Asbjornson, Karen

From: Seaquist, Sara
Sent: Monday, May 19, 2003 1:49 PM
To: Asbjornson, Karen
Subject: FW: about the Family Care "draft" report...
CR email...audit

-----Original Message-----
From: Michael J. Serpe [mailto:MSerpe@co.kenosha.wi.us]
Sent: Monday, May 19, 2003 1:22 PM
Subject: about the Family Care "draft" report...

The story I get is:

The Lewin Group submitted a Draft report and the Audit Bureau released it two weeks ago. We have now submitted comments on the draft to LAB. You might take a close look at the Conclusions section only. There it says the data they used was from very early in the implementation of Family Care and they believe it is too early to tell what the ultimate effect of the program will be.

The "draft report" is the least professional document purporting to be an evaluation I have ever seen. The Audit Bureau gave Lewin notice that they were in breach of contract for failure to provide three reports due. By contract, Lewin had 15 days to cure the breach. On the 15th day they sent this "report". There is no documentation of the source of the data or the methods used to analyze it. There are numerous inconsistencies throughout the report. For example, one table shows that CMOs were spending more than $500 per member per month more than their capitation rates. **How is then that they are all operating in the black?** As far as we can tell there is nothing of value in the report but it is impossible to know because nothing about the numbers presented is documented.

The best numbers we have -using methodology required by the federal government - show that Family Care cost $198 per member per month less in 2001 - a later period than Lewin examined - than the combination of waivers and fee-for-service that would have been the alternative program if Family Care didn't exist.

MJS

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"It is wrong to waste the precious gift of time on acrimony and division."
Cardinal Joseph Bernardin

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

JUL 15 2003

July 15, 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:

I am writing to offer the Department of Health and Family Services' response to the report released today by the Legislative Audit Bureau concerning the Family Care program. The report, *Wisconsin Family Care Final Evaluation Report*, was prepared by The Lewin Group and represents the first complete independent evaluation of the effects of the Family Care program. Family Care is a critical component of Wisconsin's efforts to control costs and ensures quality in long-term care for the elderly and adults with physical or developmental disabilities.

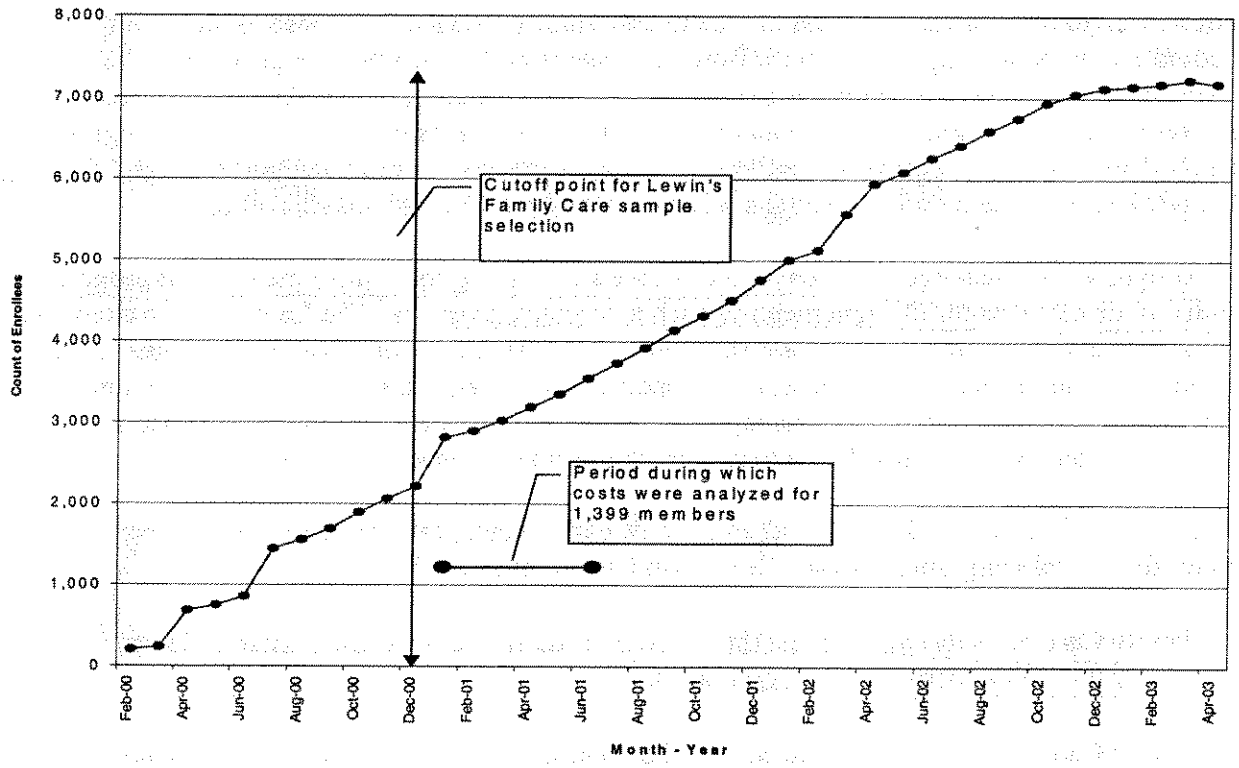
We recognize the challenge The Lewin Group faced in striving to identify meaningful program results in the early stages of implementing such a complex program. The Lewin Group exercised appropriate care to avoid inappropriate extension of any findings from those early stages to the present or to the future. For example, in its conclusions on page 109, the Lewin Group notes that "the spending data available...for this report reflected only the first year of the program's implementation and as a result failed to capture the ultimate impact of the program."

Nevertheless, The Lewin Group found, even in its early stages, that Family Care has been successful in achieving many goals. The Lewin Group concluded:

- Family Care has substantially met the goals of increasing choice and access and improving quality through a focus on social outcomes;
- Family Care has successfully eliminated the waiting lists in the Family Care counties;
- Family Care has improved access to long-term care information for the target populations, in part because outreach activities of the Resource Centers "have moved beyond the traditional approaches;"
- Virtually all of the Resource Centers have met or exceeded Department standards for contacts per capita for all target groups; and
- Consumer choice, and consumer satisfaction with choices available, have increased under Family Care, largely as the result of Care Management Organizations (CMOs) taking steps

such as increasing the number of contracted services and increasing the range of service made available in the package of services.

On the important question of whether Family Care has been a cost-effective approach to providing quality long-term care services, The Lewin Group could not be conclusive because the analysis it performed was "too early to draw conclusions regarding the program's ability to create a cost-effective system for the future." The study's cost-effectiveness analysis was limited to costs incurred in the first six months of 2001 and to only those members who had enrolled by the end of 2000 -- two and a half years ago. Below is a graphic illustration of the study period within the experience of the Family Care program.



The Lewin Group reports some encouraging signs:

- Average CMO spending for new enrollees -- those who had not been served in the waiver programs before joining Family Care -- was 58 percent of the average amount that CMOs spent on enrollees who 'rolled over' from the existing waiver programs into Family Care;

- The increase in per-person CMO spending during the 2001 study period was greater than that in the balance of the state, but was comparable to spending increases in four 'matched' counties operating traditional waiver programs; and

- Family Care is less expensive than care in nursing facilities, when costs are compared for each level of care. For example, for enrollees at the skilled nursing level of care, community-based care was 65.3% of nursing-facility care for similar individuals.

As noted on page 109, The Lewin Group concludes that the study's findings are largely mixed, and results depend on the data being compared and on assumptions made.

Furthermore, per-person spending increases reported for individuals included in the Lewin study did not occur in subsequent years or for the whole Family Care membership. The Lewin Group notes on page 95 that "since 2001, none of the CMO monthly capitation rates have increased more than three percent annually, and Portage County saw a 5 percent decline in rates in 2003." Capitation rates represent the actual per-person cost of Family Care to the State's Medicaid budget. These rates -- including the first-year rates -- were set based on the CMO members' previous years' costs, as verified by an independent actuary, plus a small inflation adjustment. Given these limited rate increases since 2001, if costs had increased at a double-digit pace as report for the six-month period studied, the individual CMOs would have lost money, and the CMOs would be experienced serious financial troubles. In fact, operating within these capitated rates, all five CMOs have had revenue in excess of costs.

Care management organizations are a new type of business for Wisconsin's counties, and managed long-term care is a new product. As with any new business delivering a new product, the CMOs could not be expected to reach their full potential for cost-effectiveness promptly after their creation. CMOs have developed many mechanisms to control costs and achieve cost-effectiveness. It is important to emphasize that Family Care was designed to achieve cost-effectiveness in two stages. Only the first stage -- high-level changes in the Medicaid long-term care delivery system -- had been largely completed by June 2001 at the end of Lewin's study period. During this stage, CMOs had been created and given authority to manage a wider range of long-term care services. The Family Care program had established a funding arrangement of flat capitated payments for each member that places the CMO at risk for financial losses if the CMO does not deliver services economically, rather than the State Medicaid program.

The longer, second stage of systems change occurs as the local organizations respond to the new incentives by adopting new business practices for the delivery of cost-effective managed long-term care. This second stage was just getting underway in June 2001 and is not yet fully completed. While there is still room for improvement, we believe the cost-effectiveness of the Family Care CMOs has improved since the close of the Lewin study period. The CMOs have been responding to the new incentives and business environment by changing many business practices. Some of the many changes include:

- Family Care care management teams include nurses who monitor members' health, coordinate services with the members' medical providers, and support the members' caregivers to prevent or delay functional decline requiring more costly care.

- Family Care care management teams use a decision-making tool that guides care-planning decisions to consider both cost and effectiveness.

- CMO fiscal and client-service staff work together with the care management teams in making cost-effective decisions.

- CMOs have increased incentives and ability to negotiate rates and service quality standards with the providers from whom they purchase services for their members. CMOs have created a more competitive local market for long-term care services and increased accountability for providers.

- The CMOs are developing improved internal management reports, more flexible personnel practices, better ways to identify and correct unauthorized purchases, improved collection from third-party payers, and other techniques to manage risk and costs.

Finally, we recognize legislative interest remains high in determining Family Care's success in achieving cost-effectiveness goals. Because it had to focus on the early years of program implementation, the Lewin Group study simply could not be conclusive on this point. However, the Department will be able to provide the Legislature and the general public with more current information and analysis of the results of the Family Care program later this year. We have contracted with APS Healthcare, Inc., to perform an independent assessment of Family Care's cost-effectiveness, as required by the federal Centers for Medicare and Medicaid Administration. This analysis, which will be released in September 2003, relies on cost data through 2002 and is making extensive use of comparison methods that adjust for differences in the level of care needs among individuals, so that the costs of serving Family Care members can be compared to groups of people who are matched in age, disability level, and other factors.

In conclusion, we appreciate The Lewin Group's extensive analytical efforts and thoughtful conclusions about the early stages of Family Cares' implementation and results. We also appreciate the continued legislative interest in, and support for, the Family Care program. Wisconsin needs to find a way to reform long-term care so that the growing needs of the target populations are met in a cost-effective manner. Forthcoming analyses should contribute to determining the extent to which Family Care has made progress in achieving this goal.

Sincerely,

Kenneth Munson
Deputy Secretary

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

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July 15, 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., in 1999 to conduct an evaluation of the Family Care pilot program. This report is the final document in a series of reports prepared under the terms of the contract.

Family Care is a restructuring of Wisconsin's long-term care system for the elderly, the physically disabled, and the developmentally disabled. The first three Lewin reports focused on state and county-level implementation of the program, including the operation of Resource Centers in nine counties and Care Management Organizations in five of the counties with Resource Centers. The draft version of this final report, which examines the early outcomes and cost-effectiveness of the program, was released May 1, 2003. This final version also includes Lewin's final implementation update.

As we noted when releasing the May 2003 draft, the Lewin Group did not complete this report within the time frame required by our contract. However, the report was reviewed in draft and final form by this office and the Department of Health and Family Services. This final report reflects a number of revisions Lewin made for clarity and to correct inconsistencies in the draft report but includes only one substantive change, involving a nursing home utilization comparison.

Lewin concludes that the program has substantially met the goals of increasing choice and access and improving quality through a focus on social outcomes, but that through June 2001, it had yet to demonstrate improved health quality for its participants. Lewin further states that it is too early to draw conclusions regarding the program's long-term cost-effectiveness.

A summary of the report's key findings is enclosed. A copy of the entire report is also available on our Web site: www.legis.state.wi.us/lab.

I hope you find this information useful. Please contact me if you have any questions.

Sincerely,

Janice Mueller
State Auditor

JM/KW/bm

Enclosures

cc: Senator Robert Cowles
Senator Alberta Darling
Senator Gary George
Senator Jeffrey Plale
Representative Samantha Kerkman
Representative Dean Kaufert
Representative David Cullen
Representative Mark Pocan

FAMILY CARE PILOT PROGRAM

Family Care was created in 1999 Wisconsin Act 9 to eliminate a perceived bias toward institutional care and to streamline a fragmented funding system for long-term care services. It is administered by the Department of Health and Family Services and is currently operating as a pilot program in nine counties.

The Family Care model creates two new community organizations:

- Resource Centers, which provide elderly and physically and developmentally disabled residents in all nine counties with "one-stop shopping" for information and assistance; and

- Care Management Organizations (CMOs), which help to arrange and manage services in five counties for those determined eligible under the program.

The program also uses managed care principles, including capitated payments, in an effort to help control costs.

The fiscal year (FY) 2002-03 budget for Family Care totals $155.9 million, including $142.4 million for the costs of the CMOs, $8.3 million for the Resource Centers, and $5.2 million for other costs. The program is funded with a mix of federal funds and general purpose revenue (GPR). In FY 2002-03, approximately $71.9 million in GPR was appropriated for Family Care.

Services covered by the Family Care capitated payment include residential services, personal care, home health, physical therapy services, adult day care, and supported employment services. Hospital care, physician care, prescription drugs, and several other services are not provided as part of the Family Care benefit or reflected in the Family Care budget but are received on a fee-for-service basis under Medicaid. The monthly capitated payment amounts vary by county. In 2003, they ranged from $1,721 in Milwaukee County to $2,491 in Portage County. Family Care enrollment in December 2002 was 6,966.

The enclosed report from the Lewin Group is lengthy and detailed. We have summarized some of its major findings to assist the reader in interpreting the results of Lewin's evaluation.

Access to Services and Information

One way to measure information and outreach services by Resource Centers is in terms of contacts per 1,000 in county population. From 2001 to 2002, average monthly contacts increased for all nine counties with Resource Centers except Portage, which changed the manner in which it counted some contacts in conformance with a request by the Department. Lewin notes that contact goals for the elderly and physically disabled, as established through contracts with the Department, were met in all counties, and only Marathon and Kenosha counties failed to meet monthly contact goals for the developmentally disabled target population.

One of the program's principal goals was elimination of waiting lists for community-based services. Waiting lists were eliminated in all five CMO counties by the end of 2002, and all

CMO counties reached entitlement status by that date. Consequently, in these counties all persons found financially and functionally eligible must be offered access to benefits under the Family Care program. In contrast, the report notes that in the rest of the state, waiting lists for waiver services have continued to grow.

As noted, enrollment in Family Care's five CMOs reached 6,966 in December 2002. From December 2001 to December 2002, enrollment grew by 48 percent. By county, enrollment growth ranged from a low of 17 percent in Fond du Lac to a high of 74 percent in Milwaukee.

Lewin notes that outside Milwaukee County, enrollment growth was greatest for younger, physically disabled individuals in the two-year period from December 2000 to December 2002. Milwaukee County's Family Care program is restricted to the elderly, which affects program demographics statewide. Lewin notes that 76 percent of CMO enrollees statewide were elderly in December 2002, but the percentage of elderly CMO participants would fall to 47 percent if Milwaukee were excluded.

The report notes that the size of the program's provider network has generally increased over time, and many different provider types are used. The CMOs write contracts with service providers and also purchase some services without formal contracts. From May 2001 to May 2003, Lewin reported increases in the number of providers under contract in three of the five CMO counties: a 16 percent increase in La Crosse, a 34 percent increase in Fond du Lac, and a 73 percent increase in Portage. As of May 2003, Lewin found that all CMOs had established procedures to identify service needs among program participants.

Infrastructure Development

Information technology system development has been very important in implementation of Family Care. However, while an electronic "functional screen" developed by the Department of Health and Family Services is uniformly used to determine the functional status and eligibility of individuals, a number of systems have been put in place for other aspects of Family Care administration. For example, the report notes that Resource Centers use different systems to record information on referrals, and the five CMO counties use four different software systems for this purpose. The report also notes the existence of various manual and automated systems to record assessments, case notes, service plans, prior authorization of services, billing, and claims processing.

Lewin also reports that CMOs face staffing challenges because of both Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements and a shortage of registered nurses, who must be part of the interdisciplinary care management team for each program participant.

Quality of Life and Quality of Care

The Department has developed an interview tool to assess participants' perceptions of the program and its effects on their quality of life. The Department recently completed a third round of interviews with care managers, randomly selected Family Care participants, and participants in

other community-based waiver programs. Family Care participants reported more positive outcomes than the others surveyed 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 compared the incidence of four traditional indicators of quality of care for CMO enrollees with the incidence of those indicators in the remainder of the state during the first six months of 2001. The report notes slightly lower levels of hospital and emergency room use, diagnosis of decubitis ulcers, and death for Family Care recipients, but no statistically significant differences.

Expenditures

Under a capitated payment system, the Department pays the CMOs a fixed amount per participant per month to provide the CMO-covered services. The CMOs actually spend more or less per participant based on assessed need. To determine how individuals who had received waiver services prior to enrolling in a CMO fared under the new system, Lewin compared actual spending levels for services delivered in the initial four CMO counties during two six-month periods—before the pilot program, or from October 1999 through March 2000, and again during the pilot program, from January through June 2001. Three areas were compared:

- the Family Care CMO counties;
- a matched "comparison" county for each Family Care CMO county; and
- the remainder of the state.

Lewin found the greatest cost increase in the Family Care CMO counties, where average monthly expenditures increased 25.2 percent, from $2,001 to $2,505 per person. In the remainder of the state, expenditures increased 10.9 percent, from $2,160 to $2,395 per person.

The services for which average monthly expenditures were highest statewide were personal care, residential services, and prescription drugs. In the CMO counties, expenditures for drugs increased at a slower rate: the increase was 10.6 percent, compared to 16.9 percent statewide. However, for inpatient care, physician services, and dental services, the increase in spending was considerably higher in the Family Care CMO counties. For all acute care services, average monthly expenditures increased 25.2 percent in the CMO counties, compared to 12.1 percent in the remainder of the state.

Lewin also measured the cost of Family Care by comparing average pre-Family Care expenditures to capitated payments made to the CMOs. In addition, Lewin examined expenditure changes

among target populations. These analyses were conducted on a county-by-county basis, as well as at the state level. Lewin found:

- Statewide, expenditures for the elderly increased 21 percent; however, in the CMO counties, expenditures for this group increased 29 percent,

- Statewide, expenditures for the physically disabled decreased 13 percent; however, in the CMO counties, expenditures for this group increased 15 percent,

- Statewide, expenditures for the developmentally disabled increased 14 percent; however, in the CMO counties, expenditures for this group increased 24 percent.

The county-by-county analysis yielded other significant results. For example, expenditures for the elderly in the La Crosse CMO increased 61 percent, while expenditures in the comparison county, Manitowoc, increased 28 percent. In contrast, expenditures for the elderly in the Fond du Lac CMO increased 24 percent, while expenditures in the comparison county, Waupaca, increased 47 percent.

Comparison of Community and Nursing Facility Costs

Comparing Family Care expenditures for care in the community to costs associated with care provided in nursing facilities was an important goal of this evaluation, and the report compares spending for long-term care services in the community to nursing facility spending at three levels of care: intermediate; skilled nursing; and intensive skilled nursing. Lewin noted that more data on service costs per individual are available for Family Care participants than for individuals in nursing facilities, and the data on individuals' functional status are collected using a different methodology for Family Care than for nursing facilities. Lewin addressed these issues by developing comparable functional measures and using various proxy measures to make cost comparisons.

Lewin found that expenditures were lower for community care services under Family Care than for nursing home care. When functional status was considered, average spending for long-term care services in the community was 74.3 percent of nursing home spending. However, if level of care was considered, the difference diminished as the level of care increased. At the intermediate level of care, average community costs were 49.8 percent of nursing home costs: $1,048 per person per month in the community, compared to $2,104 in a nursing home. At the skilled nursing level, average community costs were 65.3 percent of nursing home costs: $1,658 per person per month in the community, compared to $2,538 in a nursing home. Finally, at the intensive skilled nursing level of care, average community costs per month were 95 percent of the average nursing home costs: $2,827 per person per month in the community, compared to $2,976 in a nursing home.

****

Wisconsin Family Care Final Evaluation Report

Prepared for:

Wisconsin Legislative Audit Bureau

Prepared by:

The Lewin Group

Lisa Maria B. Alecxih
BrieAnne Olearczyk
Christina Neill
Sharon Zeruld

June 30, 2003

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PART ONE:
INTRODUCTION

I. PROGRAM OVERVIEW

Family Care, an innovative experiment designed to improve Wisconsin's long-term care system, has been 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 array of funding streams for services. Family Care created 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 introduced managed care principles in an attempt to control escalating costs.

In 1999, the Governor and Legislature authorized the Department of Health and Family Services (DHFS) to pilot the Family Care Program in a limited number of counties. Fond du Lac, Portage, La Crosse and Milwaukee Counties began operating RCs in 1999 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.[1] 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, Family Care will provide frail older adults and younger adults with physical or developmental disabilities with greater access to flexible services that promote independence and facilitate a higher quality of life. Family Care involves several innovations:

- Family Care in CMO counties transforms home and community-based services (HCBS) into an entitlement for individuals eligible for Medicaid. Previously, these individuals were entitled to institutional care, but were often placed on a waiting list for HCBS.
- Family Care in CMO counties incorporates managed care principles into long-term care, one of only a few such experiments nationwide.
- Family Care creates a single entry point resource center that provides information and education to all individuals in need of long-term care regardless of Medicaid eligibility.
- Family Care includes strong requirements for consumers to have the option of directing their own care and the involvement of stakeholders in the development and implementation of the program.
- Family Care in CMO counties unifies service delivery systems for three target populations, frail older adults, younger adults with physical disabilities (PD), and adults with mental retardation or other developmental disabilities (MR/DD). It should be noted that in Milwaukee, only individuals age 60 and older receive services through the CMO.

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[1] Some counties already had informational and referral functions similar to the Resource Centers prior to the passage of the Family Care legislation.

A. Eligibility

Exhibit I-1 summarizes the different components of eligibility criteria for Family Care benefits. As noted above, the target populations for the Family Care benefit are frail older adults, adults with physical disabilities and adults with developmental disabilities. The Resource Centers make information and referral services and options counseling available to all income and functional need groups. The Care Management Organization benefits are restricted to individuals meeting a comprehensive or intermediate level of care and, during most of the program's three years, to individuals who met Medical Assistance (MA) financial criteria (three percent were non-MA in December 2002).

Exhibit I-1
Eligibility for Family Care Benefits

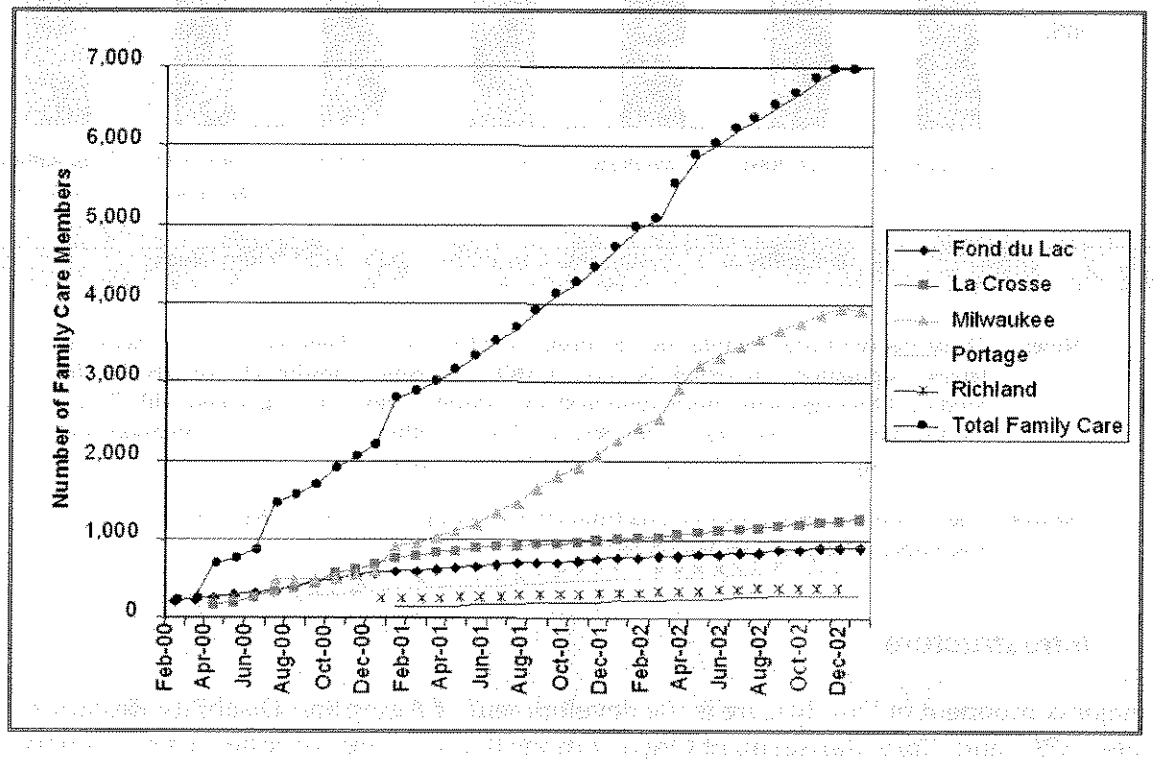
<table>
<tr><th>Target Population</th><th>Frail Older Adults</th><th>Adults with Physical Disabilities</th><th>Adults with Developmental Disabilities</th></tr>
<tr><td></td><td>Age 65+, except Milwaukee age 60+</td><td>Age 17 years and 9 months and older</td><td>Age 17 years and 9 months and older</td></tr>
<tr><th colspan="4">Resource Center (RC) Services</th></tr>
<tr><th>Eligibility</th><td colspan="3">Individuals of all income and functional need can access information and referral services and options counseling</td></tr>
<tr><th colspan="4">Care Management Organizations (CMO) Benefits</th></tr>
<tr><th rowspan="2">Functional Eligibility</th><th>Comprehensive Functional Level</th><th colspan="2">Intermediate Functional Level</th></tr>
<tr><td>Unable to safely perform any of the following:
• 3 or more Activities of Daily Living (ADLs)
• 2 or more ADLs & 1 or more IADLs
• 5 or more IADLs
• One or more ADL(s) and 3 or more IADLs and has a cognitive impairment
• 4 or more IADLs and has a cognitive impairment</td><td colspan="2">Unable to safely perform any of the following:
• One or more ADL(s)
• One or more of the following critical IADLs:
➢ Management of medications and treatment
➢ Meal preparation and nutrition
➢ Money management
And at least one of the following applies:
• In need of Adult Protective Services
• Qualify for Medical Assistance
• Grandfathered from an existing LTC program</td></tr>
<tr><th rowspan="2">Financial Criteria</th><th colspan="2">Medical Assistance (MA) (Title XIX -- Medicaid)</th><th>Non-Medical Assistance</th></tr>
<tr><th>HCBS Waiver/ Nursing Facility</th><th>Medically Needy</th><td></td></tr>
<tr><td></td><td>Income: 300% of Supplemental Security Income (SSI) limit
Individual: $1,656/mo or $19,872/yr
Couple: $2,487/mo or $29,844/yr
Resources:
Individual: $2,000
Couple: Spousal impoverishment provisions of $2,000 + ½ combined countable assets greater than $100,000 where spouse may retain a minimum of $50,000 and maximum of $90,600</td><td>Income: Gross monthly income - medical expenses < $591.67/mo.
Resources:
Individual: $2,000
Couple: $3,000
Cost-share/deductible required</td><td>Service plan costs > gross monthly income + 1/12th countable resources
Cost-share/deductible required</td></tr>
</table>

Note: Countable resources include bank accounts, stocks, bonds, and the face value of life insurance policies greater than $1,500. The value of the individual's owned primary place of residence, one automobile, burial plots, home furnishings, and personal jewelry are not included.

Source: The Lewin Group based on Wisconsin Medical Assistance and Family Care Eligibility information.

Family Care CMO enrollment has increased significantly since its inception and only recently appears to have begun to level off (***Exhibit I-2***). Family Care CMOs had 2,202 members by December 2000, 4,706 by December 2001 and 6,966 by December 2002. Each CMO county had a different December 2002 distribution of enrollees by target group, with frail older adults consistently the highest proportion (76 percent overall), followed by individuals with developmental disabilities (14 percent overall) and those with physical disabilities (10 percent overall) (***Exhibit I-3***). Excluding Milwaukee, which only includes older frail adults, and focusing on the four counties serving all three target groups, as expected, shows higher proportions for individuals with developmental disabilities (31 percent) and those with physical disabilities (21 percent) and a lower proportion of older frail adults (47 percent).

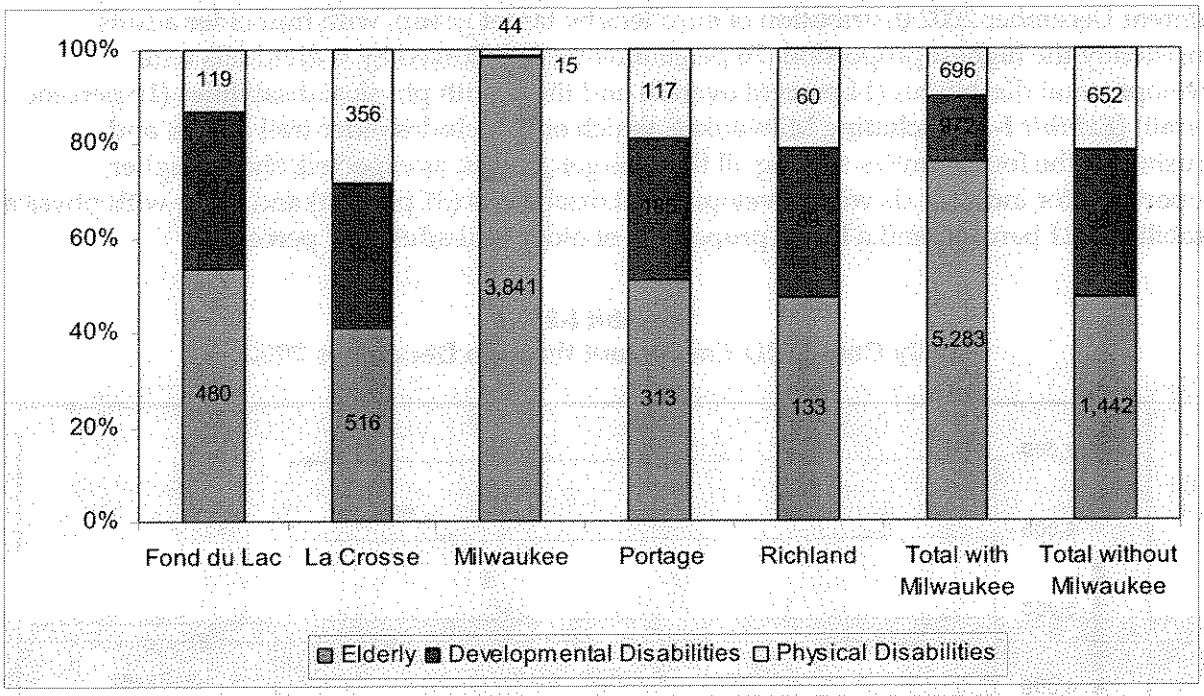
Exhibit I-2
Family Care CMO Enrollment through December 2002



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.

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.

Exhibit I-3
Family Care CMO Enrollment by Target Group, December 2002



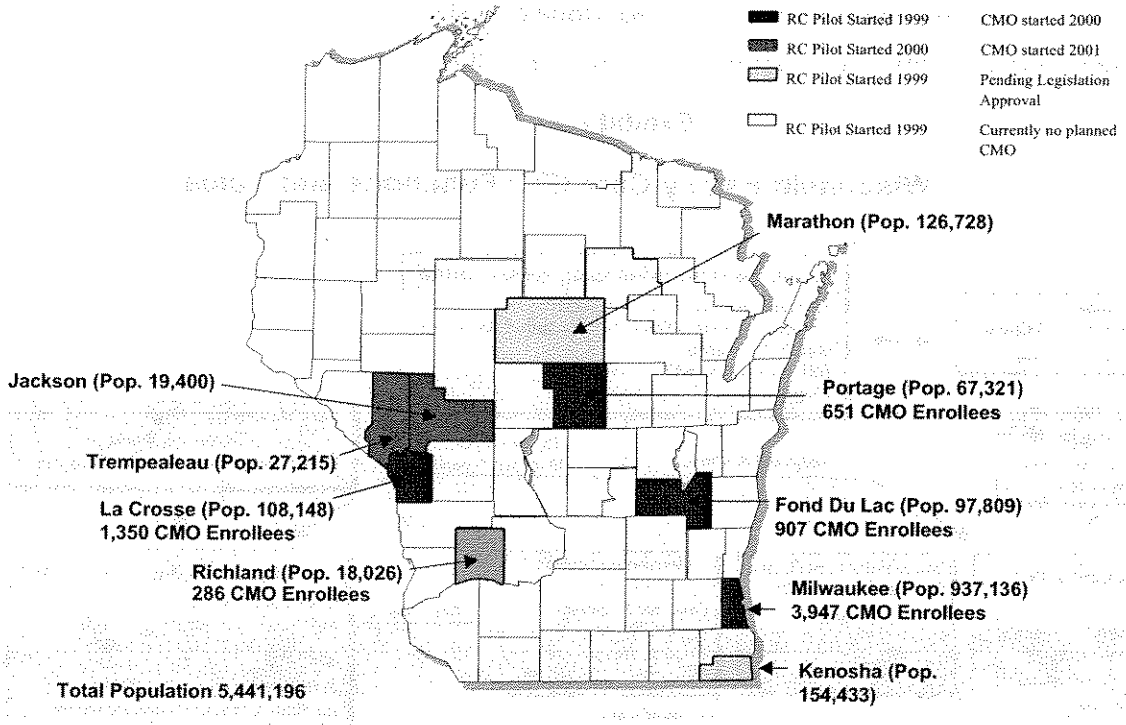
Note: These distributions exclude the 15 enrollees (12 in Milwaukee) that did not have the target population identified because CMO members' enrollment records in the Medicaid Management Information System (MMIS) cannot yet be matched with Target Group data from the Functional Screen, due to different Medicaid Evaluation and Decision Support (MEDS) data warehouse load schedules.

Source: The Lewin Group analysis of data from DHFS Family Care Activity Report for December 2002 available March 2003.

B. Infrastructure

A major component of Family Care is the development of Aging and Disability Resource Centers (RC) and Care Management Organizations (CMO). Four counties have RCs only -- Jackson, Kenosha, Marathon, and Trempealeau -- and five counties operate both RCs and CMOs -- Fond du Lac, La Crosse, Milwaukee, Portage and Richland. ***Exhibit I-4*** depicts the location and indicates the start year for each entity, as well as CMO enrollment as of May 2003.

Exhibit I-4
Family Care Sites



Source: Total CMO enrollment , 7,141, as of May 1, 2003, as posted on http://www.dhfs.state.wi.us/LTCare/Generalinfo/EnrollmentData.htm and population estimates from Population Division, U.S. Census Bureau, Table CO-EST2002-01-55 - Wisconsin County Population Estimates: April 1, 2000 to July 1, 2002, Release Date: April 17, 2003

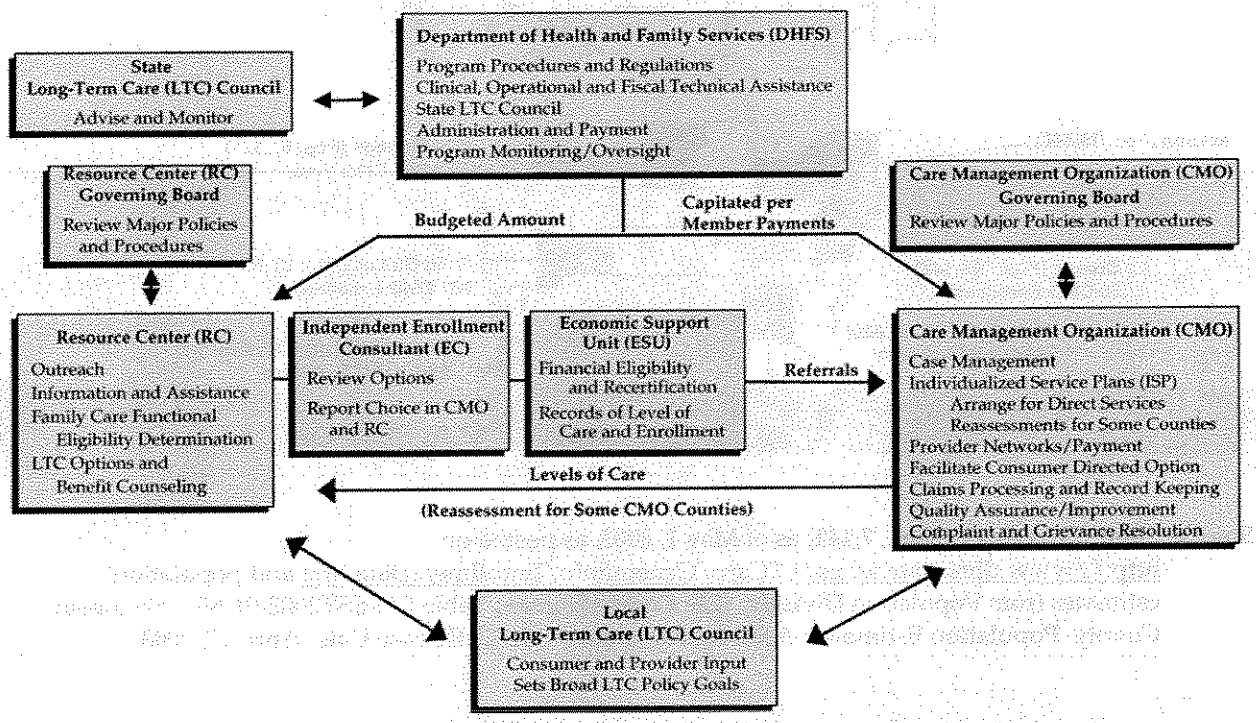
Family Care involves the partnership and interaction among a number of entities at both the state and local level (***Exhibit I-5***). Similar to programs prior to Family Care, the long term care counseling and the provision of benefits occurs at the local level, primarily through the Resource Centers and Care Management Organizations (discussed more below). These two entities have separate governing boards, in part to address federal concerns regarding the same entity, currently counties, being ultimately responsible for all aspects of eligibility determination and enrollment under a fiscal model that includes incentives to restrict care or possibly limit eligibility. Also elaborated on below, to further mitigate any potential conflicts of interest related to the county's role in enrollment and service provision, the Centers for Medicare and Medicaid Services (CMS) required the inclusion of an Independent Enrollment Consultant. As a result, in order to access the Family Care CMO benefit, an individual must be:

- found functionally eligible at the comprehensive or intermediate levels (determined by the RC);
- found financially eligible for Medical Assistance (MA) and/or be willing to enroll with a cost-share agreement (determined by the Economic Support Unit (ESU));

- provided choices about enrollment (performed by the RC and the Independent Enrollment Consultant);
- entered into the state data system as enrolled (done by ESU); and
- provided services (delivered or arranged for by the CMO).

Exhibit I-5

Wisconsin Family Care (FC) Functions and Roles



Source: The Lewin Group, based on site visits and document review.

The Department of Health and Family Services, primarily through the 25 member staff of the Center for Delivery Systems Development and with assistance from the Division of Supportive Living (reconfigured and renamed in 2003 to the Division of Disability and Elder Services) and the Bureau of Information Systems, oversees the program and provides technical assistance to the county entities. The statewide Long Term Council, created by the statute in 1999, served as an advisory committee to the Governor, the Legislature, and DHFS concerning Family Care, as well as the future of all long-term care programs in the state; while the county-based Local Long Term Care Councils (LLTCCs) provide general planning and oversight to the CMO county RCs and CMOs as advisory bodies with the perspective of the overall long-term care system in the county.

Resource Centers

Resource Centers provide assistance to individuals seeking information about long-term care services and service personnel working with populations in need of long-term care services. They offer 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. In addition, the RCs provide general counseling about long-term care options, conduct pre-admission counseling targeted to individuals considering admission to a long term care facility, employ benefit specialists, and determine functional eligibility for the Family Care benefit. Services are provided to consumers at the RCs, and via telephone or home-visits. Resource Centers are responsible for implementing and monitoring the quality of their operations. They are overseen by governing boards that provide oversight on the development of a mission statement for the Resource Center, determine relevant structures, policies, and procedures of the Resource Center consistent with state requirements and guidelines, identify unmet needs, and propose plans to address unmet needs. County RCs receive an annual budget from the DHFS based on the size of the county's target population and those that conduct functional screens can recoup these expenses through Medicaid. Many of the counties provide in-kind support for the RCs through space in county buildings and IT support.

Care Management Organizations

CMOs receive per member per month payments to deliver services to 7,141 individuals receiving the Family Care benefit as of May 2003.[2] The state chose to contract with the counties on a sole source basis for CMO operation at the start of the program. The CMOs must develop a provider network sufficient to provide services to the target populations enrolled in Family Care in their respective counties. CMO staff perform comprehensive interdisciplinary assessments of consumer needs and preferences and work with consumers to develop a plan of care. CMOs are also responsible for monitoring and assuring the quality of services provided. CMOs also have Governing Boards with representation that reflects the ethnic and economic diversity of the CMO's service area and is at least one-fourth consumer representatives. The Boards provide advice regarding CMO policies and procedures.

Independent Enrollment Consultant

Beginning in January of 2002 (April 2002 in Milwaukee), counties incorporated an independent enrollment consultant (EC) into the enrollment process for the Family Care benefit. Funding for the ECs was reallocated from the state budget for RCs. The EC must be independent of the county and functions to provide unbiased information to the consumer about his or her choices. Additionally, the EC ensures the consumer's freedom of choice in enrolling with a managed care organization in order to meet a standard federal Medicaid managed care requirement. In all of the CMO counties, with the exception of Milwaukee, which offers other managed care programs such as PACE and Partnership, eligible consumers must choose between Medicaid fee-for-service and the CMO to receive publicly-supported home-and-community-based waiver services. Consumers who choose Medicaid fee-for-service long-term care can either reside in a nursing facility or stay at home with services limited to what is available through the State plan. ***Exhibit I-6*** indicates long-term care services available through the State Medicaid Plan as fee-for-service, or card services, and those available only through the CMO benefit (***Appendix A*** provides detailed definitions for the CMO covered services from the CMO contract). The

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[2] To receive the Family Care benefit an individual must qualify functionally and financially. Cost-share options are available for individuals who do not meet financial requirements; however, few individuals are not Medicaid eligible.

Medicaid fee-for-service benefit does not provide the range of community options available through the CMO, but does include personal care services. Individuals choosing fee-for-service may include: those living in the community that are satisfied with the level and range of benefits they receive from the MA card personal care benefit, those who do not wish to have a care manager, and those who would rather receive nursing facility care when the CMO may recommend community services.

Exhibit I-6
CMO Only Services and Medicaid Fee-for-Service Long Term Care Services

Medicaid Long Term Care Services Available Only Through The Family Care CMO Benefit	Medicaid Fee-For-Service Long Term Care Services
Comprehensive Assessment and Care Plan Residential Services: Residential Care Apartment Complex (RCAC), Community Based Residential Facility (CBRF), Adult Family Home Consumer Directed or Self Directed Supports Consumer Education and Training Adult Day Care Habilitation Prevocational Services Supported Employment Respite Care Family Support Program Protective Payment/Guardianship Personal Emergency Response System Services Orthotics/Adaptive Equipment Home Modifications Housing Counseling Meals: home delivered and congregate Transportation by Specialized Medical Vehicle Providers (for other than medical visits) Other Flexible Services when appropriate and approved	Targeted Case Management Home Care Services Personal Care Skilled Nursing Therapies Physical Therapy Occupational Therapy Speech Therapy Language Pathology Mental Health/Substance Abuse Services Day Treatment Child/Adolescent Day Treatment Community Support Program Services In-Home Intensive Psychotherapy In-Home Autism Treatment Nursing Facilities Intermediate Care Facility for People with Mental Retardation (ICF/MR) Institute for Mental Disease (IMD) Disposable Medical Supplies Durable Medical Equipment (DME)

DHFS contracted with the Southeastern Wisconsin Area Agency on Aging (AAA) to provide staff for the enrollment consultant role. The agency employs three Full-Time Equivalent staff to conduct the enrollment consultant function. One full-time staff person covers La Crosse, Portage, and Richland. The other two full-time positions, divided among three employees, serve Milwaukee and Fond du Lac.

Economic Support Unit

County Economic Support Units (ESU) determine financial eligibility for MA and processes enrollment by: 1) inputting the final level of care (LOC) determination for Family Care supplied by the RC for CMO reimbursement purposes; and 2) determining cost-sharing and inputting that amount into the Client Assistance for Re-Employment and Economic Support (CARES) system. These ESU functions in the CMO counties constitute one of the many eligibility determination and ongoing tracking functions carried out by ESU staff for programs targeted to the low income population, including other non-Family Care Medical Assistance (MA), Wisconsin Works (W-2), which is Wisconsin's Temporary Assistance to Needy Families (TANF) program, the continuance of child-only cases, child care assistance, and food stamps, among others.

C. Benefits

Prior to Family Care, the state and consumer groups expressed concerns about the long-term care system, which included the fragmented and confusing array of funding streams, as well as a structural bias toward institutional services. CMO benefits place both institutional and home and community-based services under the same capitated payment mechanism, reducing any bias to one setting or another. ***Exhibit I-7*** presents the Medicaid covered services that the CMO must include in the Family Care benefit package and the Medicaid services not covered in the benefit package, but CMO care managers must facilitate and sometimes coordinate access to services not covered by the CMO benefit package.

A key service that has changed dramatically under the CMO model is care management or support coordination. Under Family Care, care management strives to balance consumer preference and cost through addressing the core issues facing consumers. In this model, care management acts as an organizational approach to control costs, facilitate consumer direction, and consider acute and primary care needs. Family Care care management focuses on the unique needs of the individual and involves a holistic approach by the use of an interdisciplinary team, consisting of the CMO member (consumer), social workers, RNs, providers, and family members.

D. Quality Assurance/Improvement

DHFS developed a comprehensive plan to assess quality in Family Care that constitutes a large component of their overall evaluation of the program. The plan addresses components of quality at the county level and at the individual member level across target populations. This multi-level strategy is intended to promote quality monitoring at both the program and consumer levels. In doing so, the Department, CMOs, RCs, the enrollment consultants, and the Family Care members all play vital roles in promoting quality assurance. ***Exhibit I-8*** summarizes the components of the Department's strategy to monitor quality at the county and individual levels. In addition, as part of federal requirements, the Department contracted with Innovative Resource Group (renamed APS Health Care, Inc.) to conduct an independent assessment of the Family Care program for calendar year 2002 and 2003 (the first two years of the approved 1915(b) Medicaid waiver).

Family Care relies on a consumer-centered approach that includes process measures, such as CMO contract 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' perceptions 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 (***Exhibit I-9***).

Exhibit I-7
CMO and Medical Assistance (MA) Card Covered Services

Medicaid Services Included In The Family Care CMO Benefit	Services Coordinated Through Medicaid Fee-For-Service
Adaptive Aids (general and vehicle)	Ambulance Transportation
Adult Day Care	Audiology
Alcohol and Other Drug Abuse Day Treatment Services (in all settings)	Chiropractic
Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis	Crisis Intervention Services
Case Management (including Assessment and Case Planning)	Dentistry
Chore Service	Eyeglasses
Communication Aids/Interpreter Services	Family Planning Services
Community Support Program	Hearing Aids
Consumer Directed or Self Directed Supports	Batteries, Accessories, Devices
Consumer Education and Training	Repair and Maintenance
Counseling and Therapeutic Resources	Hospice
Daily Living Skills Training	Hospital
Day Services/Treatment	Inpatient (except DME)
Durable Medical Equipment (DME), except for hearing aids and prosthetics	Outpatient (Except Physical Therapy Occupational Therapy, Speech Therapy, Mental Health, Substance Abuse Treatment)
Home Health	Independent Nurse Practitioner Services
Homemaker	Lab and X-ray
Home Accessibility Screening and Modifications	Mental Health Services (MD; Inpatient)
Housing Counseling	Nurse Midwife Services
Meals: home delivered and congregate	Optometry
Medical Supplies	Pharmaceuticals
Mental Health Day Treatment Services (in all settings)	Physician Services
Mental Health Services, except physician provided or on an inpatient basis	Podiatry
Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease (IMD)	Prenatal Care Coordination
Nursing Services (including respiratory care, intermittent and private duty nursing) and Skilled Nursing Services	Prosthetics
Occupational Therapy (in all settings except for inpatient hospital)	School-Based Services
Personal Care	Transportation by Common Carrier
Personal Emergency Response System Services	
Physical Therapy (in all settings except for inpatient hospital)	
Prevocational Services	
Protective Payment/Guardianship Services	
Residential Services: Residential Care Apartment Complex (RCAC), Community Based Residential Facility (CBRF), Adult Family Home	
Respite Care (For caregivers and members in non-institutional settings)	
Specialized Medical Supplies	
Speech and Language Pathology Services (in all settings except for inpatient hospital)	
Supported Employment	
Supportive Home Care	
Transportation: select Medicaid covered (i.e. Medicaid covered Transportation Services except Ambulance and transportation by common carrier) and non-Medicaid covered	

Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, (May 2002) *Family Care: A Pilot Program for Redesigned Long-Term Care, Progress Update.*

Exhibit I-8
DHFS' Multi-Level Quality Plan

LEVEL	CMO	CMO Status	RC	RC Status
Family Care County System Level	CMO Certification	Includes written quality plan; Ongoing	RC Certification	Includes written quality plan; Ongoing
	Annual Site Reviews			
	Technical Assistance Plans Developed At Time Of Site-Visit			
	CMO Performance Reporting	• Complaints, Grievances, and Resolution • Quarterly Narrative Reports • Annual Outcome Focused Performance Improvement Projects • Quality Indicators	RC Performance Reporting	• Monthly Information and Assistance • Monthly Pre-Admission Consultation reporting • Annual QA/QI Project • Monthly reporting / Quarterly Reviews • Quarterly Narrative Reports
Individual Member/ Target Population Level	DHFS Family Care Outcomes Monitoring	• Conduct additional analysis from the CMO Member Outcomes • CMO Member-Centered Service Plan Review	RC Consumer Satisfaction	RC consumer satisfaction surveys

Source: The Lewin Group, based on DHFS provided quality framework, site visits, and document review.

Exhibit I-9
Member Outcome Tool Domains and Measures

Domain	Choice And Self-Determination	Community Integration	Health And Safety
Outcomes Measured	• 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	• People choose where and with whom they live • People participate in the life of the community • People remain connected to informal support networks	• People are free from abuse and neglect • People have the best possible health • People are safe • People experience continuity and security

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

As of July 1, 2002, the Department contracted with MetaStar to conduct external quality review (EQR) activities for the Family Care program, previously conducted by DHFS. EQR activities evaluate the quality of the contracted services arranged for or provided to Family Care enrollees

or potential enrollees. DHFS' stated goal of EQR activities "is to gain an understanding of how each CMO is or is not meeting the needs of its enrolled population, how each RC and the enrollment consultant program is meeting the needs of potential Family Care enrollees, and how differences in State and CMO, RC or enrollment consultant approaches affect outcomes."[3]

Pilot counties have their own responsibility to provide quality services and monitor the quality of care at the RCs and the CMOs. The Department continues to encourage the pilots to oversee quality of the Family Care program locally. Each RC and CMO must submit a quality plan to the Department for approval. The counties update the Department regularly through quarterly narrative reports, complaint and grievance reports, and through data reporting. They also participate in workgroups sponsored by the Department that allow exchange of information and ideas around incorporating components of quality in provider contracts, care management, self-directed supports, and information technology.

At the individual level, the Family Care model empowers the consumer to hold the county accountable for service delivery. Advocacy support for consumers is provided internally by the CMO and was offered externally by the independent advocate, funding for which was eliminated in the 2001-03 Biennial Budget. Consumers are also empowered to participate in the development of the Family Care program through the county Long Term Care Councils and CMO governing boards.

E. Financing

More than forty state and locally-administered programs that offer various services with differing eligibility requirements constitute Wisconsin's long-term care system.[4] The implementation of Family Care consolidated the major sources through the CMO benefit, including:

- State and county funded Community Options Program (COP-R);
- Four Medicaid home and community-based waivers (HCBS) called Community Options Program Waiver (COP-W) and Community Integration Programs (CIP IA, IB and II) which are restricted to individuals who meet income requirements and limited in size by state requests and federal approval of the number of individuals that can be served; and
- Other Medicaid long term care services available to enrolled individuals including home health and nursing facility care as well as the personal care option.

In order to operate a program that restricts choice of providers for Medicaid services and provides services in the home and community, the Department had to apply for a 1915(b)/(c) waiver combination from the Centers for Medicare and Medicaid Services (see ***Exhibit I-10***). The 1915(b) waiver mandates Medicaid enrollment into managed care, uses a "central broker", and limits the number of providers for services (i.e. limits access to waiver services through the CMOs only). The 1915(c) waiver allows the Department to provide long-term care services as an alternative to institutional placement with a more generous income criteria than Medicaid

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3 External Quality Review Contract with MetaStar, June 27, 2002 found at http://www.dhfs.state.wi.us/LTCare/StateFedReqs/EQROContract.pdf.

4 Request for Proposal for the Evaluation of the State of Wisconsin Family Care Program Department of Health and Family Services: RFP: LAB-0199. (1999, September). Issued by the Wisconsin Legislative Audit Bureau, Madison, WI.

eligibility through avenues other than the waiver. Both waivers eliminate the requirement for state-wideness and comparability of services. The (b)/(c) waiver combination affords the Department the opportunity to offer home and community based services to an expanded population with the 1915(c) waiver through a managed care system with the 1915(b) waiver.

Exhibit I-10
Requirements Waived by the 1915 (b) and 1915 (c) Waivers

b/c Waiver Combination	
Freedom of choice 1915(b) Waiver	Home and Community Based 1915(c) Waiver
State-wideness	State-wideness
Comparability of services	Comparability of services
Freedom of choice	Community income and resource rules for the medically needy

In June 2001, CMS approved the Department's request for two 1915(b) waivers - one for Milwaukee County for frail older adults and one for Fond du Lac, Kenosha, La Crosse, Portage, and Richland counties for all three target groups. The waivers, effective for two years, began January 1, 2002. The 1915 (c) waiver was also approved June 1, 2001 for three years. Prior to January 2002, Family Care CMO enrollment was voluntary and the counties continued to operate their fee-for-service waiver programs. Subsequent to January 2002, once a county converted all of its prior waiver recipients to the CMO, individuals that wished to access waiver services had to enroll in the CMO.

The final fiscal year 2001 to 2003 biennial budget included $113.4 million for FY 2001-02 and $155.9 million for FY 2002-03 with the majority of funding (54 percent) from federal Medicaid match (***Exhibit I-11***). CMOs comprise 89 to 91 percent of the total funding, RCs 5 to 7 percent, with most of the remaining 3 to 4 percent devoted to planning and program accountability and oversight measures.

Exhibit I-11
Funding for Family Care

	FY 2001-2002	FY 2002-2003
Total Projected Cost	$113,396,100	$155,881,500
Source		
Federal Funding	$61,065,200	$83,955,200
State Funding (GPR)	$52,330,900	$71,926,300
Component		
Resource Centers	$7,910,100	$8,264,200
Care Management Organizations	$100,574,900	$142,354,300
Other Costs	$4,631,900	$4,960,200
Adult Protective Services	$279,200	$302,800

Source: DHFS budget for Family Care found at http://www.dhfs.state.wi.us/LTCare/StateFedReqs/FCBUDGET0103.htm.

Exhibit 1-12 shows the monthly capitated rates paid to the CMOs during calendar year 2003. Milliman USA calculated the rates based in part on historical county per user spending for the target population, level of care for nursing facilities and ICF-MRs, instrumental activities of daily living (IADL) impairments and activities of daily living (ADL) impairments. The payment covers benefits identified earlier and includes approximately 12 percent to cover CMO operating expenses. As of the beginning of 2003, all five of the CMOs had accepted full risk, which means that any spending over the aggregate capitated payments to the CMO become the responsibility of the CMO through their reserves.

Exhibit I-12
Prospective CY 2003 Monthly Capitation Rates

CMO County	CY 2003 Prospective Capitation Rate
Comprehensive Level of Care	
Fond du Lac	$1,897.04
La Crosse	$1,748.84
Milwaukee	$1,720.63
Portage	$2,491.01
Richland	$1,941.49
Intermediate Level of Care	
All CMO Counties	$640.74

Source: DHFS provided information.

II. OVERVIEW OF THE EVALUATION

This is 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
Draft Outcomes and Cost-Effectiveness Evaluation Report – May 2003
Final Report: Combined Implementation Process, Outcomes and Cost-Effectiveness Evaluation Report

This report incorporates revisions to the *Draft Outcome and Cost-Effectiveness Evaluation Report* and also provides a summary of the implementation of Family Care through May 2003, as well as major conclusions and future considerations for the program. 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 the outcome analysis generally reflect only the first year of the program's implementation, and, as a result, does not capture the ultimate impact of the program. 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. This report also updates the baseline fidelity measure (see ***Appendix C***), a measure of program progress outlined in the previous report, with information as of May 2003.

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 the outcome and cost-effectiveness analyses.

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.

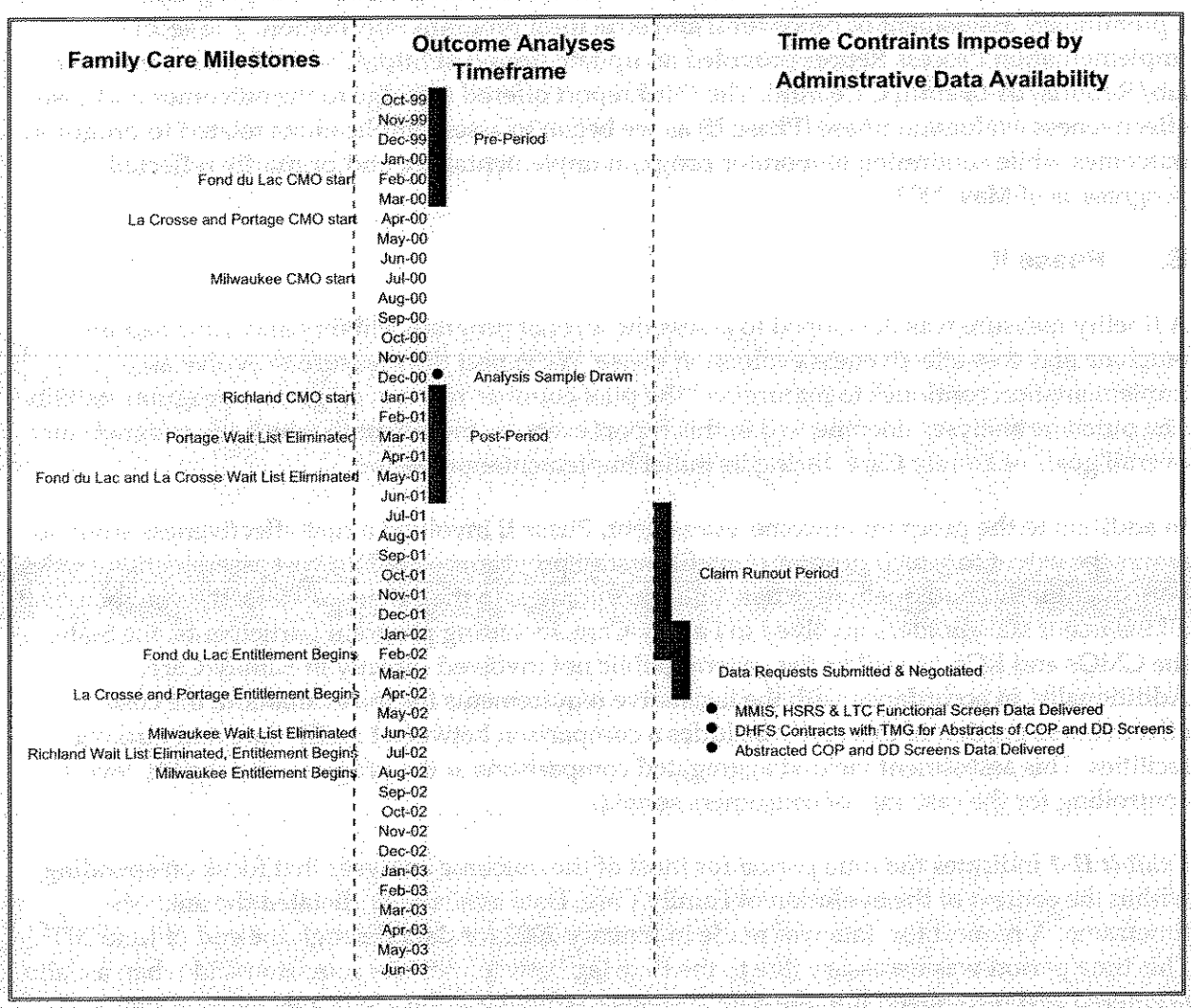
B. Phase II

A fidelity measure was developed to assess the level of program stability and informed the outcome and cost-effectiveness evaluation phase. We expect the measure to evolve as implementation continues to mature and the pilot counties reach even greater program stability. The outcome analyses documented in this report examine the extent to which the program met overall goals of Family Care during its initial implementation period.

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. 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.

Exhibit II-1 indicates the time period for most of the outcome analyses that focus on spending within the context of the evolution of Family Care. 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 the Medicaid claims system). DHFS provided information regarding lag factors associated with different types of services in the Medicaid Management Information System (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. In conducting the analyses, we did not adjust for the up to 10 percent of unobserved spending because the analyses were carried out at the individual level and it would not be possible to accurately predict which individuals would incur the unobserved spending.

Exhibit II-1
Family Care Outcome Analyses Timeframe



III. METHODOLOGY

This report focuses on both the implementation update and the outcome and cost-effectiveness analyses. The implementation update relied primarily on a review of the documentation and data provided by the Department of Health and Family Services (DHFS) and the Family Care pilot counties, and follow-up correspondence by e-mail. Specifically, we reviewed the following documentation and data supplied by the pilot county staff and DHFS:

DHFS Monthly Activity Reports and Quarterly Family Care Activity Reports;

Resource Center (RC), Care Management Organization (CMO), Enrollment Consultant (EC), External Quality Review Organization and (EQRO), Independent Assessment (IA) 2003 Contracts; and

Pilot County Quarterly Narrative Reports.

Implementation information for the prior reports, which is incorporated here, was gathered through: 1) site visits to each of the pilot counties operating both a CMO and a RC -- Fond du Lac, La Crosse, Milwaukee, Portage, and Richland – once each year from 2000 to 2002; 2) telephone communication with DHFS staff; 3) documentation and data provided by the DHFS and the Family Care pilot counties; and 4) provider telephone interviews. The remainder of this section focuses on the data and analytic techniques for the outcome and cost-effectiveness analyses.

The outcome and cost-effectiveness portions of the report 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 approach accounts for changes over time unrelated to the Family Care program by adjusting for the change experienced by a

similar group not subject to Family Care (comparison areas). The underlying assumption is that the time trend in the control group is an adequate proxy for the time trend that would have occurred in the Family Care CMO counties in the absence of Family Care. 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 program versus the comparison sites).

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

Similar information for MR/DD services by county was not available for our analysis. 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.

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.

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.

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.[5] The random sample approach has the advantage of diversifying the comparison area and precluding the possibility of selecting a county that looks well-matched based on available information 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.

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.

Using the matched county and remainder of the state samples, the analyses included the groups depicted in ***Exhibit III-2***. The "existing enrollees" had to receive Medicaid HCBS waiver (COP-W, CIP IA, CIP IB, or CIP II) services and/or be a Family Care enrollee in both December 2000 and December 1999. "New enrollees" were not Medicaid HCBS waiver participants in 1999, but were enrolled in either waiver programs or Family Care in December 2000.

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

Exhibit III-2
Analysis Groups

	Geographic Areas	Status 12/00	Status 12/99
Existing Enrollees			
Family Care CMO	Fond du Lac La Crosse Milwaukee Portage Total Family Care – 4 counties combined	Family Care enrollees	Medicaid HCBS Waiver participants (COP-W, CIP IA, CIP IB, CIP II)
Comparison Areas	Waupaca Pierce Manitowoc Rock Remainder of the State (Non-FC counties)	Medicaid HCBS Waiver participants (COP-W, CIP IA, CIP IB, CIP II)	Medicaid HCBS Waiver participants (COP-W, CIP IA, CIP IB, CIP II)
Milwaukee Non-Family Care	Milwaukee	Medicaid HCBS Waiver participants (COP-W, CIP IA, CIP IB, CIP II)	Medicaid HCBS Waiver participants (COP-W, CIP IA, CIP IB, CIP II)
New Enrollees			
Family Care CMO	Fond du Lac La Crosse Milwaukee Portage Total Family Care – 4 counties combined	Family Care enrollees or relevant waiver participants that enrolled in a CMO by 6/01	Not enrolled in Medicaid HCBS Waiver

In addition to the DID analyses, the authorizing legislation for this evaluation specified comparing the costs of care in a nursing facility to the costs of care in a community setting. To fulfill this requirement, we examined Medicaid-funded nursing facility residents in the Family Care counties during December 2000. ***Exhibit III-3*** provides information about nursing facilities in the CMO counties.

Exhibit III-3
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 an electronic functional status measure for this population (the MDS, which is required in skilled nursing facilities certified for Medicare and Medicaid residents, 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-4*).

Exhibit III-4
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-5 summarizes the key characteristics of the data sources used in the analyses for this report.

Exhibit III-5
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 Disability and Elder Services (formerly the Division of Supportive Living); 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

As noted earlier, 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);
- Milwaukee non-Family Care enrollees; 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.

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-6*** 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 enrollees rolled-over from the waiver, one-half received Medicaid waiver services during December 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 Family Care target group waiver recipients from December 1999.
- For Milwaukee, a goal of 400 waiver recipients age 60 and over in December 1999 were sampled, half of whom enrolled in the CMO in December 2000. Using this stratification in Milwaukee permitted analyses of pre-post for CMO members and for those still in the waiver, in addition to the comparison area analyses. The nearly 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.

Exhibit III-6
Samples for Level of Care Abstracting Among those in Pre- and Post-Period

	Participants Who Were Elderly or Physically Disabled		Participants with Developmental Disabilities		Individuals	Number of Screens to Abstract
	1999	2000	1999	2000		
Fond du Lac	199		110		309	309
Waupaca	82	82		77	159	238
La Crosse	302		151		453	453
Manitowoc	174	174		79	253	426
Milwaukee (elderly only)	392	198			392	590
Rock	252	252		38	290	542
Portage	142		103		245	245
Pierce	48	49		76	125	174
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 includes 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.

Those functional 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 functional 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 were adjusted in the analyses by developing weights based on the original proportions. This weighting scheme essentially holds the target population distribution constant across the Family Care CMO and comparison area samples for the analyses.

Exhibit III-7 presents the sample sizes for existing and new enrollees used in the analyses.

Exhibit III-7
Sample Frame and Analysis Sample Sizes

	Existing Enrollees		New Enrollees	
	Sample Frame	Analysis Sample	Sample Frame	Analysis Sample
Fond du Lac	313	237	274	274
Waupaca	158	140		
La Crosse	445	355	262	262
Manitowoc	228	220		
Milwaukee (elderly only)	444	186	223	223
Rock	236	189		
Portage	249	194	105	105
Pierce	126	108		
Family Care CMO Co.	1,451	972	864	864
Statewide Sample	12,758	482		

Appendix B provides information regarding the characteristics of each of the Family Care CMO samples compared to each of the comparison area samples, both unweighted and weighted. In general, when the comparison area population is weighted by target group to be the same as the Family Care CMO enrollment in December 2000, the populations have similar distributions of characteristics with a few exceptions, as noted in the Appendix. The most differences exist between the Milwaukee and Rock county samples, and even Milwaukee early Family Care enrollees differed from those individuals that were still receiving waiver services in Milwaukee in terms of impairments in activities of daily living. However, by focusing on the change over time between the groups, even these differences do not bias the results of the difference-in-difference analyses.

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 co-payments) and may not fully capture use and certainly does not reflect total health care 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 been required and the timeframe for completion of 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:
PROGRAM PROGRESS

IV. OVERVIEW OF PROGRAM PROGRESS

Over the course of the implementation process evaluation, The Lewin Group monitored the progress of the Family Care model using the fidelity measure, introduced in our 2001 report. The measure provided a baseline assessment of Family Care implementation by county for each of the core domains and program components. Please see ***Appendix C*** for the complete fidelity measure for 2001, 2002 and 2003.

- Our discussion of program progress is organized around the core components of the fidelity measure:

- Infrastructure development;
- Governance;
- Access to services and information; and
- Care management, consumer direction and quality.

The Family Care pilot counties have now achieved many of the implementation milestones established by DHFS. ***Exhibit IV-1*** highlights some of the markers of program progress and offers a map for reference while reading about the implementation, particularly for the CMOs, across the pilot counties. ***Appendix D*** contains a glossary of terms to assist readers less familiar with the program and its terminology.

Achievements of particular note include:

- The establishment of nine Resource Centers that provide a single source across populations (in all but Milwaukee) for easy access to information, referrals, options counseling, and, in the CMO counties, coordination of the CMO enrollment process.
- The use of a single web-based functional screen for all three target groups that was recently instituted statewide.
- The introduction of procedures for institutional diversion through requiring providers to submit pre-admission consultation (PAC) referrals to the RCs for individuals inquiring about nursing home care.
- The creation of five Care Management Organizations that built upon the existing county long term care functions of service brokerage and contracting and added provider development, enhanced care management, and quality assurance and improvement.
- The elimination of wait lists for home and community-based services (HCBS) and the establishment of an entitlement to HCBS in the CMO counties.
- The institution of interdisciplinary care management teams that, in addition to long-term care, consider acute and primary care needs and strive to balance consumer preference and cost.