choice of technique depends on the nature of the benefits specified. In CEA, the benefits are expressed in non-monetary terms related to health effects, such as life-years gained or symptom-free days, whereas in cost–utility analysis they are expressed as quality-adjusted life-years (QALYs) and in cost–benefit analysis in monetary terms. As with all economic evaluation techniques, the aim of CEA is to maximize the level of benefits – health effects – relative to the resources available.

What constitutes a cost? In economics, the notion of cost is based on the value that would be gained from using resources elsewhere– referred to as the opportunity cost. In other words, resources used in one program are not available for use in other programs, and, as a result, the benefits that would have been derived have been sacrificed. It is usual, in practice, to assume that the price paid reflects the opportunity cost and to adopt a pragmatic approach to costing and use market prices wherever possible. In Family Care, the "cost" per member is set through the program payment methodology to determine a monthly capitated amount that does not truly reflect price determined by the market. The capitated amounts and these analyses also do not include any member cost-share amounts (these generally represent less than one percent of total spending for Medicaid services), nor the start-up and other costs, such as DHFS staff time and training, associated with the program. In addition, for some services, such as nursing home care, costs are not available at the individual level because Wisconsin's Medicaid payment rates do not vary within a nursing home.

Within the context of Family Care, the entity that incurs the cost becomes a key factor. From the state's perspective, the state general revenue and county costs are of greater importance than the federal Medicaid match, Medicare and member cost-share expenditures. To the extent that the state and counties are able to shift spending to Medicaid, which has a 58.6% match from the federal government, the more they are able to reduce their own obligations or serve more individuals for the same amount of spending. However, if the program is to be fairly evaluated, all of the costs would be taken into consideration.

Can benefits be quantified? A particular challenge for the Family Care program is quantifying the program's benefits. Medicaid and Community Options Program (COP) administrative data primarily reflect use and cost measures for before and after the implementation of Family Care. The functional screen information is not available in electronic form prior to Family Care and screenings are usually performed only annually. As a result, it is not possible to develop measures of days of improved functioning, only whether functioning improved, stayed the same or declined. Due to the limited nature of the data, it is difficult to translate these data into measures of benefits. In addition, the evolving nature of the member outcome tool means that these more direct measures of program benefits cannot yet be tracked over time and therefore, do not yet offer a measure of benefits gained. However, results from individuals on the other waiver offer a relative comparison.

To what should costs and benefits be compared? We have pursued a methodology that focuses on specific counties selected for their similarity regarding measurable characteristics of their long-term care

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[3] Sloan F (ed). Valuing Health Care: Costs, benefits and effectiveness of pharmaceutical and other medical technologies. Cambridge: Cambridge University Press, 1996.

systems and the remainder of the state for the period prior to and after Family Care. The legislation authorizing Family Care also required a comparison to nursing home costs.

The outcome and cost-effectiveness analyses focused on the key components of the Family Care program: access to information and services; choice and self-determination; community integration; health and safety; quality of care; and spending. ***Exhibit IV-1*** summarizes the key outcomes and cost analyses conducted.

Exhibit IV-1
Key Outcomes and Cost Analyses Conducted

Indicator	Analysis
Access	
Wait Lists	CMO counties trend relative to rest of state
Resource Center Contacts	Trend by county
CMO Enrollment	Trend by county and by target population
Service Packages	Pre/post CMO counties relative to comparison
Quality of Life/Care	
Choice and Self-Determination	Member Outcome Tool CMO & waiver
Community Integration	Member Outcome Tool CMO & waiver
Health and Safety	Member Outcome Tool CMO & waiver
Quality of Care	CMO compared to remainder of state
Spending	
Total Medicaid & state benefit spending	Pre/post CMO counties relative to comparison
LTC Medicaid & state spending	Pre/post CMO counties relative to comparison
Spending on new enrollees	Pre/post CMO counties relative to comparison
Nursing Facility versus Community	CMO counties

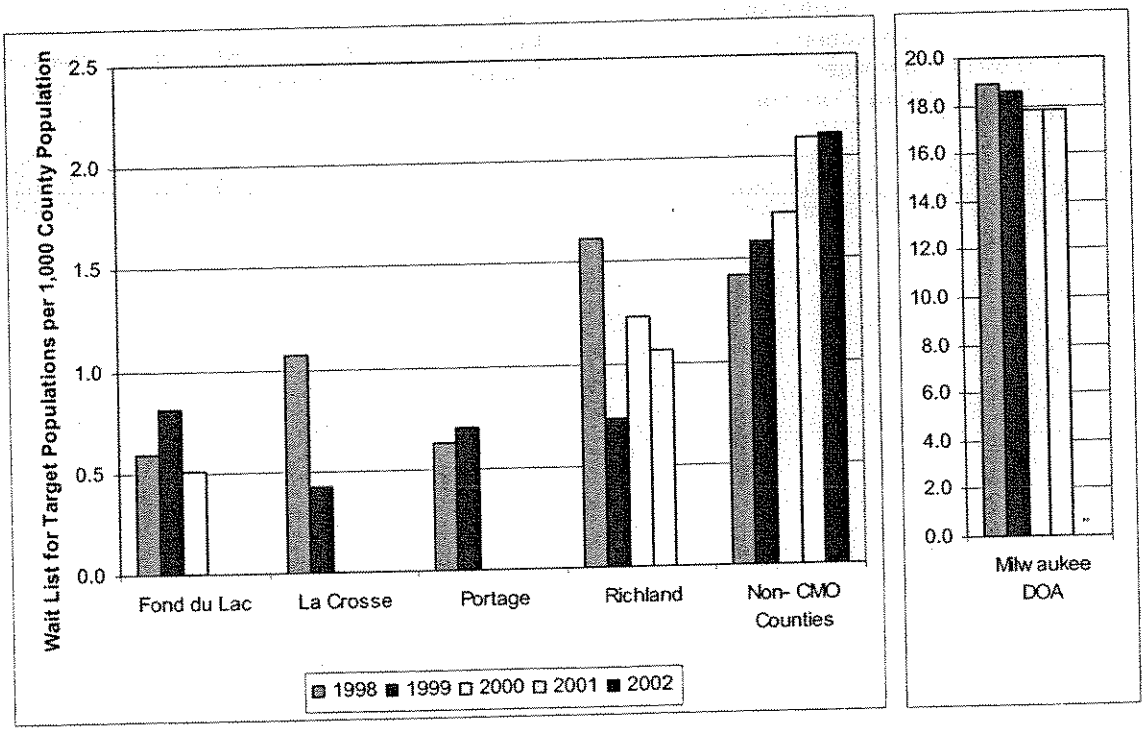
V. ACCESS

Family Care was designed to provide appropriate long-term care services to all eligible individuals without delay. The two main organizational components of the program, the Resource Center (RC) and the Care Management Organization (CMO), each play an important role in improving consumers' access to long-term care. With the exception of Richland County, which began operating in November 2000, the RCs have been operating for nearly five years and have emerged as a successful model of centralized information and assistance. Pre-Family Care waiting lists have been eliminated in all five counties that implemented CMOs. In each of these counties, consumers have more immediate access to services relative to pre-Family Care. The pilot counties continue to experience increasing enrollment into Family Care, with different rates of enrollment among the elderly, physically disabled, and developmentally disabled populations.

A. Elimination of Wait Lists

As of the end of 2002, the wait lists in the CMO counties were eliminated while the wait list in the non-CMO counties continued to climb. No wait lists means that individuals applying for services begin receiving them soon after they become a CMO enrollee.

Exhibit V-1
Wait List for Target Population per 1,000 County Population



Note: The non-CMO counties include individuals under age 60, while the scale for Milwaukee only includes individuals age 60 and over. The estimates for non-CMO counties and the CMO counties other than Milwaukee prior to the elimination of the wait list include children with physical disabilities or developmental disabilities.

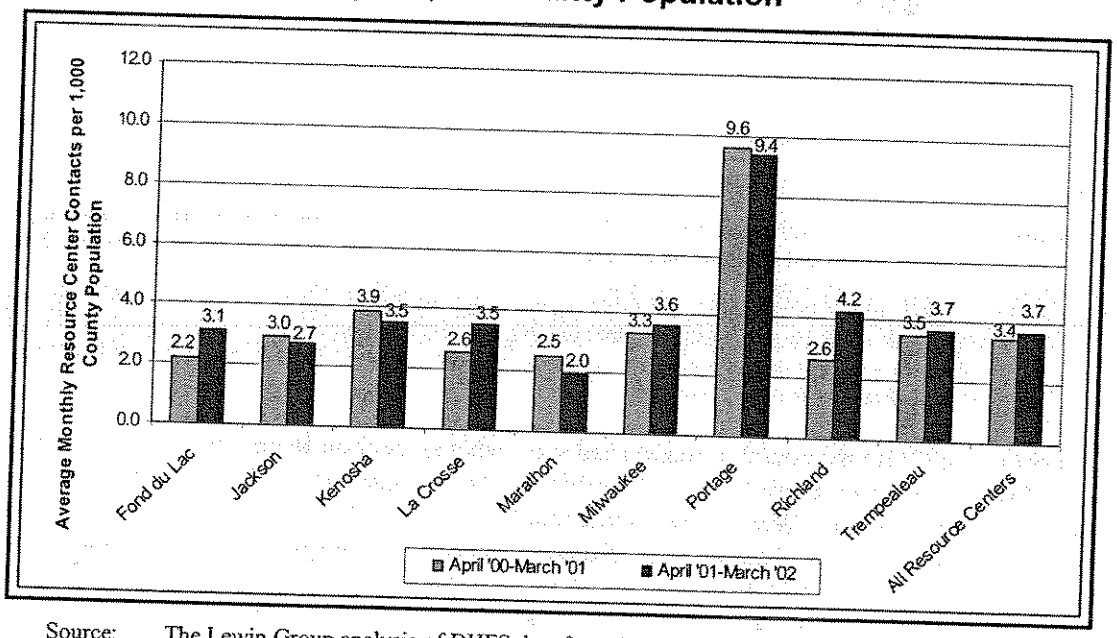
Source: The Lewin Group calculations based on DHFS provided wait list data.

B. Information and Outreach Activities

Aging and Disability Resource Centers play a critical role for long-term care information and service seekers. In the five CMO counties, RCs are involved in outreach and intake related to the CMO benefit, as well as broader information and outreach efforts. In addition to the five counties that have CMOs, four other counties provide information and assistance through RCs.

Examining the average monthly RC contacts per 1,000 people in the county provides an indication of the effectiveness of overall outreach. ***Exhibit V-2*** shows that the average RC contacts per month for all of the RCs combined, increased slightly from the period of April 2000-March 2001 to the period of April 2001-March 2002. Except for Portage, all of the CMO counties experienced increases in the number of contacts. The Portage RC continued to report approximately nine contacts per 1,000 county population, in large part due to receiving voluntary PAC referrals from the county hospital even after the requirement was lifted in October 2000. The Portage RC also operates within a senior center and meal site, and therefore experiences more drop-in contacts than other counties.

Exhibit V-2
Average Monthly Resource Center Contacts per 1,000 County Population



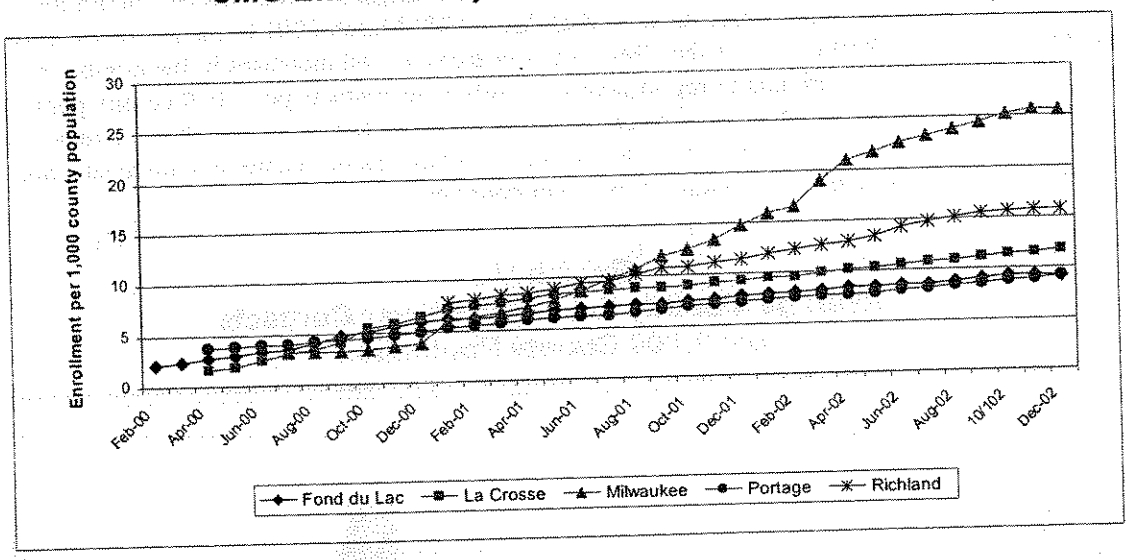
Source: The Lewin Group analysis of DHFS data from the Family Care Activity Reports, December 2001, February 2002 and March 2002.

C. CMO Enrollment Activity

CMO enrollment continued to increase through the end of 2002 (***Exhibit V-3***). Generally, the CMOs enrolled existing Community Options Program (COP) and waiver program consumers during an initial enrollment phase during the first six to 12 months of operations (Milwaukee was an exception) followed by new enrollees primarily from the wait lists until they reached full entitlement – Spring 2001 for Fond du Lac, La Crosse and Potage and Summer 2002 for Milwaukee and Richland. Enrollment continues to increase in all of the counties since having reached full entitlement, although in the most recent months the growth appears to have leveled off.

As of December 2002, enrollment exceeded budgeted enrollment by 12 percent as calculated by The Office of Strategic Finance staff for their September 2001 cost model. Milwaukee and Portage had the greatest difference in actual versus budgeted enrollment, with actual enrollment 17 percent greater than budgeted enrollment. Enrollment in Richland was 11 percent greater than budgeted, while Fond du Lac and La Crosse were eight and three percent higher, respectively.

Exhibit V-3
CMO Enrollment per 1,000 County Population

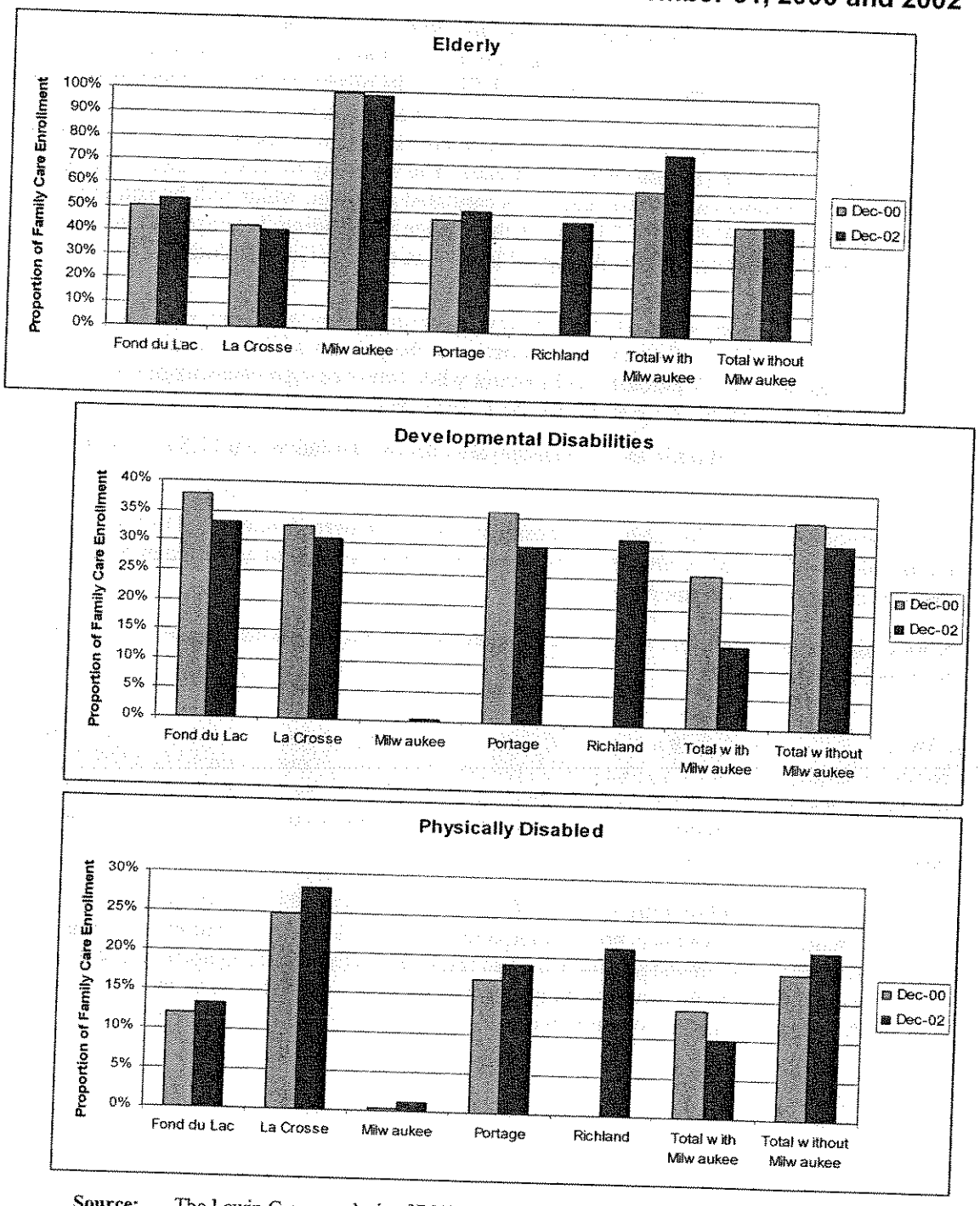


Source: The Lewin Group analysis of data from DHFS Monthly Monitoring Reports from February 2000 to December 2000 and from the Family Care Activity Report for December 2002 available March 2003.

Note: Enrollment data since January 2001 reflect totals presented in the most recent Family Care Activity Report. Revised data for 2000 were not available possibly affecting the curve of data presented. Milwaukee's enrollment per capita based on the population age 60 and over and therefore is expected to be higher than the other counties.

The composition of CMO membership has shifted somewhat since their inception. During the initial transition of waiver program participants to Family Care, the composition of Family Care members mirrored the waiver programs. While the absolute numbers in all of the target groups continue to increase, the CMO counties other than Milwaukee experienced a faster rate of growth for younger individuals with physical disabilities. Excluding Milwaukee, 47 percent of CMO enrollees were elderly as of December 2002 compared to 46 percent in December 2000; 31 percent had developmentally disabilities (DD) compared to 35 percent; and 21 percent were younger individuals with physical disabilities (PD) compared to 19 percent (see ***Exhibit V-4***). By including Milwaukee's primarily elderly membership in the total count of CMO enrollees, the proportion of elderly enrollees jumps to 76 percent in December 2002. The proportion of elderly members in all CMOs may continue to increase as targeted outreach to nursing facilities advances and the program responds to demographic shifts.

Exhibit V-4
Enrollees by Target Population as of December 31, 2000 and 2002



Source: The Lewin Group analysis of DHFS provided data.

D. Service Packages

Changes in the patterns of service packages provided to individuals in CMOs provide a measure of shifting care management approaches and possibly greater choice. Our analyses focused on the types of services and spending individuals received because the HSRS units of service data reported by the CMOs is considered unreliable by DHFS staff. ***Exhibit V-5*** shows the percent using different categories of service in the pre- and the post-period and indicates the percent change in the proportion using for CMO members and those on waivers in the remainder of the state. The spending for CMO reflects that reported for the individuals in our sample and not the program's capitated payment, which will be addressed in ***Section VII Spending. Exhibit V-6*** and ***V-7*** illustrate the change in spending. Increases in use and spending for CMO members occurred for a number of long-term care services, including:

- Habilitation, therapies and mental health services spending increased 85 percent relative to a decline for the remainder of the state, in part because the percent of CMO members using therapies increased from 17 percent to 22 percent while fewer of the remainder of the state waiver participants used therapies between the pre- and post-period;
- Respite care where spending in the comparison area declined relative to a 11.5 percent increase for CMO members;
- Transportation spending for CMO members increased 17.8 percent compared to 5.1 percent for the remainder of the state waiver participants, primarily as a result of an 11.2 percent increase in the participants using transportation;
- Residential support, personal care, adult day care, all of which increased almost twice as much for CMO members; and
- Case management spending increased 53.1 percent for CMO members compared to 8.5 percent for the remainder of the state even though the percentage receiving remained close to 100 percent in both periods. The increased spending resulted from the increased requirements of the team approach that includes a nurse and a greater level of involvement in coordinating all aspects of supports for CMO members.

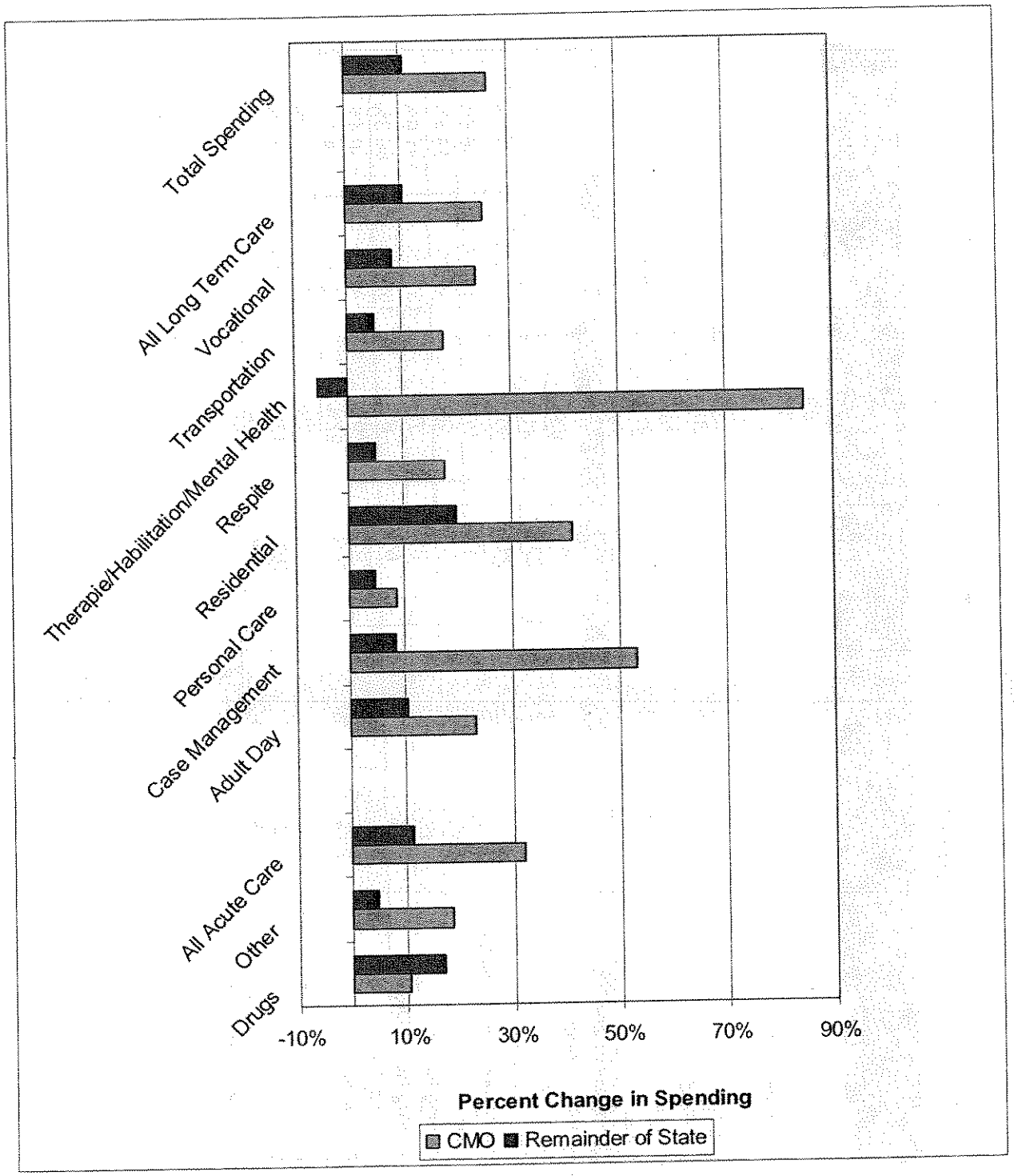
The smaller increase in prescription drug spending for CMO members (a 10 percent increase relative to 17 percent) is also worth noting because prescription drug spending is one of the fastest growing Medicaid services. If CMO care management is able to reign in prescription drug spending which represent over one-half of the acute care spending for CMO members (almost 10 percent overall), it could offer mechanism for offsetting potential additional costs or possibly saving money overall.

Exhibit V-5
Percent Using Services in the Pre- and Post-Period

Acute Care	Pre-Period		Post-Period		Percent Change	
	CMO Members	Remainder of State	CMO Members	Remainder of State	CMO Members	Remainder of State
Inpatient	11%	12%	16%	18%	50.9%	44.0%
Outpatient	36%	33%	37%	33%	1.5%	0.2%
Emergency Room	15%	16%	16%	17%	5.2%	9.5%
Physician	36%	42%	37%	46%	4.2%	9.1%
Dental	23%	21%	25%	20%	7.3%	-4.5%
Lab/Radiology	41%	41%	47%	42%	14.4%	4.1%
Drugs	91%	91%	91%	91%	-0.1%	-0.3%
Other	82%	78%	82%	79%	-0.2%	1.6%
Long-term Care						
Adaptive Equipment/DME	61%	61%	65%	63%	6.3%	3.5%
Adult Day	20%	21%	22%	21%	15.1%	-1.7%
Case Management	98%	100%	98%	99%	0.4%	-1.1%
Habilitation/Therapies/MH	17%	15%	22%	14%	29.2%	-6.6%
Housing	6%	4%	5%	2%	-5.9%	-36.4%
Nursing Home	3%	3%	8%	7%	139.2%	131.6%
Nursing Home Drugs	2%	4%	6%	6%	169.9%	60.3%
Personal Care	76%	76%	73%	76%	-4.6%	-0.4%
Residential	23%	24%	26%	27%	15.4%	8.7%
Respite	12%	8%	12%	8%	3.2%	2.5%
Transportation	45%	41%	50%	42%	11.2%	3.4%
Vocational	19%	15%	21%	15%	9.6%	-5.5%

Source: The Lewin Group analyses.

Exhibit V-6
Relative Use for Selected Types of Services



Source: The Lewin Group analyses.

Exhibit V-7
Changes in Average Monthly Spending Per Capita by Type of Service

	Care Management Organizations					Remainder of the State				
	Pre-Period	Post-Period	Diff.	% of Diff.	% Diff.	Pre-Period	Post-Period	Diff.	% of Diff.	% Diff.
Acute Care										
Inpatient	$16	$74	$58	11.4%	362.6%	$28	$45	$17	7.2%	61.1%
Outpatient	$23	$23	$0	0.0%	-1.5%	$29	$23	-$6	-2.5%	-17.7%
Emergency Room	$4	$4	$0	0.0%	-13.9%	$3	$4	$1	0.4%	16.3%
Physician	$9	$12	$3	0.6%	39.5%	$14	$10	-$4	-1.7%	-31.9%
Dental	$5	$7	$2	0.4%	36.0%	$5	$4	-$1	-0.4%	-7.1%
Lab/Radiology	$4	$6	$2	0.4%	44.3%	$5	$4	-$1	-0.4%	-20.0%
Drugs	$206	$227	$21	4.1%	10.6%	$196	$229	$33	14.0%	16.9%
Other	$47	$39	-$8	-1.6%	-18.4%	$83	$88	$5	2.1%	5.3%
Non-CMO Capitation	$0	$6	$6	1.2%		$0	$0	$0	0.0%	
Acute Subtotal	$314	$398	$84	16.5%	26.8%	$363	$407	$44	18.6%	12.1%
Long-term Care										
Adaptive Equip/DME	$82	$71	-$11	-2.2%	-13.3%	$61	$53	-$8	-3.4%	-13.2%
Adult Day	$142	$175	$33	6.5%	23.2%	$107	$118	$11	4.7%	10.5%
Case Management	$83	$128	$45	8.9%	53.1%	$125	$135	$10	4.2%	8.5%
Habilitation/Therapies/MH	$8	$15	$7	1.2%	84.7%	$16	$15	-$1	0.0%	-5.7%
Housing	$26	$8	-$18	-3.5%	-70.4%	$19	$3	-$16	-6.8%	-86.5%
Nursing Home	$26	$128	$102	20.1%	393.2%	$16	$75	$59	25.0%	374.5%
Nursing Home Rx	$2	$11	$9	1.8%	403.4%	$4	$9	$5	2.1%	109.6%
Personal Care	$738	$802	$64	12.6%	8.7%	$882	$923	$41	17.4%	4.6%
Residential	$360	$509	$149	29.3%	41.4%	$413	$494	$81	34.3%	19.8%
Respite	$37	$42	$5	1.0%	11.5%	$18	$17	-$1	-0.4%	-4.8%
Transportation	$57	$67	$10	2.0%	17.8%	$48	$50	$2	0.8%	5.1%
Vocational	$126	$156	$30	5.9%	23.9%	$88	$96	$8	3.4%	8.5%
LTC Subtotal	$1,688	$2,112	$424	83.5%	25.2%	$1,797	$1,989	$192	81.4%	10.6%
Total	**$2,002**	**$2,510**	**$508**	**100.0%**	**25.4%**	**$2,160**	**$2,396**	**$236**	**100.0%**	**10.9%**

Note: Diff = Post-Period minus Pre-period; % of Diff = Service/Number/Total Diff.; % Diff. = Diff/Pre-Period. The categories of service are not directly mapped to those included in the CMO capitated payment, but those in the long-term care category are generally covered by Family Care.

Source: The Lewin Group analyses.

VI. QUALITY OF LIFE/QUALITY OF CARE

Efforts to improve the members' quality of life and the quality of services provided constitutes a cornerstone of the Family Care program. The ideal quality standard for long-term care services has yet to be developed. The nature of the services, a mix of social supports and custodial care, coupled with the goal of allowing individuals to make their own choices, make traditional standards based solely on the clinical experience and opinions of professionals or experts inappropriate. Geron concludes that "the standards for long-term care that have been promulgated often have little to do with quality in the areas of care considered most important to consumers."[4]

Family Care relies on a consumer-centered approach that includes process measures, such as CMO contact compliance and quality site reviews, but more heavily relies on consumer-defined outcomes captured by the Member Outcome Tool, developed in partnership with the Council for Quality and Leadership (the Council). The tool measures consumers' perception of outcomes and whether or not supports exist to achieve those outcomes in several areas: privacy, the ability to choose services, housing, safety, the degree to which members are respected, and experience continuity, and satisfaction with services.[5]

The Department conducted the first round of member interviews between November 2000 and January 2001. They interviewed 355 randomly selected CMO members and the care managers serving them. The second round of interviews was conducted between May 2001 and November 2001 in which 492 randomly selected members and their care managers were interviewed. The third round is currently being completed. DHFS has refined the process measures over the course of the program and continues to develop benchmarks for the outcome measures. The counties have begun to buy into a systematic approach to quality and the groundwork related to basic research techniques for monitoring quality has been laid.

DHFS cautions against drawing comparisons between results from the two rounds for several reasons. They noted that the interview process continues to evolve with changes in the way in which consumers were contacted to participate and the directions given to the care managers. Although the tool has been used by the Council to evaluate programs for individuals with disabilities, BALTCR and consumer representatives continue to adapt the tool for appropriate use with the elderly population in an attempt to validate the instrument. Additionally, DHFS noted that they have not yet developed benchmarks for each outcome. They believe that with the results from the application of the tool to other programs which have begun, such as, PACE, Partnership[6], and other waiver programs across the state, they will be able to establish some benchmarks. In lieu of DHFS established benchmarks, we provide a comparison to the other waiver program results.

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4 Geron, Scott M. (2001) "The Quality of Consumer-Directed Long-Term Care," *Generations*, Vol. 24, No. 3.

5 Please see http://www.dhfs.state.wi.us/LTCare/ResearchReports/CMOMemberOutcomes.htm for DHFS' full report on the Member Outcome Interviews.

6 Program for the All-Inclusive Care of the Elderly (PACE) and Partnership are other DHFS Medicaid managed care programs. The Partnership Program, serving older adults and adults with physical disabilities since 1996, currently operates in three Wisconsin counties: two sites in Dane County, one site in Milwaukee County, and one site in Eau Claire. As of August 2002 1,303 individuals were enrolled. The program integrates all medical and long-term care services in a community-based setting. PACE was initiated in Milwaukee County in 1994 for individuals 55 and older at the nursing home level of care to provide on-site, comprehensive integrated medical and psychosocial services by a multi-disciplinary team. As of August of 2002, there were 420 enrollees. Information from http://www.dhfs.state.wi.us/medicaid7/managed_care_summary_table.htm. Accessed November 25, 2002.

DHFS stressed that, at this point, the primary value in the results of the outcome interviews was to provide a framework for quality improvement efforts at the CMO level. As the process continues, county staff will be able to use the results to track the success of their consumer-centered quality efforts.

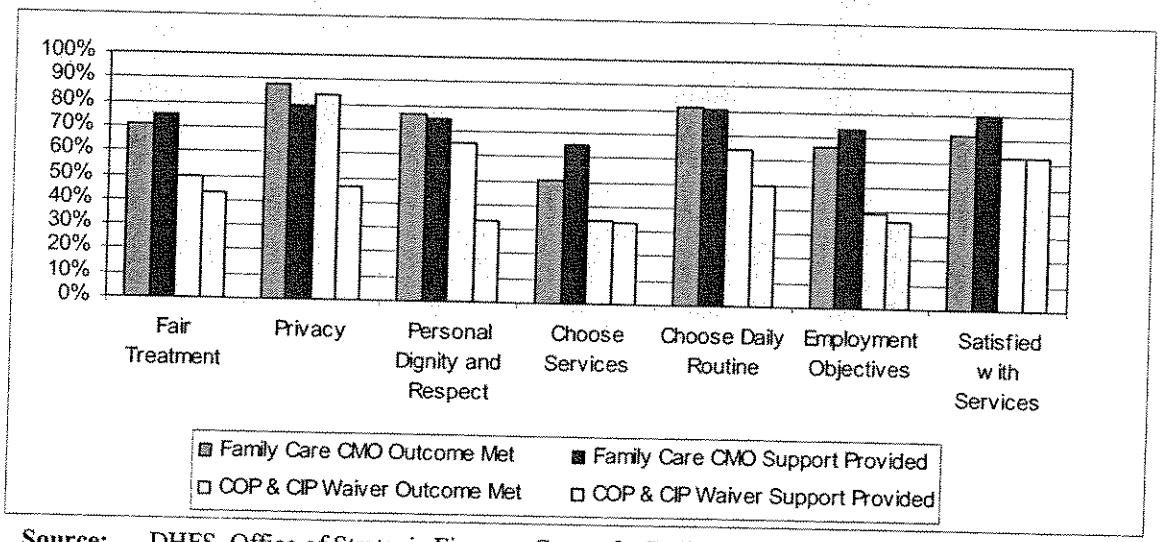
A. Choice and Self-determination

Family Care measures choice and self-determination for the following specific outcomes:

- People are treated fairly
- People have privacy
- People have personal dignity and respect
- People choose their services
- People choose their daily routine
- People achieve their employment objectives
- People are satisfied with services

The results from the second round of member and care manager interviews are presented in ***Exhibit VI-1***. For these outcomes, a majority of individuals indicated that the outcome was present, with the exception of being able to choose their own services. The lack of choice may be due in part to the implementation stage in which the CMOs found themselves during the interview period. For many of the CMOs, case management staff were doing everything they could to complete the existing rollovers from waivers which often meant primarily putting in place the existing service package. In addition, at that point, the CMOs had not had much opportunity to expand their provider networks to accommodate increased choice. The Family Care CMO member outcomes are consistently higher than the other waiver results.

Exhibit VI-1
Choice and Self Determination Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Health Care Wisconsin*, 2002.

B. Community Integration

Family Care measures community integration for the following specific outcomes:

- People choose where and with whom they live
- People participate in the life of the community
- People remain connected to informal support networks

The results from the second round of member and care manager interviews are presented in ***Exhibit VI-2***. For these outcomes, over 60 percent of individuals indicated that the outcome was present. Again, for this domain, the Family Care CMO member outcomes are consistently higher than the other waiver results.

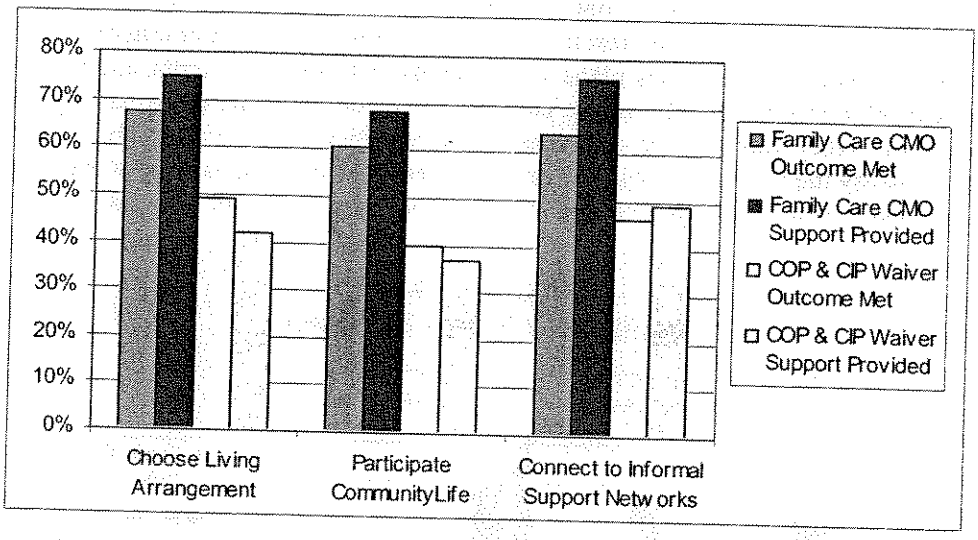
Two of the counties took active efforts related to community integration as a result of the first round of member outcome interviews:

- **Fond du Lac** sought to improve outcomes around "people chose where and with whom to live." They reduced bed size at community-based residential facilities (CBRFs) to allow for members to have private rooms if they so desired. They successfully offered financial incentives to CBRFs to downsize, resulting in improved outcomes for 2001.[7]

[7] DHFS cautions against comparing 2001 and 2002 results due to continued development and testing of the tool.

- **Portage** used consumer focus group information to design their first quality improvement project. The project focused on improving community integration opportunities for physically disabled members based on the consumer outcome "people participate in the life of the community."

Exhibit VI-2
Community Integration Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Health Care Wisconsin*, 2002.

C. Health and Safety

Family Care measures health and safety for the following specific outcomes:

- People are free from abuse and neglect
- People have the best possible health
- People are safe
- People experience continuity and security

The results from the second round of member and care manager interviews are presented in ***Exhibit VI-3***. For the safety and free from abuse and neglect outcomes, over 80 percent of individuals indicated that the outcome was present. The other two outcomes – best possible health and continuity and security -- had approximately one-half of interviewees indicate that the outcome was present. For these three of the outcomes in this domain, when compared to the other waiver results, the differences were not as great for meeting the outcomes as all of the others.

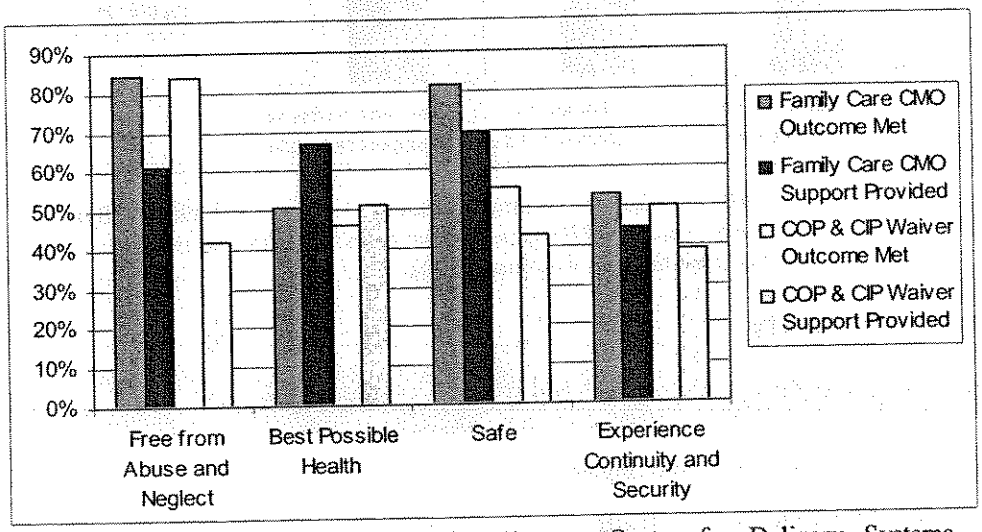
Two of the counties took active efforts related to health and safety as a result of the first round of member outcome interviews:

- **Milwaukee's** CMO performance improvement project included improving the appropriateness of placements in alternate care settings. "Members experience continuity and security" was one of the lower scores for Milwaukee on the first round of member outcomes. Through independent

investigation, the CMO determined that only three percent of members in sub-acute residential care settings should have been there based on member care needs and other risk factors. The CMO developed clinical processes to ensure appropriate placement in the future. Milwaukee is also trying to involve providers in the interdisciplinary team during the re-certification, and reported that CBRFs and ADCs seem to appreciate the involvement.

- **La Crosse** focused on the outcomes of "people are safe" and "people chose where and with whom to live", after reviewing results from the first round of member outcome interviews. They attempted to devise emergency plans, install smoke detectors for clients, and refine the assessment to examine safety issues. The CMO also educated care managers about some of the assumptions they may make in determining where a client might want to live. The La Crosse CMO quality improvement project "improving retention of personal care workers for people with physical disabilities" is intended to enable members to stay in their own homes longer.

Exhibit VI-3
Health and Safety Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Health Care Wisconsin*, 2002.

D. Quality of Care

We examined five more traditional indicators of the quality of care provided to CMO members relative to the remainder of the state:

- Hospital use;
- Emergency room use;
- Nursing facility use;
- Decubitis ulcers; and
- Deaths.

Exhibit VI-8 summarizes the results. These measure reflect the prevalence of the indicators among individuals in the post -period. Among CMO members relative to the sample for the remainder of the

state, there was no significant difference in the use of hospitals, emergency rooms, a diagnosis of a decubitis ulcer or death. However, assuming that the CMOs diligently reported all covered nursing facility stays, Family Care members entered nursing facilities at about half the rate of the remainder of the state. The nursing facility use is lower for both groups than indicated earlier because it captures use among those who did not have nursing home use in December 2000.

Exhibit VI-4
Quality of Care Indicators for Family Care Members Compared to the Remainder of the State

Indicator	Family Care Members	Remainder of State	Significance Test
Hospital Use	16.3%	17.8%	0.36
Emergency Room Use	16.1%	17.2%	0.57
Nursing Facility Use	3.6%	6.6%	0.01*
Decuibitis Ulcer	3.3%	4.6%	0.23
Death	3.1%	3.3%	0.81

* Difference is statistically significant.

Source: The Lewin Group analyses.

VII. SPENDING

We conducted three groups of analyses of spending for Family care members: 1) examining the change in spending between the pre- and post-periods relative to comparison areas (difference-in-difference); 2) spending for new members versus members who rolled over from the waivers; and 3) spending for individuals in the community versus those in nursing facilities.

A. Difference-in-Difference

Medicaid spending for CMO members falls into two categories, those services covered by the CMO capitation payment, which are nearly all long term care services and include some payments previously paid for by the counties, and those services paid on a primarily fee-for-service basis under the traditional Medicaid program, sometimes referred to as card services. Our analyses examined total government spending for CMO members, spending for CMO benefits for the individuals in our samples, the CMO capitated payment and the non-CMO Medicaid benefits. ***Exhibit VII-1*** provides a summary of these components for the post-period all CMOs sample. For this group, the CMO capitated services constituted over 80 percent of their spending and the capitated payment was somewhat less than the spending for the services provided. This is possible under a capitated rate that allows for some individuals to receive services greater than the average while others will receive fewer, based on their determined need.

Exhibit VII-1
Components of Difference-in-Difference
Spending Analyses for Post-Period
All CMO Members Sample

	Average Monthly Per Capita Spending	Percent of Total
Services Not Included in CMO Capitation (Card Services)		
Acute	$398	15.9%
LTC	$13	0.5%
CMO Capitated Services		
Service Payments	$2,099	83.6%
Total	$2,510	100.0%
CMO Capitated Payment	$1,885	82.1%
Total	$2,296	100.0%

Source: The Lewin Group analyses.

As discussed in the ***Methodology*** section, in order to assess whether the Family Care CMOs had an effect on costs, we examined changes in costs for CMO members from prior to implementation of the CMOs to a period following implementation. We then compared these changes to changes among comparison groups. This combined pre-post and comparison group non-experimental design is called a difference-in-difference (DID) analysis.

Exhibit VII-2
Difference in the Change in Average Spending Using Alternative Measures and Comparisons

	Total Spending			Individual Long-term Care			CMO Capitation		Non-LTC		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Fond du Lac	$2,219	$2,757	24%	$1,827	$2,334	28%	$1,794	-2%	$392	$423	8%
Wapauca	$1,935	$2,415	25%	$1,685	$2,152	28%			$250	$263	5%
Difference-in-Difference			-0.6%			0.0%		-29.5%*			2.7%
La Crosse	$1,846	$2,412	31%	$1,561	$2,014	29%	$1,744	12%	$285	$398	40%
Manitowoc	$1,813	$2,240	24%	$1,506	$1,889	25%			$307	$351	14%
Difference-in-Difference			7.1%			3.6%		-13.7%*			25.3%
Milwaukee	$1,460	$1,845	26%	$1,123	$1,363	21%	$1,610	43%	$337	$482	43%
Rock	$1,838	$2,201	20%	$1,472	$1,819	24%			$366	$382	4%
Difference-in-Difference			6.6%			-2.2%		19.8%*			38.7%*
Portage	$2,429	$2,888	19%	$2,163	$2,561	18%	$2,407	11%	$266	$327	23%
Pierce	$2,575	$2,998	16%	$2,348	$2,743	17%			$227	$255	12%
Difference-in-Difference			2.5%			1.6%		-5.5%			10.6%
CMO Members	$2,002	$2,510	25%	$1,681	$2,099	25%	$1,885	12%	$321	$411	28%
Rem. of State	$2,160	$2,396	11%	$1,802	$2,024	12%			$358	$372	4%
Difference-in-Difference			14.4%*			12.5%*		-0.2%			24.1%*

* Significant at the 0.05 level

Source: The Lewin Group analyses.

The change in total spending for CMO members from the pre- to the post-period when including the actual spending for long-term care services rather than the capitated amount, was consistently greater than the change in the comparison areas; although the change was significant only the combined CMO members relative to the remainder of the state (***Exhibit VII-2***). The difference-in-difference ranged from less than one percent for the Fond du Lac-Waupaca comparison to over 14 percent for the remainder of the state comparison. These results imply that individuals that rolled over from a waiver to a CMO had larger increases in their spending than comparison individuals who received waiver services during both periods. Focusing solely on the long-term care spending produced similar results, but the differences were somewhat less for most of the comparison areas. The similar results occur because the long-term care spending represents between 74 and 91 percent of the total spending captured.

When the Family Care capitation was substituted for the average individual long-term care spending for the members, the difference-in-difference became less for the CMOs compared to the comparison for all but the Milwaukee-Rock comparison where the difference notably increased (-2.2 percent to 19.8 percent for long-term care). This major shift for Milwaukee based on the long-term care spending measure used, partly reflects overpayments to the CMO in the initial years of the program. These overpayments were reconciled at the end of the year. Importantly, overall this result implies that when the capitated payments to the CMOs are considered, individuals that rolled over from a waiver to a CMO had much smaller increases in their spending than comparison individuals who received waiver services during both periods in three of the four counties. In Milwaukee, spending appears to have increased using the capitated rate and for the remainder of the state comparison the difference-in-difference was negligible.

Taking a closer look at the spending by target group shows variations based on the comparison area (***Exhibit VII-3***). For example, for the elderly, the increase in total spending for individuals receiving services in the pre- and post-period was greater than the comparison area for Fond du Lac, La Crosse and the remainder of the state, but not for Milwaukee and Portage. This compares to the difference not being greater for those with physically disabilities or developmental disabilities for the matched counties, but increasing more in the CMO counties compared to the reminder of the state analysis.

Overall, for the CMOs relative to the remainder of the state, all three target groups, elderly, developmentally disabled and physically disabled have greater increases in spending for the total and the long-term care portion when considering the actual long-term care spending rather than the capitated payment. Factoring the capitation payment implies that the elderly showed greater increase in long-term care payments while the developmentally disabled, and in some cases, the physically disabled received lower increases than the comparison areas. This occurs and differs from what the individualized spending indicates because the capitated rate does not differentiate by target group and yet the CMOs can use the pooled funds for all members to appropriately serve individuals.

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8 We note that the MDS lacks standardized/scaler measures of cognitive impairment.

Exhibit VII-3
Difference in the Change in Average Spending Using Alternative Measures and Comparisons by Target Group

	Total			Individual Long-term Care			CMO Capitation		Non-LTC		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Fond du Lac											
Elderly	$1,093	$1,372	26%	$776	$1,051	35%	$1,613	108%	$317	$321	1%
DD	$3,540	$4,574	29%	$3,265	$4,190	28%	$1,984	-39%	$275	$384	40%
PD	$2,482	$2,518	1%	$1,668	$1,772	6%	$1,855	11%	$814	$746	-8%
Wapauca											
Elderly	$964	$1,416	47%	$794	$1,166	47%			$170	$250	47%
DD	$3,240	$3,921	21%	$3,010	$3,641	21%			$230	$280	22%
PD	$1,800	$1,872	4%	$1,311	$1,610	23%			$489	$262	-46%
Difference-in-Difference											
Elderly			-21.4%*			-11.4%		61%*			-45.8%*
DD			8.2%			7.4%		-60%*			17.9%
PD			-2.5%			-16.6%		-12%			38.1%
La Crosse											
Elderly	$727	$1,178	62%	$529	$926	75%	$1,545	192%	$198	$252	27%
DD	$2,951	$3,569	21%	$2,722	$3,289	21%	$1,942	-29%	$229	$280	22%
PD	$2,347	$3,091	32%	$1,713	$2,050	20%	$1,831	7%	$634	$1,041	64%
Manitowoc											
Elderly	$1,224	$1,562	28%	$906	$1,202	33%			$318	$360	13%
DD	$2,595	$3,228	24%	$2,394	$2,928	22%			$201	$300	49%
PD	$1,627	$1,799	11%	$1,115	$1,357	22%			$512	$442	-14%
Difference-in-Difference											
Elderly			34.4%*			42.4%*		159%*			14.1%
DD			-3.5%			-1.5%		-51%*			-27.0%
PD			21.1%			-2.0%		-15%			77.9%*

* Significant at the 0.05 level

Exhibit VII-3 (cont.)
Difference in the Change in Average Spending Using Alternative Measures and Comparisons by Target Group

	Total			Individual Long-term Care			CMO Capitation		Non-LTC		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Milwaukee	$1,460	$1,845	26%	$1,123	$1,363	21%	$1,610	43%	$337	$482	43%
Rock	$1,838	$2,201	20%	$1,472	$1,819	24%			$366	$382	4%
Difference-in-Difference			6.6%			-2.2%		19.8%*			38.7%*
Portage											
Elderly	$971	$1,102	13%	$768	$889	16%	$1,706	122%	$203	$213	5%
DD	$3,808	$4,747	25%	$3,536	$4,364	23%	$3,125	-12%	$272	$383	41%
PD	$2,590	$2,676	3%	$2,172	$2,202	1%	$2,355	8%	$418	$474	13%
Pierce											
Elderly	$596	$741	24%	$495	$619	25%			$101	$122	21%
DD	$4,709	$5,510	17%	$4,421	$5,165	17%			$288	$345	20%
PD	$2,151	$2,279	6%	$1,759	$1,914	9%			$392	$365	-7%
Difference-in-Difference											
Elderly			-10.8%			-9.3%		97%*			-15.9%
DD			7.6%			6.6%		-28%*			21.0%
PD			-2.6%			-7.4%		0%			20.3%
CMO Members											
Elderly	$1,141	$1,501	32%	$858	$1,146	34%	$1,676	95%	$283	$355	25%
DD	$3,253	$4,051	25%	$3,007	$3,723	24%	$2,209	-27%	$246	$328	33%
PD	$2,408	$2,771	15%	$1,776	$1,968	11%	$1,932	9%	$632	$803	27%
Remainder of State											
Elderly	$1,332	$1,620	22%	$1,082	$1,305	21%			$250	$315	26%
DD	$3,013	$3,428	14%	$2,776	$3,104	12%			$237	$324	37%
PD	$3,313	$2,892	-13%	$2,293	$2,206	-4%			$1,020	$686	-33%
Difference-in-Difference											
Elderly			9.9%*			13.0%*		75%*			-0.6%
DD			10.8%*			12.0%*		-38%*			-3.4%
PD			27.8%*			14.6%		13%			59.8%*

* Significant at the 0.05 level

Source: The Lewin Group analyses.

B. Community versus Nursing Facility

The comparison of Family Care and nursing facility care requires several considerations. First, although the service package covered by Medicaid for care in a nursing facility includes some services that waivers traditionally do not cover, such as room and board, a higher co-payment is required of the individual covered by Medicaid for nursing home residence. Second, the average community-based care costs are lower than those for nursing facilities, as shown in ***Exhibit VII-2***. Third, nursing facility care is one of the services available through Family Care, and the capitated rate for Family Care reflects the cost of both nursing facility and community care. We outline an analysis that addresses the comparison as fully as possible, given the available data.

Consistent measures of cost and case mix are required to compare the costs of serving individuals in Family Care and nursing facilities. Cost and functional screen data at the individual level were available for CMO counties after the start of the program and for a sample of non- Family Care waiver recipients. These data were not readily available at the individual level for those in nursing facilities. We used functional impairment data at the individual level for nursing facilities residents from the Minimum Data Set (MDS).[9] However, nursing facilities do not report costs at an individual level. Therefore, we relied on Medicaid payment rates to provide aggregate measures of costs at the facility level.

To examine "similar" groups, we used the MDS and HSRS data to develop a case mix measure based on common elements to both datasets. The measure borrowed, in part from the Resource Utilization Group (RUG) methodology, and included behavioral problems and cognitive impairment consistent in both the MDS and the functional screens (***Exhibit VII-3***). We used the late loss ADLs that Myers and Stauffer, in addition to other researchers, agree are more predictive of resource use and appear to be the least site-sensitive. These were eating (0-1), toilet use (0-1), and transferring (0-1). For cognitive functioning, we will used the MDS Cognitive Performance Scale (CPS) developed under a CMS contract by John Morris, et al, to assess a wide range of cognitive functioning using variables collected by the MDS. The CPS was designed to replace two separate test of cognitive functioning used in nursing homes, the Mini Mental Status Exam (MMSE), and Test for Severe Impairment (TSE). The CPS is based on an interaction of five variables found on the MDS:

- Is patient comatose (0-1 and only available from the MDS)
- Short Term Memory (0-1)
- Decision Making—Range from Independent to Severely Impaired (0-3)
- Making Self Understood—Range from Understood to Never Understood (0-3)

Unfortunately, the summary functional screen data available to us required a large group for mild to very severe cognitive impairment. Finally, for the behavioral measures we used wandering (0-1) and physical abusiveness (0-1). The scoring shown in ***Exhibit VII-4*** is consistent with the MDS and functional screen crosswalk the Department developed. It is important to re-iterate the site based limitations of the MDS discussed in the ***Methodology*** section. We have tried to choose measures that would tend to be less site dominated, for example bathing was not considered because it is generally the first ADL an individual loses independence and in a nursing facility, the choice to bath oneself may not be permitted.

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[9] We note that the MDS lacks standardized/scaler measures of cognitive impairment.

By developing an average and distribution of scores among NF residents, these measures allowed us to identify CMO members with similar scores to develop a case-mix adjusted comparison. We first weighted the home and community-based sample to be similar to the NF resident distribution. We will be sure to note caveats and limitations related to the different data sources and the constructs for cross walking between the data sources.

Exhibit VII-4
Case Mix Measure for Nursing Facility CMO Comparison

Activities of Daily Living	
Score	**ADL**
0-1	Eating
0-1	Toilet use
0-1	Transferring
0-3	Summary measure (sum of items)

Cognitive Functioning		
Score	**MDS Cognitive Performance Scale Categories**	**Definition**
0	Intact	Independent in decision making, short term memory, and making self understood
1	Borderline Intact	Independent in 2 of the following measures: decision making, short term memory, and making self understood
2	Mild Impairment	Understood/usually understood by others, and independent/modified in decision making
2	Moderate Impairment	Usually understood by others, or modified independence in daily decision making
2	Moderately Severely	Moderate impairment in decision making and sometimes/never understood
2	Severe Impairment	Severely impaired decision making and not totally dependent for eating
2	Very Severe Impairment	Severely impaired decision making and totally dependent for eating or comatose

Behavior	
Score	**Indicator**
0-1	Wandering
0-1	Physically abusive
0-2	Summary measure (sum of items)

Exhibit VII-5 compares the distribution of individuals in the community to nursing home residents and indicates how average community spending might increase if a distribution of patients similar to the nursing facility were served in the community. The ADL summary score case mix with the higher spending among the most impaired results in the largest increase – approximately one-third. This is also probably the most reasonable because it differentiates among the levels better than the other two measures. However, it also raises the concerns about setting bias possibly causing the nursing facility case mix to be skewed upward.

Exhibit VII-5
Alternative Case Mix Adjustments of Community Spending to Nursing Facility Impairment Levels

	NF Residents	Community Waiver Recipients	Average Community LTC Spending	Weighted to NF Distribution	Percent Increase
ADL Summary Score					
0	20.5%	34.6%	$860		
1	14.3%	32.1%	$1,165		
2	25.4%	17.7%	$1,846		
3	39.8%	15.6%	$2,693		
			$1,418	$1,884	32.9%
Behavior Summary Score					
0	90.9%	92.5%	$1,327		
1	8.4%	6.4%	$1,851		
2	0.8%	1.1%	$2,518		
			$1,373	$1,379	0.4%
Cognitive Impairment Summary Score					
0	15.2%	40.5%	$1,271		
1	11.8%	25.6%	$1,135		
2	73.0%	33.9%	$1,663		
			$1,369	$1,541	12.6%

Source: The Lewin Group analyses.

In order to compare the nursing facility ADL summary score casemix community spending to that in a nursing facility, we calculated an average Medicaid per diem of $95 in 2000 for nursing facilities in Wisconsin based on a weighted average of nursing facility intermediate care per diems.[10] This equates to an average monthly payment of $2,896. However, Medicaid does not pay the full cost of nursing home care. One average, Medicaid nursing facility residents pay 25 percent of the Medicaid per diem from their own resources through spend down provisions. This reduces the average monthly payment to $2,172. Finally, it is important to take into account that, on a monthly basis, the average nursing facility resident stays in a nursing facility less than a full month on average because of mid–month admissions and discharges. Using an average of 27 days reduced the average Medicaid payments to $1,929 making the nursing facility payment approximately two percent higher than the community-payment.

This analysis warrants several important caveats: 1) the casemix measures used to adjust the spending data were not developed from the same measurement tool and the cross-walk, as well as setting bias could skew the results; 2) it is important to consider the economies of scale afforded by nursing facilities in conjunction with a general shortage of aide workers; increased demand for community-based services may push up average wages and, in turn, Medicaid costs; and 3) all of the nursing home estimates had to be calculated at the aggregate level because no data were available that provided individual level cost differentials associated with different levels of impairment.

[10] The intermediate care rate was used because the majority of Medicaid nursing facility residents receive an intermediate level of care rather than the higher skilled level.

PART THREE:
CONCLUSIONS

VIII. CONCLUSIONS

This report attempted to determine whether Family Care met its goals during the initial implementation period. The goals included:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

This and our previous reports documented a number of benefits of the Family Care Program, including:

- **One-Stop Long-term Care Resource** -- Resource Centers that provide needed information and facilitate enrollment for potential CMO members and provide assistance to moderate to high-income residents trying to navigate the long-term care system.
- **Entitlement to Medicaid Waiver Services**-- No waiting lists in the CMO counties, which means that individuals begin to receive services soon after their eligibility has been determined and no longer have to wait months and sometimes years for an opening.
- **Greater Access to Services for Younger Individuals with Physical Disabilities** – The entitlement has lifted categorical restrictions on the number of individuals in different disability populations that can receive services, resulting in greater access to services for younger individuals with physical disabilities without crowding out the other disability groups.
- **Greater Access to Key Long-term Care Services** – CMO members appear to have greater access to residential care, adult day care, habilitation, therapies, and transportation as a result of Family Care.
- **Favorable Outcome Indicators for the Core Family Care Domains** -- Compared to individuals in the other waivers, higher percentages of CMO members indicated having each of the 14 outcomes met that constitute the three major domains of choice and self-determination, community integration, and health and safety.
- **Fewer Nursing Home Admissions** – Half as many CMO members entered a nursing home compared to a similar group of waiver participants in the remainder of the state. Delays in or the prevention of nursing home admissions has the potential to reduce the rate of growth in long-term care spending over time.

Our spending analyses indicated that on a per person basis using the CMO capitated payments for long-term care spending, the CMOs had not increased spending on benefits relative to the comparison areas. However, the increased enrollment in the CMOs relative to the growth in enrollment in the remainder of the state means that aggregate spending for the Family Care program increased relative to if it had not been implemented.

Based on the result of these analyses, our assessment of the Family Care's progress toward meeting its goals is that:

- The program has substantially met the goal of increasing choice and access and improving quality through a focus on social outcomes.
- The program has yet to demonstrate improved quality related to individual's health, in part for lack of reliable measures and the need for more time to fulfill the promise of better care management.
- It is too early to draw conclusions regarding the program's ability to create a cost-effective system for the future.

Whether the benefits discussed above warrant the short-term increased expenditures is a decision left to the Legislature. However, it is important to reiterate that the information in this report provides some preliminary indications of the results of the Family Care program. The data available for the pre- post-comparison for this report generally reflected only the first year of the program's implementation, and as a result failed to capture the ultimate impact of the program. The program would be expected to continue to evolve and hopefully capitalize on its successes thus far.

APPENDIX A
Acronyms and Glossary of Terms

ACRONYMS

ADL	**Activities of Daily Living:** Refers to the ability to carry out basic self-care activities. Activities include such tasks as bathing, dressing, walking, transferring (getting in and out of bed or chair), toileting (including getting to the toilet), and eating.
ALF	**Assisted Living Facilities:** Three types of residential assisted living facilities are subject to regulation. Community-based residential facilities serve five or more adults; adult family homes may serve up to three or four adults; residential care apartment complexes serve five or more adults in independent units.
AAA	**Area Agency on Aging:** A public or private non-profit organization designated by the state to develop and administer the area plan on aging within sub-state geographic planning and service area. AAAs advocate on behalf of older people within the area and develop community-based plans for services to meet their needs and administer federal, state, local and private funds through contracts with local service providers.
BOALTC	**Board on Aging and Long-term Care:** An independent state agency that advocates on behalf of elderly and disabled persons who are receiving long-term residential care, mainly by monitoring development and implementation of policies and programs and investigating complaints about care. As part of the Family Care initiative, BOALTC's responsibilities were expanded to provide advocacy services to potential or actual recipients of the Family Care benefit and authorized to contract for the external advocacy service.
BALTCR	**Bureau of Aging and Long-Term Care Resources:** A unit within the Wisconsin Department of Health and Family Services designated for planning, coordinating, funding and evaluating state and federal programs for older adults.
CARES System	**Client Assistance for Re-Employment and Economic Support:** The CARES system uses data supplied by an applicant for public assistance benefits to determine an applicant's eligibility for MA, Wisconsin works, food stamps and child care programs, to issue public assistance benefits and to track program participation.
CBRF	**Community-Based Residential Facility:** A place in which five or more unrelated adults live and where they receive care, treatment, or services, but not nursing care on any permanent basis, in addition to room and board. CBRFs are licensed by DHFS under ch. HFS 83 rules.[11]
CHF	**Congestive Heart failure:** a condition in which the heart is unable to maintain an adequate circulation of blood in the bodily tissues or to pump out the venous blood returned to it by the veins causing the buildup of fluid accumulating in the lungs and around the heart.
CIP	**Community Integration Program:** • CIP-IA is for developmentally disabled persons relocated or diverted from DD centers;

[11] Ch HFS 83—DHFS administrative rules for community-based residential facilities for 5 or more adults

- CIP-IB is for developmentally disabled persons relocated or diverted from nursing homes;
- CIP-II is for elderly and physically disabled persons diverted or relocated from nursing homes to appropriate community settings with the assistance of home and community-based care and with continuity of care. Care in the community is financed by MA (Medical Assistance).

CMO	**Care Management Organization:** Entity that provides or arranges for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. The CMO must coordinate care across different delivery systems (including primary health care, long-term care [LTC], and social services) and funding sources (including Medicaid fee-for-service and other commercial health insurance, Medicare, and funding sources for vocational and social services).
CMS	**Centers for Medicare & Medicaid Services** (formerly HCFA): The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).
CMUs	**Care Management Units:** Milwaukee CMO contracts with CMUs, private agencies, to serve as care managers with CMO members.
COP-W	**Community Options Program Waiver:** In January of 1987, Wisconsin received approval of the COP-Waiver request from the federal government. The waiver permits the use of federal Medicaid funds to finance services provided to eligible persons in the community, as an institutional alternative.
COP	**Community Options Program:** A DHFS financed, county-administered program to support individuals who desire to remain in the community setting. The program involves assessing the need of Medical Assistance eligible persons faced with nursing home placement and assisting them via a range of available supportive services in the community, care planning and management, and paying for gap-filling supportive services to make continued or new community residence possible.
CSDRB	**Community Services Deficit Reduction Benefit**: A program under which counties, tribes, and local health departments are able to claim the federal matching dollars to cover approximately 60% of their deficits for certain Medicaid-covered services. These public agencies are responsible for providing the non-federal matching dollars (approximately 40% of total costs) with local funds.[12]
DD	**Developmentally Disabled:** See MR/DD definition.
DHCF	**Division of Health Care Financing**: Responsible for administering the Medical Assistance (Medicaid), Chronic Disease Aids, WisconCare, Health Insurance Risk Sharing Program (HIRSP) and General Relief programs.[13]

[12] Definition from the DHFS cost model November 1999.

[13] Definition from http://www.dhfs.state.wi.us/aboutdhfs/DHCF/dhcf.htm

DHFS	**Department of Health and Family Services:** Wisconsin State Department of Health and Family Services, began July 1, 1996 and oversees Medicaid and other health programs and social service programs.[14]
DHHS	**Department of Health and Human Services**: The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
DME	**Durable Medical Equipment:** Covered by the Family Care benefit and includes items such as wheelchairs, canes, etc.
DMS	**Disposable Medical Supplies**: A benefit included in the Family Care program that supplies members with disposable medical supplies intended for one-time or temporary use, such as cotton balls, dressing materials, etc.
DSL	**Division of Supportive Living:** Within the State Department of Health and Family Services, the division manages and regulates programs involving mental health, substance abuse, developmental disability, as well as aging and long-term support programs.
DWD	**Department of Workforce Development:** Directs the Eligibility process for the following programs: Child Care Child Support Enforcement Food Stamps Medical Assistance Temporary Assistance for Needy Families (TANF) Welfare to Work W-2 Welfare Initiative
ESU	**Economic Support Unit:** County unit responsible for fiscal resources in the county.

14 Definition From http://www.dhfs.state.wi.us/aboutdhfs/BiennialReport9799

FC	**Family Care:** A voluntary long-term care managed care program. The State contracts with Care Management Organizations (CMOs) that provide or arrange for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. Family Care will foster recipients' independence and quality of life, while recognizing the need for support to remain independent.
FDD	**Facility for the Developmentally Disabled:** A type of nursing home primarily for developmentally disabled persons. State centers for developmentally disabled persons are FDDs. Licensed under ch. HFS 134 rules.[15]
FFES	**Functional and Financial Eligibility Screen:** A tool developed by DHFS and used by trained Resource Center staff to determine functional and financial eligibility for Family Care.
HCBS	**Home and Community-Based Services:** Alternatives to nursing home care that provide services to people living in the community. With further developments in community supports and technological advances, there is an increased opportunity for individuals at many levels of disability to be effectively served in the community.
HIPAA	**Health Insurance Portability and Accountability Act of 1996:** The act offers improved portability and continuity of health insurance coverage and regulations to guarantee patients rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information.
I & A	**Information and Assistance:** Service provided by the Resource Centers using a telephone number that is toll-free to all callers in its service area. Information provided is related to aging, physical and developmental disabilities, chronic illness and long-term care, including referrals to and assistance in accessing services.
IADL	**Instrumental Activities of Daily Living:** Refers to tasks required to maintain an independent household. Activities include such tasks as meal preparation, light housework, using the telephone, arranging and using transportation and the ability to be functional at a job site.
ICF	**Intermediate Care Facility:** A federal Title XIX term for Medical Assistance reimbursement purposes to a lower level of nursing care than that provided in a skilled nursing facility (SNF).
ICF-MR	**Intermediate Care Facilities for Individuals with Mental Retardation:** An ICF serving only or mainly mentally retarded residents providing active treatment for residents, and certified under 42 Code of Federal Regulations (CFR) 435 and 442. In Wisconsin, these are called facilities for the developmentally disabled (FDDs).
ISP	**Individual Service Plan:** A plan of care developed by the CMO and the Family Care member. It is based on a comprehensive assessment of the individual and reflects the individual's values and preferences for care.

[15] HFS 134 - DHFS administrative rules for facilities for the developmentally disabled (FDDs)

IT	**Information Technology:** IT refers to information and businesses regarding computers, software, telecommunications products and services, as well as, Internet and online services.
LAB	**Legislative Audit Bureau:** A non-partisan legislative service agency created to assist the Legislature in maintaining effective oversight of state operations. The Bureau conducts objective audits and evaluations of state agency operations to ensure financial transactions have been made in a legal and proper manner and to determine whether programs are administered effectively, efficiently, and in accordance with the policies of the Legislature and the Governor. The LAB is the agency administering the contract to The Lewin Group for the independent evaluation of Family Care.[16]
LOC	**Level of Care:** The level at which an individual screens functionally eligible for Family Care, either comprehensive or intermediate.
LTC	**Long-Term Care:** A range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self-care. Services may be continuous or intermittent but are delivered for sustained periods to individuals who have a demonstrated need, usually measured by some index of functional incapacity.
MA Card	**Medical Assistance Card:** Card provided by Wisconsin Medicaid and covers a broad range of health care services, including home health and nursing facility care as well as the Personal Care option.
MA	**Medical Assistance:** Wisconsin's term for the Medicaid (Title XIX) program which pays for necessary health care services for persons whose financial resources are not adequate to provide for their health care needs.
MOU	**Memorandum of Understanding:** Document clearly defining respective responsibilities of multiple entities.
MCO	**Managed Care Organization:** Any system that manages healthcare delivery to control costs.
MCP	**Member-Centered Plan:** The plan developed by the CMO staff and the Family Care member which outlines the member's preferences and personal outcomes. The plan should inform the Individualized Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.
MR/DD	**Mentally Retarded/Developmentally Disabled** **Mentally Retarded:** Individual with subnormal intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following: (1) maturation, (2) learning, (3) social adjustment. **Developmentally Disabled:** Disorder in which there is a delay in develop-ment based on that expected for a given age level or stage of development. These

16 Definition from http://www.legis.state.wi.us/lab/AgencyInfo.htm

impairments or disabilities originate before age 18, may be expected to continue indefinitely, and constitute a substantial impairment.17

PAC — **Pre-Admission Consultation:** Consultations designed to inform individuals of available long-term care options and counsel them regarding their options before making permanent decisions on their LTC. It is also an opportunity to determine if they are eligible for family care.

PD — **Physical Disability:** A physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person.

RAD — **Resource Allocation Decision method:** Developed as a tool for the care management team to determine how best to use resources and serves to identify individual outcomes and derive cost-effective options to meet these outcomes.

RAP — **Resource Allocation Program:** Under ch. 150, Wisconsin Statutes*, and ch. HSS 122 Wisconsin Administrative Code, the program of adjusting caps on nursing home and FDD beds, distributing newly available beds, and prior review of capital expenditures of nursing homes and facilities for the developmentally disabled (FDDs). [18]

17 © On-line Medical Dictionary at http://www.graylab.ac.uk/omd/

18 Definition from http://www.legis.state.wi.us/rsb/stats.html

RC	**Resource Center:** Entity offering a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers that are available in the local communities. The RCs also provide counseling about long-term care options and eligibility determination for the Family Care benefit and serve as a clearing-house of information designed to assist service personnel working with populations in need of long-term care services.
RCAC	**Residential Care Apartment Complex:** New name for Assisted Living Facility (1997 Wisconsin Act 13 amended statutes to change official name to Residential Care Apartment Complex).
RFP	**Request for Proposal:** Document that solicits proposals from outside parties in a competitive bidding process.
RN	**Registered Nurse:** A graduate trained nurse who has been licensed by a state authority after qualifying for registration.
SNF	**Skilled Nursing Facility:** A federal Titles XVIII and XIX certification term and state licensing term for long-term care facilities that provide care to residents who no longer need the type of care and treatment provided in a hospital but do require some medical attention and continuous skilled nursing observation.
WCA	**Wisconsin Coalition for Advocacy:** An independent non-profit agency with experience in consumer advocacy, especially around advocacy issues, to protect and promote the interests of developmentally disabled persons and mentally ill persons.
WHCA	**Wisconsin Health Care Association:** A non-profit organization representing 250 primarily for-profit nursing homes.
WAHSA	**Wisconsin Association of Homes and Services for the Aging:** A non-profit organization with 190 not-for-profit members principally serving the elderly and disabled, including nursing home facilities for the developmentally disabled, community-based residential facilities, independent living facilities and community service agencies.

GLOSSARY

Direct Services	Services provided directly to people by agency staff rather than purchased by the agency from an outside provider.
Indirect Services	Services to people provided by DHFS through various public and private agencies under contract.
Nursing Home	A facility that provides 24 hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care. Nursing homes are licensed by DHFS under ch. HFS 132 rules (Health and Family Services).
Options Counseling	RCs offer consultation and advice about the options available to meet an individual's long-term care needs. This consultation will include discussion of the factors to consider when making long-term care decisions. Resource centers will offer pre-admission consultation to all individuals with long-term care needs entering nursing facilities, community-based residential facilities, adult family homes and residential care apartment complexes to provide objective information about the cost-effective options available to them. This service is also available to other people with long-term care needs who request it.[19]
Personal Care	Refers to assistance with activities of daily living such as eating, dressing, bathing and walking.
Selective Contracting	The process by which CMOs will begin to include quality requirements as part of the contracts process with providers.
Supportive Home Care	Care provided to elderly and disabled persons residing in their own homes; consists of assistance with daily living needs, including household care and personal care.
Community Aids	Community Aids provides core funding to counties for basic community services to people with developmental and other disabilities and other needs. When the Community Aids system was established in 1974, the state used a combination of state and federal dollars to provide approximately 90% of the funding for county-run human services. Counties had to provide a "match" of approximately 10% in order to capture funding. Over time, the amounts contributed by some counties have grown larger than 10%.

[19] Definition from Family Care web-site at http://www.dhfs.state.wi.us/LTCare/Generalinfo/RCs.htm