approximately 75 percent higher than Fond du Lac and Portage, while La Crosse's was 28 percent higher. Decennial census data indicate that Richland had higher disability rates and lower income than the other three counties across all three target groups. This higher proportion of the adult population served may contribute to the slowdown in enrollment that Richland has experienced since July 2002 when they reached full entitlement and eliminated their wait list.

Direct comparisons of Milwaukee's relative enrollment to the other counties is hindered by the lack of comparable target populations. Using the adult population measure, Milwaukee appears to have a much lower enrollment rate compared to the other counties with 0.6 percent. Yet, including individuals age 18 to 59 in the denominator when they are not part of the target population depresses this measure. Restricting the denominator to the relevant population age 60 and older, however, inflates the measure relative to the others because the proportion of individuals in need of long-term care increases with age.

Exhibit X-2
Disability and Economic Data for the CMO Counties

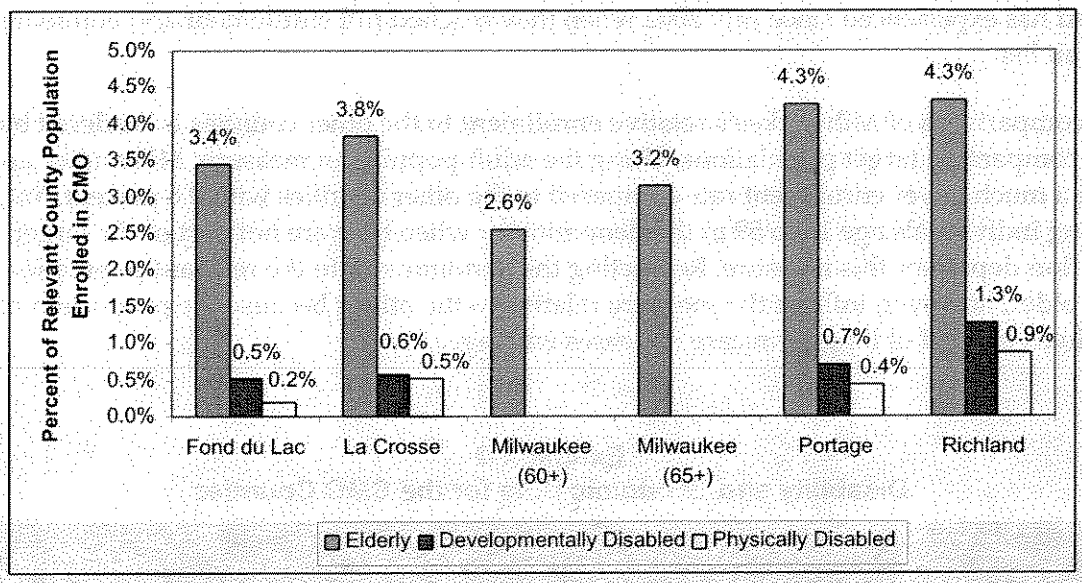
	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Disability Rates in 2000					
Age 5-20	7.5%	7.5%	9.8%	6.5%	8.1%
Age 21-65	11.9%	13.4%	19.6%	11.5%	14.6%
Age 65+	36.6%	35.4%	39.7%	36.1%	39.6%
Economic Status in 1999					
% Below Poverty (All)	5.8%	10.7%	15.3%	9.5%	10.1%
% Below Poverty (age 65+)	8.2%	7.5%	8.5%	8.0%	9.1%
Median Household Income	$45,578	$39,472	$38,100	$43,487	$33,998
Median Per Capita Income	$20,022	$19,800	$19,939	$19,854	$17,042
County Population Growth 2000-2002	0.5%	1.0%	-0.3%	0.2%	0.6%

Source: U.S. Census Bureau, Census 2000 Summary File 3, Matrices P18, P19, P21, P22, P24, P36, P37, P39, P42, PCT8, PCT16, PCT17, and PCT19.

Note: Individuals were classified as having a disability if any of the following three conditions were true: (1) they were 5 years old and over and had a response of "yes" to a sensory, physical, mental or self-care disability; (2) they were 16 years old and over and had a response of "yes" to going outside the home disability; or (3) they were 16 to 64 years old and had a response of "yes" to employment disability.

Standardizing for the relevant age groups across counties indicates a smaller range of enrollment rates among older individuals, with Milwaukee at the low end with 3.2 percent and Portage and Richland at the high end with 4.3 percent (***Exhibit X-3***). Milwaukee having the lower enrollment rate is not explained by its higher disability rate among the elderly and similar poverty rate based on Decennial census data. Among individuals with developmental disabilities, Fond du Lac, La Crosse and Portage have similar enrollment rates between 0.5 and 0.7 percent, with Richland at twice these rates at 1.3 percent. Enrollment rates among individuals with physical disabilities showed the greatest variation between 0.2 percent and 0.9 percent, with Richland again at the high end.

Exhibit X-3
CMO Enrollment Rates among Age-Relevant Adult County Population

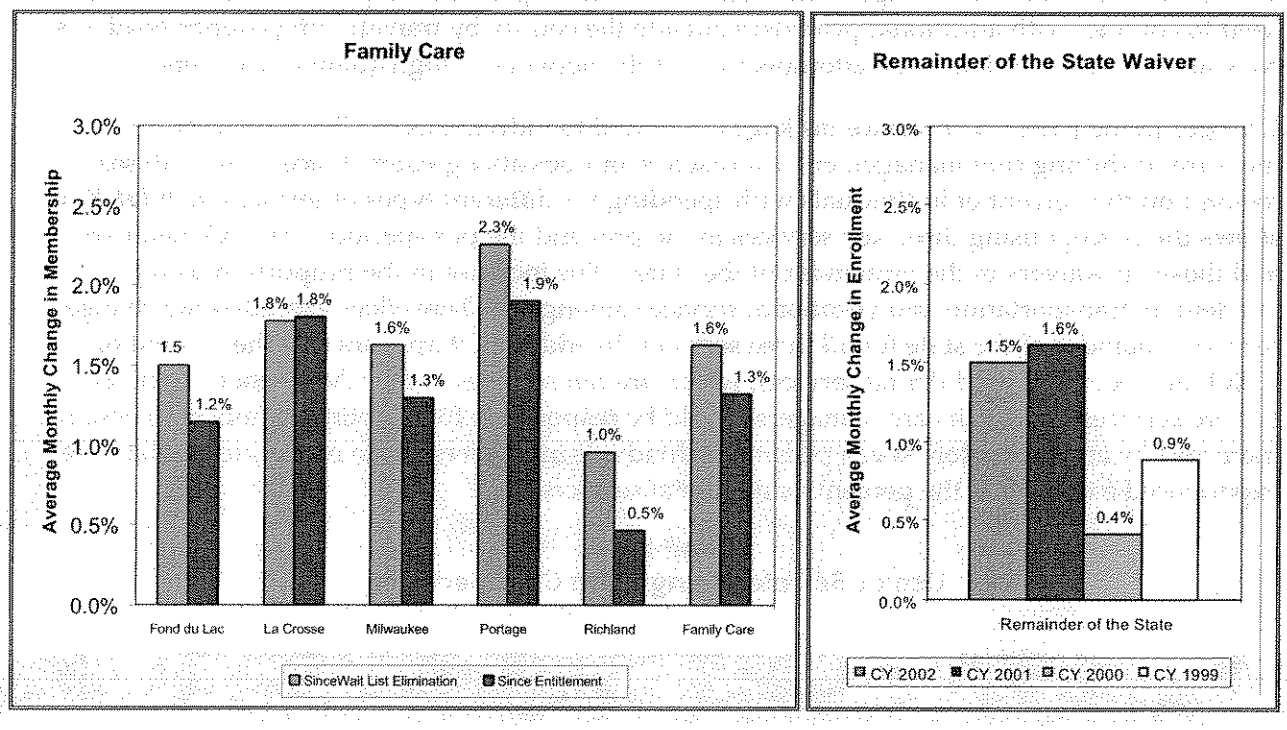


Source: The Lewin Group analysis of data from DHFS Monthly Monitoring Reports for December 2002 available March 2003.

Whether or not enrollment has reached a steady state is a key consideration for program budgeting and achieving any potential savings because it will be difficult to achieve any savings if enrollment increases at an accelerated rate for a prolonged period. As of December 2002, enrollment exceeded budgeted enrollment by 12 percent as calculated by the Office of Strategic Finance for their September 2001 cost model. Milwaukee and Portage had the greatest difference in actual versus budgeted enrollment, with actual enrollment 17 percent greater than budgeted enrollment. Enrollment in Richland was 11 percent greater than budgeted, while Fond du Lac and La Crosse were eight and three percent higher, respectively.

The budget had anticipated an average monthly net increase in enrollment of 3.2 percent at the start of 2002, tapering off to 2.3 percent at the end of the year. It is difficult to know what would be the "right" percentage to expect. Examining the average monthly net change in enrollment since each of the CMOs eliminated their wait lists and since entitlement may provide some insight. On average through the end of calendar year 2002, membership had grown approximately two percent per month since the CMO counties reduced their target population wait lists to zero; this rate is somewhat lower than the rate anticipated in the budget, but higher than the average waiver enrollment rates for the remainder of the state over the last four years (***Exhibit X-4***). The average for the reminder of the state provides a point of reference, but is not an indicator of steady state enrollment expectations because of the limits on enrollment imposed by the state and federal approval process. Average monthly change in enrollment rates for all five counties dropped to 1.3 percent following full entitlement, making net enrollment growth in the mid-range of the rates of growth in the remainder of the state during the last several years.

Exhibit X-4
Average Monthly Change in Enrollment



Source: The Lewin Group calculations based DHFS Monthly Monitoring Reports for December 2002 available March 2003 and data from the Department of Health and Family Services Medicaid statistics found at http://www.dhfs.state.wi.us/Medicaid1/caseload/intro.htm

3. *Service Availability*

The two measures of service availability used were: 1) the number of CMO contracted providers over time; and 2) changes in the use of different types of services between the period prior to instituting the CMOs (October 1999 to March 2000) to a period after the CMOs (January 2001 to June 2001) for individuals in a CMO and/or the waiver for both periods in the CMO counties relative to the remainder of the state.

The number of contracted CMO providers over time serves as one indication of the change in the number and range of choices since the CMOs were launched; however; CMOs' practices of allowing some providers to serve CMO members without a formal contract means that the numbers do not fully represent available providers. In addition, the measure does not effectively indicate how available providers may or may not have changed from prior to 2000.

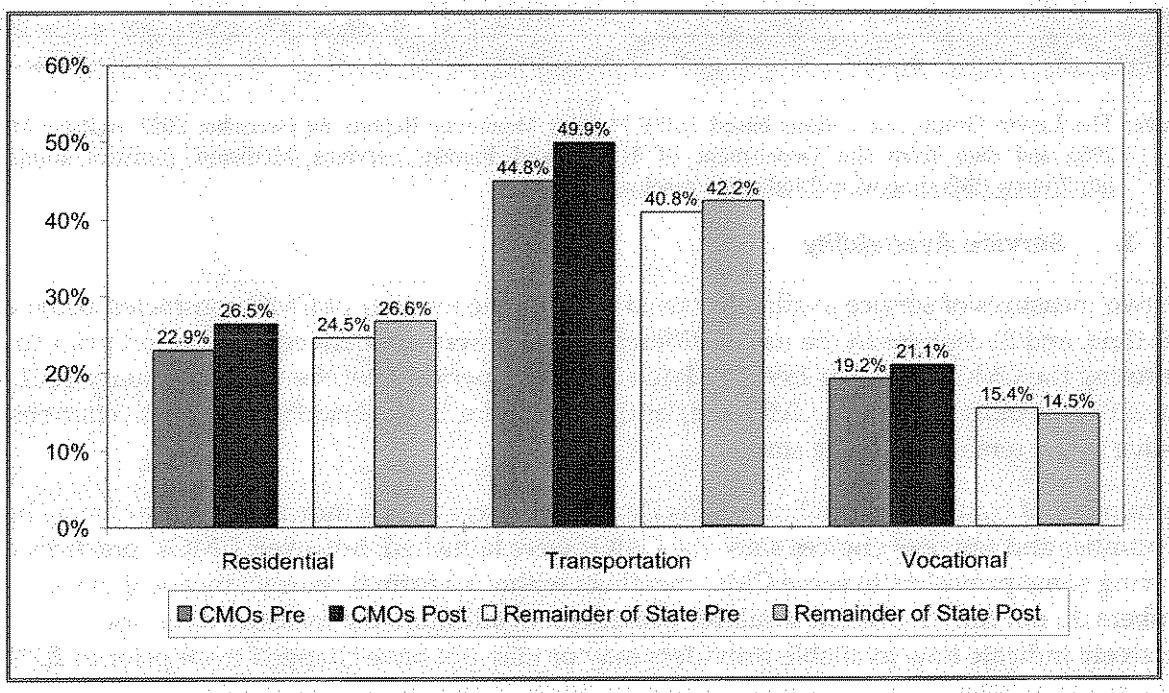
As indicated previously in this report, for the three CMOs for which the number of contracted providers were available over time (Fond du Lac, La Crosse and Portage), the number and range of contracted providers increased between May 2001 and May 2003 (see ***Exhibit VII-8*** and ***Appendix E***).[16] In particular, alternative residential facilities increased in the three counties and

[16] Accurate change over time could not be calculated for Milwaukee and Richland due to the methods used for data collection and provider contracting practices.

also in Milwaukee which reported 2002 and 2003 information. Respite care providers increased in both Fond du Lac and Portage. Decreases in contracted providers represented eliminating the need to contract with additional providers outside the county by transitioning county residents back to the county or deliberate attempts to limit the network to high quality providers.

Changes in the patterns of service packages provided to individuals in CMOs provide a measure of shifting care management approaches and possibly greater choice. Our analyses focused on the percent of individuals with spending for different types of services. ***Exhibit X-5*** shows the percent using three key services in the pre- and the post-period for CMO members and those on waivers in the remainder of the state.[17] The increase in the proportion using residential, transportation and vocational services among CMO enrollees exceeded the change for the remainder of the state for all three services. In addition, it appears that the percent of CMO members that used dental services, which are not services in the CMO benefit package but are services for which care managers would be responsible for assisting members to obtain, increased by approximately seven percent; individuals in waivers in the remainder of the state experienced a decline in the percent using dental services.

Exhibit X-5
Use of Selected Long Term Care Services



Source: The Lewin Group analyses.

Note: The pre-period includes October 1999 to March 2000 and the post-period includes January to June 2001. The analysis includes individuals enrolled in a CMO or waiver in December 2000 and also enrolled in a waiver in December 1999.

[17] We also analyzed the percent using services for the CMO counties relative to the matched counties and found similar patterns, except in Milwaukee where the initially enrolled population appeared to significantly differ from Rock County, particularly in having a small percentage using residential services in Milwaukee.

XI. QUALITY OF LIFE/QUALITY OF CARE

Efforts to improve the members' quality of life and the quality of services provided constitutes a cornerstone of the Family Care program. The ideal quality standard for long-term care services has yet to be developed. The nature of the services, a mix of social supports and custodial care, coupled with the goal of allowing individuals to make their own choices, make traditional standards based solely on the clinical experience and opinions of professionals or experts inappropriate. Geron concludes that "the standards for long-term care that have been promulgated often have little to do with quality in the areas of care considered most important to consumers."[18]

As indicated previously, 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' perception of outcomes and whether or not supports exist to achieve those outcomes in several areas: privacy, the ability to choose services, housing, safety, the degree to which members are respected, and experience continuity, and satisfaction with services.[19]

The Department conducted the first round of member interviews between November 2000 and January 2001. They interviewed 355 randomly selected CMO members and the care managers serving them. The second round of interviews was conducted between May 2001 and November 2001 in which 492 randomly selected members and their care managers were interviewed. The third round was completed during the first half of 2003. DHFS has refined the process measures over the course of the program and continues to develop benchmarks for the outcome measures. The counties have begun to buy into a systematic approach to quality and the groundwork related to basic research techniques for monitoring quality has been laid.

DHFS cautions against drawing comparisons between results from the first two rounds for several reasons. They noted that the interview process continues to evolve with changes in the way in which consumers were contacted to participate and the directions given to the care managers. Although the tool has been used by the Council to evaluate programs for individuals with disabilities, BALTCR and consumer representatives continue to adapt the tool for appropriate use with the elderly population in an attempt to validate the instrument. Additionally, DHFS noted that they have not yet developed benchmarks for each outcome. They believe that with the results from the application of the tool to other programs which have begun, such as, PACE, Partnership[20], and other waiver programs across the state, they will be

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

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

20 Program for the All-Inclusive Care of the Elderly (PACE) and Partnership are other DHFS Medicaid managed care programs. The Partnership Program, serving older adults and adults with physical disabilities since 1996, currently operates in three Wisconsin counties: two sites in Dane County, one site in Milwaukee County, and one site in Eau Claire. As of August 2002 1,303 individuals were enrolled. The program integrates all medical and long-term care services in a community-based setting. PACE was initiated in Milwaukee County in 1994 for

able to establish some benchmarks. In lieu of DHFS established benchmarks, we provide a comparison to the other waiver program results.

In comparing the results for the Family Care CMO enrollees and 365 interviewed participants in the existing waiver programs in the remainder of the state, readers should keep in mind that the existing waiver program does not explicitly embrace the concepts and goals of Family Care, and, unlike CMO care managers, the waiver care management staff have not had the advantage of prior results from the member outcome tool. In terms of the comparability of the waiver and CMO samples, the CMO samples tend to have been in the program for less time and to have a higher proportion of older frail adults.

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

A. Choice and Self-Determination

The Member Outcome Tool measures for choice and self-determination included the following specific outcomes:

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

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

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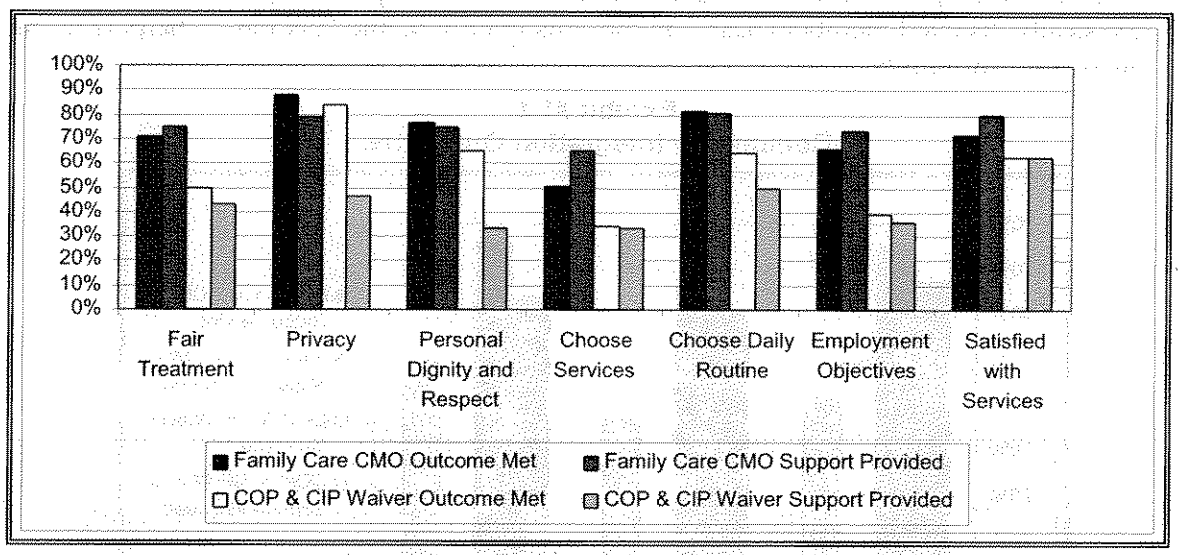
individuals 55 and older at the nursing home level of care to provide on-site, comprehensive integrated medical and psychosocial services by a multi-disciplinary team. As of August of 2002, there were 420 enrollees. Information from http://www.dhfs.state.wi.us/medicaid7/managed_care_summary_table.htm. Accessed November 25, 2002.

Exhibit XI-1
Choice and Self Determination Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Member Outcomes in the Home and Community Based Waivers*, 2002.

B. Community Integration

The Member Outcome Tool measures for community integration included the following specific outcomes:

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

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

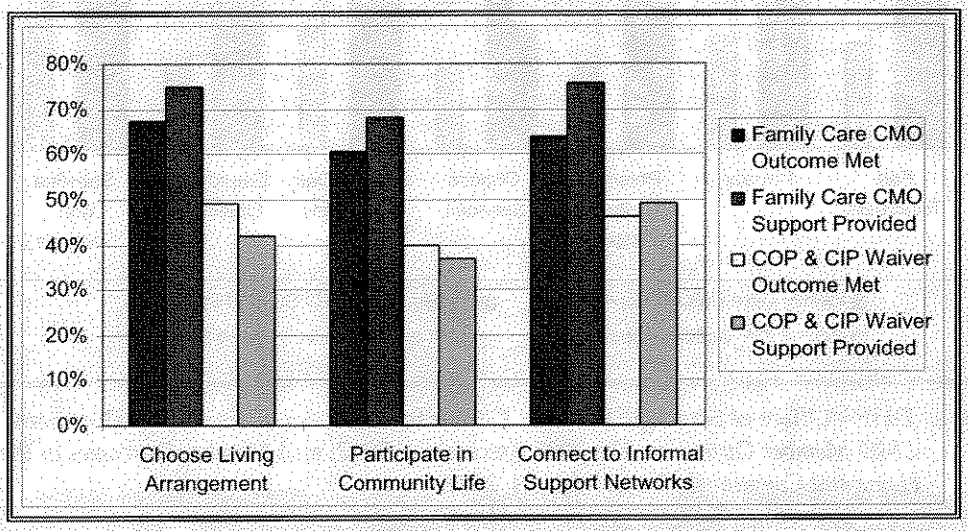
Two of the counties took active efforts related to community integration as a result of the first round of member outcome interviews:

- **Fond du Lac** sought to improve outcomes around "people choose where and with whom to live." They reduced bed size at community-based residential facilities (CBRFs) to allow for members to have private rooms if they so desired. They successfully offered financial incentives to CBRFs to downsize, resulting in improved outcomes for 2001.[21]

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

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

Exhibit XI-2
Community Integration Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Member Outcomes in the Home and Community Based Waivers*, 2002.

In addition to the Member Outcome Tool measures, we examined two additional community integration measures: residential care use and nursing home use (***Exhibit XI-3***). These measures reflect the prevalence of the indicators among individuals in the post -period. Among CMO members that were existing enrollees relative to the sample for the remainder of the state, there was no significant difference in the use of alternative residential settings or nursing facilities.

Exhibit XI-3
Community Integration Measures for Family Care Existing Enrollee Members Compared to the Remainder of the State

Indicator	Family Care Members	Remainder of State
Alternative Residential	26.5%	26.6%
Nursing Facility Use	8.2%	7.2%

Source: The Lewin Group analyses.

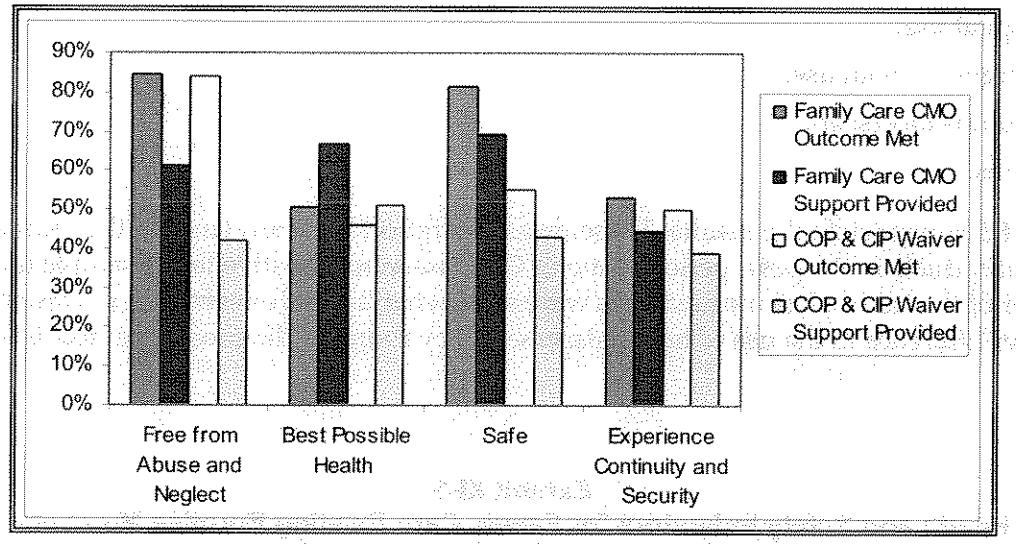
C. Health and Safety

The Member Outcome Tool measures for health and safety included the following specific outcomes:

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

The results from the second round of member and care manager interviews are presented in ***Exhibit XI-4***. For the safety and free from abuse and neglect outcomes, over 80 percent of Family Care members indicated that the outcome was present. The other two outcomes—best possible health, and continuity and security—had approximately one-half of interviewees indicate that the outcome was present. For three of the outcomes in this domain, the Family Care results, compared to the other waiver results, were similar; only for the safety outcome was the Family Care result considerably different form the other waiver program results (80 percent versus 55 percent). With the exception of "free from abuse and neglect," all of the differences between the Family Care and Waiver results were significant.

Exhibit XI-4
Health and Safety Outcomes



Source: DHFS, Office of Strategic Finance, Center for Delivery Systems Development, *CMO Member Outcomes: The 2001 Assessment*, 2002; and *Member Outcomes in the Home and Community Based Waivers*, 2002.

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

- **Milwaukee's** CMO performance improvement project included improving the appropriateness of placements in alternate care settings. "Members experience continuity and security" was one of the lower scores for Milwaukee on the first round of member outcomes. Through independent investigation, the CMO determined that only three percent of members in sub-acute residential care settings should have been there based on member care needs and other risk factors. The CMO developed clinical processes to ensure appropriate placement in the future. Milwaukee is also trying to involve providers in the interdisciplinary team during the re-certification, and reported that CBRFs and adult day care centers seem to appreciate the involvement.
- **La Crosse** focused on the outcomes of "people are safe" and "people choose where and with whom to live", after reviewing results from the first round of member outcome interviews. They attempted to devise emergency plans, install smoke detectors for clients, and refine the assessment to examine safety issues. The CMO also educated care managers about some of the assumptions they may make in determining where a client might want to live. The La Crosse CMO quality improvement project "improving retention of personal care workers for people with physical disabilities" is intended to enable members to stay in their own homes longer.

We examined four more traditional indicators of health and safety provided to CMO members relative to the remainder of the state:

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

Exhibit XI-5 summarizes the results. These measures reflect the prevalence of the indicators among individuals in the post -period. Among CMO members relative to the sample for the remainder of the state, all of the measures were somewhat lower, however, there was no significant difference in the use of hospitals, emergency rooms, a diagnosis of a decubitis ulcer or death.

Exhibit XI-5
Health and Safety Indicators for Family Care Existing Enrollee Members Compared to the Remainder of the State

Indicator	Family Care Members	Remainder of State
Hospital Use	16.3%	17.8%
Emergency Room Use	16.1%	17.2%
Decubitis Ulcer	3.3%	4.6%
Death	3.1%	3.3%

Source: The Lewin Group analyses.

XII. SPENDING

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

A. CMO Spending for Existing and New Enrollees

As outlined in the ***Methodology*** section, in order to determine whether services for individuals in the CMOs cost more or less than they would have in the absence of the Family Care program, individuals enrolled in a CMO in December 2000 who were also enrolled in a waiver in December 1999 were compared to individuals in a waiver in both December 1999 and December 2000, referred to as "existing enrollees", in selected areas. The comparison areas included: 1) counties matched to the initial four CMO counties based on similarities in their 1999 long-term care systems; 2) a random sample of individuals in the remainder of the state; and 3) for Milwaukee, individuals who had not enrolled in a CMO in December 2000, but lived in Milwaukee were enrolled in the waiver in both December 1999 and December 2000. ***Appendix B*** includes detailed information about the samples used.

The changes in the spending for the period October 1999 through March 2000 (pre-period) and from January 2001 through June 2001 (post-period) were analyzed. The time period was dictated by data availability. Focusing on the relative difference in the change from the pre- to post-period accounts for changes over time unrelated to the Family Care program and approximates the time trend that would have occurred in the absence of the program. Thus, if the percent change in spending is higher for CMO enrollees than for the comparison group, we would conclude that more was being spent on existing enrollees. Focusing on the change also mitigates most issues related to whether the CMO and the comparison areas are equivalent or whether differences between the areas in the absolute estimates for a given point-in-time can be adequately accounted for in the analysis.

Medicaid spending for CMO members falls into two categories, those services covered by the CMO capitation payment, which are nearly all long-term care services and include some payments previously paid for by the counties, and those services paid on a primarily fee-for-service basis under the traditional Medicaid program, sometimes referred to as card services. Our analyses examined total state, federal, and county spending for Medicaid and long-term care benefits captured in the administrative data.[22]

We present two measures of spending: 1) spending for benefits covered by the CMO payments; and 2) the CMO capitated payment. ***Appendix F*** provides the detailed tables for the analyses and includes two additional measures: 1) total spending captured; and 2) non-CMO benefits. These measures are not presented in the body of the report because the results were generally consistent with the CMO benefit results. ***Exhibit XII-1*** provides a summary of these components for the post-period for all CMO existing enrollees in the sample. For this group, the CMO capitated services constituted 83.6 percent of their spending and the capitated payment ($1,881) was somewhat less than the spending for the services provided ($2,072). This is possible under a capitated rate that allows for some individuals to receive a higher dollar value of

[22] See the ***Methodology*** section for a complete explanation of the spending captured in the analyses.

services than the average while others will receive a lower dollar value, based on their determined need.

Exhibit XII-1
Components of Difference-in-Difference
Spending Analyses for Post-Period
Existing Enrollees in All CMOs Sample

	Average Monthly Per Capita Spending	Percent of Total
Services Not Included in CMO Capitation (Card Services)		
Acute	$398	16.1%
LTC	$7	0.3%
CMO Capitated Services		
Service Payments	$2,072	83.6%
Total	$2,477	100.0%
CMO Capitated Payment	$1,881	82.3%
Total	$2,286	100.0%

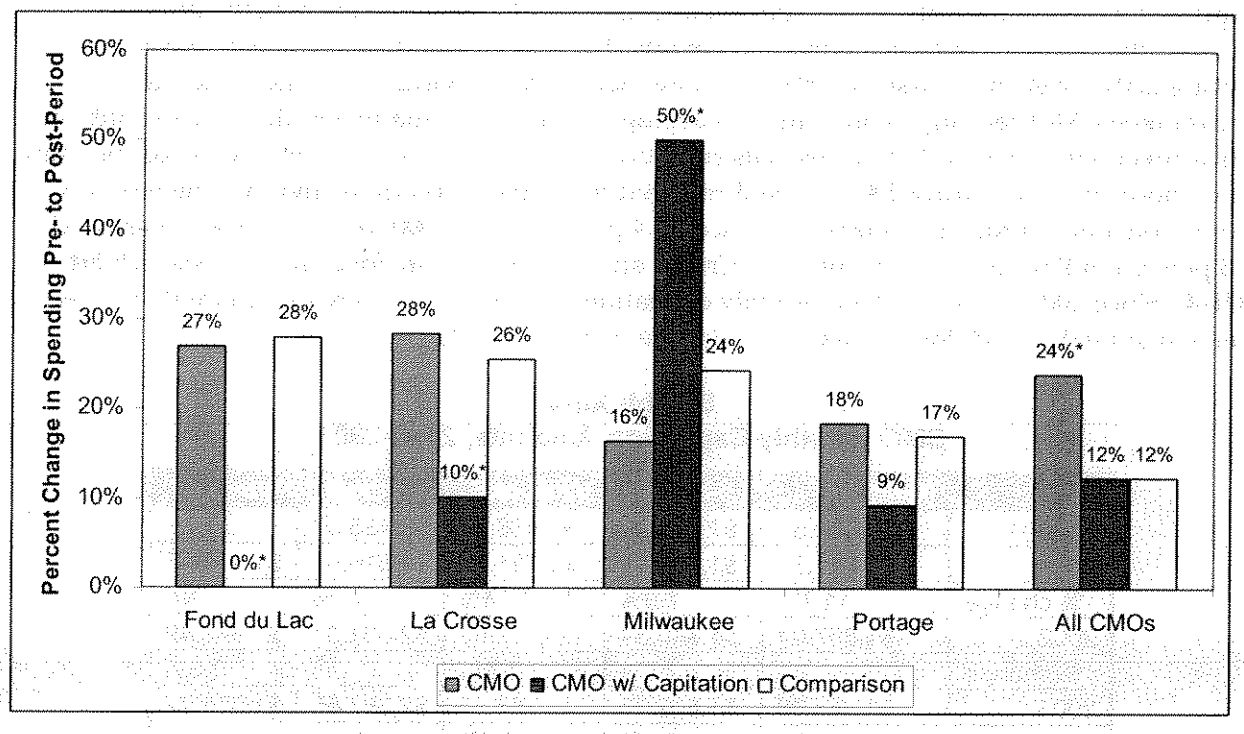
Source: The Lewin Group analyses.

Exhibit XII-2 shows changes in benefit spending with the implementation of Family Care. The change in spending for the benefits covered by the CMO payments among CMO members (labeled CMO) was greater than the change in the comparison areas (labeled Comparison) for La Crosse, Portage and all CMOs combined, and less for Fond du Lac and Milwaukee. The change was significant, however, only for the combined CMO members relative to the remainder of the state (***Exhibit XII-2***). The difference-in-difference ranged from -8 percentage points for the Milwaukee-Rock comparison (16% vs. 24%) to 11.4 percentage points for the remainder of the state comparison (24% vs. 12%). The absolute magnitude in the change in spending found in the remainder of the state comparison, and the statistical significance of this measure, highlights the potential importance of accounting for key characteristics of the long-term care system in establishing the areas to compare. Using the alternative comparison for Milwaukee that included existing enrollees in Milwaukee still receiving services from the waiver further highlighted this point. The Milwaukee CMO members had a higher increase in spending than the waiver enrollees statewide (16% vs. 12%), whereas they had a lower increase than Rock county waiver participants (16% vs. 24%). It should be noted that neither of these differences was statistically significant for Milwaukee.

Substituting the CMO monthly capitation for the average actual spending for the CMO benefits for existing enrollees, the difference-in-differences became less for all the CMOs compared to the comparison with the exception of the Milwaukee-Rock comparison as shown in Ex XII-2. The result for the counties other than Milwaukee and the CMOs combined reflects the fact that, for existing enrollees, the capitated payment amount was lower than the spending for the covered benefits provided to these CMO members.

Comparing the CMO benefit spending for existing enrollees and new enrollees demonstrates how the capitated payment balances out between the groups , as shown in ***Exhibit XII-3***. In the counties other than Milwaukee, spending for new enrollees averaged 60 percent or less than the spending for existing enrollees.

Exhibit XII-2
Percent Change in CMO Benefit Spending for Existing Enrollees, Pre- to Post-Period



* Difference is significant at the 0.05 level.

Source: The Lewin Group analyses.

Note: The pre-period period covers October 1999 through March 2000 and the post-period covers January 2001 through June 2001. Existing enrollees are individuals enrolled in a CMO and/or a waiver for both December 1999 and December 2000. See ***Appendix B*** for information about the samples and ***Appendix F*** for detailed analysis tables.

Exhibit XII-3
Average Monthly CMO Benefit Payments for Existing and New CMO Members, January through June 2001

CMO	Existing	New	Difference Existing - New	Ratio New/ Existing
Fond du Lac	$2,321	$1,258	$1,063	54.2%
La Crosse	$1,989	$1,135	$854	57.1%
Milwaukee	$1,307	$1,364	-$57	104.4%
Portage	$2,539	$1,010	$1,529	39.8%
All Family Care	$2,072	$1,209	$863	58.3%

Source: The Lewin Group analyses.

Note: Existing enrollees are individuals enrolled in a waiver in December 1999 and a CMO in December 2000. New enrollees are CMO members in December 2000 who were not waiver recipient in December 1999. See ***Appendix B*** for information about the samples and ***Appendix F*** for detailed analysis tables.

In Milwaukee, the capitated spending amount was higher than the spending for covered benefits and the difference compared to Rock county was significant at the 0.5 percent level. The capitated payment for Milwaukee appears unusually high relative to the benefits provided because the payment reflects a retrospective rate that was adjusted for the actual experience during 2001. Over the course of 2001, the more than 1,500 individuals enrolled into the Milwaukee CMO had higher spending on average than those initially enrolled. As a result, our Milwaukee sample included individuals enrolled during 2000 who had lower average spending than those enrolled during 2001, yet still received the higher capitation amount. The monthly capitation amount for Milwaukee increased 17.4 percent from 2000 to 2001, while it increased 3.3 percent in Portage, 7.9 percent in La Crosse and 11.7 percent in Fond du Lac (See ***Exhibit XII-4***). Since 2001, none of CMO monthly capitation amounts have increased more than three percent annually, and Portage saw a 5% decline in rates in 2003.

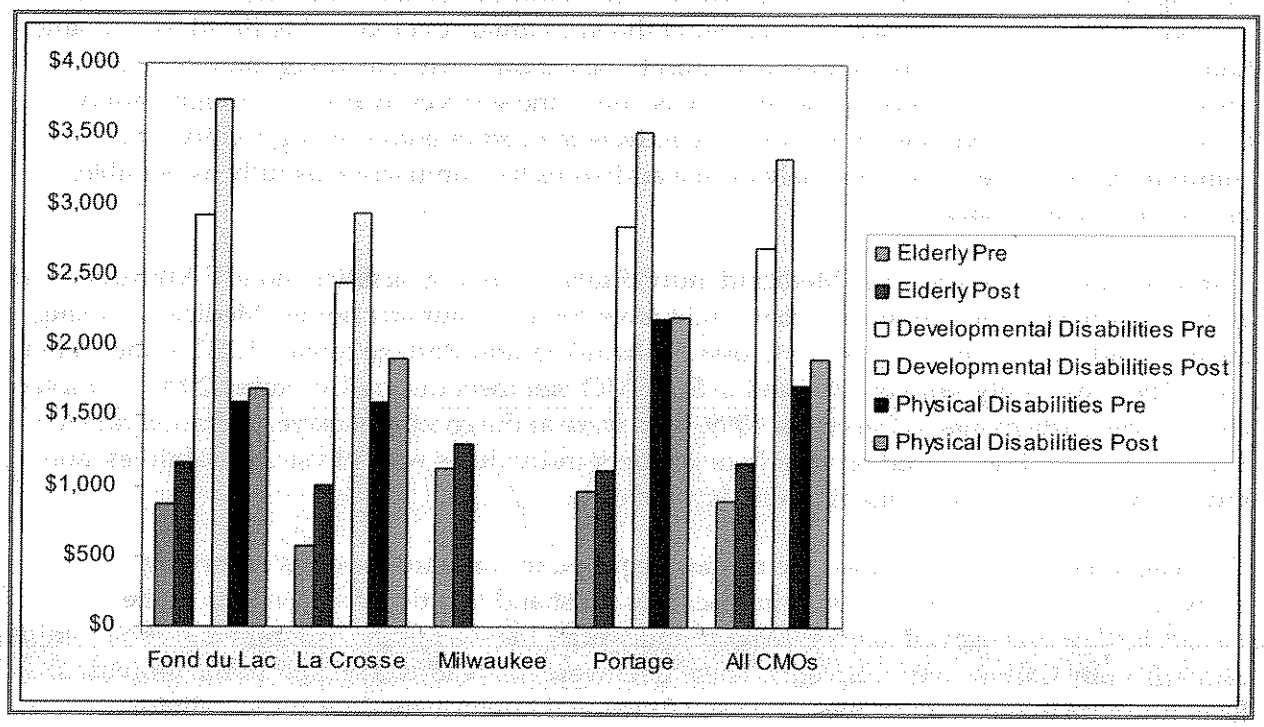
Exhibit XII-4
CMO Monthly Capitation Amounts, 2000-2003

	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
2000	$1,651.32	$1,583.86	$1,466.64	$2,435.57	
2001	$1,844.30	$1,709.12	$1,721.77	$2,516.51	$1,910.15
% change	11.7%	7.9%	17.4%	3.3%	NA
2002	$1,897.04	$1,748.84	$1,720.63	$2,491.01	$1,941.49
% change	2.9%	2.3%	-0.1%	-1.0%	1.6%
2003	$1,945.08	$1,802.23	$1,767.57	$2,367.65	$1,975.77
% change	2.5%	3.1%	2.7%	-5.0%	1.8%

Source: DHFS.

A particular area of interest among advocates has been how the different target groups have faired in the CMOs. Prior to Family Care, payments per waiver participant for individuals with developmental disabilities were higher on average than those for younger individuals with physical disabilities, followed by payment levels for older frail adults. Taking a closer look at the spending by target group for the CMO existing enrollees shows these patterns hold in the post-period (***Exhibit XII-5***). Overall, for the CMOs relative to the remainder of the state, all three target groups, elderly, developmentally disabled and physically disabled have higher spending levels than the actual CMO benefit payments as opposed to the capitated payment which was consistently higher for the elderly and those with physical disabilities and lower for those with developmental disabilities. This occurs because the capitated rate does not differentiate by target group and yet the CMOs can use the pooled funds for all members to appropriately serve individuals.

Exhibit XII-5
Average Monthly CMO Benefit Spending by Target Group for Existing Enrollees, Pre- and Post-Period



Source: The Lewin Group analyses.

Note: The pre-period period covers October 1999 through March 2000 and the post-period covers January 2001 through June 2001. Existing enrollees are individuals enrolled in a CMO and/or a waiver for both December 1999 and December 2000. See ***Appendix B*** for information about the samples and ***Appendix F*** for detailed analysis tables.

B. Community versus Nursing Facility

In past reports, the Department of Health and Family Services compared the cost of care per day for CIP II and COP –W participants to nursing home residents, adjusting the average nursing home payment to reflect the level of care distribution among the community participants. This analysis resulted in a statewide estimate of $64.16 for the community versus $79.80 for nursing homes for calendar year 2000.[23] Focusing solely on Medicaid spending, the Department estimated $55.67 for community and $79.68 for nursing homes, implying community Medicaid costs are 70 percent of the nursing home costs. In our analysis, we also conducted a level of care comparison and added several other measures of case mix. As a result, our comparisons adjust the community participants to the nursing facility case mix and focus solely on the Medicaid spending for long-term care benefits.

[23] Department of Health and Family Services (2002). *Community Options Program Report to the Legislature: Calendar Year 2000.*

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

Our analyses were restricted to Medicaid individuals in nursing facilities (no ICF-MR residents) and individuals in the community that might have been in a nursing home. Medicaid nursing facility residents in Fond du Lac, La Crosse, Milwaukee, and Portage totaled 5,252 at the end of 2000. The community sample consisted of 570 CMO members during December 2000 who were also waiver participants in December 1999, who were at the comprehensive capitation rate for Family Care, qualified based on elderly or younger individuals with physical disabilities, and did not have a developmental disability level of care.

Consistent measures of cost and case mix are required to compare the costs of serving individuals in Family Care and nursing facilities. Cost and functional screen data at the individual level were available for CMO counties after the start of the program and for a sample of non-Family Care waiver recipients. These data were not readily available at the individual level for those in nursing facilities. We used functional impairment data at the individual level for nursing facility residents from the Minimum Data Set (MDS).[24] However, nursing facilities do not report costs at an individual level. Therefore, we relied on Medicaid payment rates to provide aggregate measures of costs at the facility level.

To examine "similar" groups, we used the level of care groupings used for determining nursing facility payment levels, as well as the MDS and the functional screen data to develop a case mix measure based on elements common to both datasets. The level of care measure is based on the same distinctions used in Medicaid payment for nursing facilities in Wisconsin – Intensive Skilled Nursing, Skilled Nursing, and Intermediate Care. The case mix measure borrowed, in part, from the Resource Utilization Group (RUG) methodology, and included impairments in activities of daily living, behavioral problems and cognitive impairment consistent in both the MDS and the functional screens (See ***Appendix G*** for more information). It is important to re-iterate the site based limitations of the MDS discussed in the ***Methodology*** section. We have tried to choose measures that would tend to be less site-dominated; for example, bathing was not considered because it is generally the first ADL an individual loses independence and in a nursing facility, the choice to bathe oneself may not be permitted.

By developing the distribution of scores among nursing facility residents, these measures allowed us to identify CMO members with similar scores to develop a case-mix adjusted comparison. ***Exhibit XII-6*** compares the distribution of individuals in the community to those in nursing facilities. Those in the community had fewer impairments than those in nursing

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

facilities. Those in the community were less likely to meet a skilled or greater nursing home level of care criteria (28.3 percent in the community and 87.9 percent in nursing facilities). Those in the community were less likely to have two or more of the three ADLs examined (eating, toileting and transferring) with 33.6 percent of those in the community with this level of impairment compared to 65.2 percent in nursing facilities. Those in the community were also less likely to have the mild or greater cognitive impairment based on the MDS cognitive impairment scale with 35.6 percent of those in the community compared to 73 percent in nursing facilities. The behaviors measured did not differ much between the existing CMO enrollees and the nursing facility sample, primarily because the measure did not reflect a very wide range of functioning (over 90 percent of individuals in both nursing facilities and the community did not exhibit wandering or physically abusive behavior).

Exhibit XII-6
Alternative Case Mix Adjustments of Community to Nursing Facility Impairment Levels

	NF Residents	Community Recipients	Percent Difference Comm. minus NF
Nursing Home Level of Care			
No Nursing Home Level of Care	0.0%	9.6%	9.6%
Intermediate and Limited	12.2%	62.1%	49.9%
Skilled Nursing	83.2%	26.5%	-56.7%
Intensive Skilled Nursing	4.7%	1.8%	-2.9%
	100.0%	100.0%	100.0%
ADL Summary Score			
0	20.5%	32.4%	11.9%
1	14.3%	34.0%	19.7%
2	25.4%	18.7%	-6.7%
3	39.8%	14.9%	-24.9%
	100.0%	100.0%	100.0%
Behavior Summary Score			
Neither Wanders or is Physically Abusive	90.9%	92.6%	1.7%
Wanders or is Physically Abusive	8.4%	6.1%	-2.3%
Both Wanders and is Physically Abusive	0.8%	1.2%	0.4%
	100.0%	100.0%	100.0%
Cognitive Impairment Summary Score			
Intact	15.2%	39.6%	24.4%
Borderline Intact	11.8%	24.7%	12.9%
Mild to Very Severe	73.0%	35.6%	-37.4%
	100.0%	100.0%	100.0%

Note: The 55 "No Nursing Home Level of Care" individuals in the community include those with a diagnosis of Alzheimer's only or they were grandfathered into the program.

Source: The Lewin Group analyses.

With the exception of the cognitive impairment score, the alternative case mix measures demonstrate expected variation in the average monthly spending with greater impairment averaging higher payments (***Exhibit XII-7***). The widest variation in estimated monthly spending for the case mix measures was based on the nursing home level of care (55.8 percent for no LOC to 240.9 percent for intensive skilled nursing) and the smallest range was for the cognitive impairment score (87.9 percent for "borderline intact" to 109.7 percent for "mild or very severe"). The more variation in spending captured by the case mix indicator, the better it can differentiate the spending between the two settings.

Exhibit XII-7
Average Monthly Community 2001 Long Term Care Medicaid Spending for Alternative Case Mix Adjustments

	Average Community LTC Spending	Percent of Average for All Community
Nursing Home Level of Care		
No Nursing Home LOC	$745	55.8%
Intermediate	$1,128	84.5%
Skilled Nursing	$1,913	143.2%
Intensive Skilled Nursing	$3,218	240.9%
All	$1,336	
ADL Summary Score		
0	$812	60.1%
1	$1,048	77.6%
2	$1,658	122.7%
3	$2,827	209.2%
All	$1,336	
Behavior Summary Score		
Neither Wanders or is Physically Abusive	$1,311	97.9%
Wanders or is Physically Abusive	$1,580	118.0%
Both Wanders and is Physically Abusive	$2,213	165.3%
All	$1,336	
Cognitive Impairment Summary Score		
Intact	$1,318	98.5%
Borderline Intact	$1,177	87.9%
Mild to Very Severe	$1,468	109.7%
All	$1,336	

Source: The Lewin Group analyses.

Directly comparing the average monthly Medicaid spending for the nursing home level of care measures between the community and nursing home indicates lower average monthly Medicaid long-term care spending in the community compared to the nursing facility for each of the levels of care (***Exhibit XII-8***).[25] The difference in the spending declines as the level of care increases, with the community spending approximately 50 percent of the nursing facility spending for the intermediate level of care and 95 percent at the skilled level of care.

Exhibit XII-8
Average Monthly Community and Nursing Facility 2001 Medicaid Long Term Care Spending for Nursing Home Level of Care Categories

	Average Nursing Facility Spending	Average Community LTC Spending	Percent of Average for All Community
Intermediate	$2,104	$1,048	49.8%
Skilled Nursing	$2,538	$1,658	65.3%
Intensive Skilled Nursing	$2,976	$2,827	95.0%

Source: The Lewin Group analyses.

Standardizing each of the case mix measures to the nursing home population provides four alternative estimates of the Medicaid spending for long term care in the community versus the nursing facility (see ***Exhibit XII-9***). The nursing home level of care adjustment results in the highest estimate of community Medicaid long-term care costs with $1,880 per month, while the behavior summary score resulted in the lowest with $1,342 per month. The ADL summary score meets the criteria of reflecting a range of functioning (i.e., not having a large proportion of individuals in any one category) and differentiating spending across the levels (i.e., having a fairly wide range in the spending from lowest to highest). This measure estimates average monthly Medicaid long-term care community spending to have been approximately 74 percent of nursing facility spending and is consistent with the estimate based on the nursing home level of care measure. We note that both the nursing home level of care and ADL summary score ratios of Medicaid community to nursing facility care spending are higher than the Department's 2000 statewide estimate of 70 percent.

[25] The average monthly Medicaid nursing facility spending is based on a weighted average of the 2001 Medicaid per diem rates for Fond du Lac, La Crosse, Milwaukee and Portage adjusted for the portion paid from a resident's own financial resources (22 percent) and an average of 29 nursing facility days per month.

Exhibit XII-9
Average Monthly Community and Nursing Facility 2001 Medicaid Long Term Care Spending for Nursing Home Level of Care Categories

	Average Nursing Facility Spending	Average Community LTC Spending	Community as a Percent of Nursing Home
Nursing Home LOC	$2,507	$1,880	75.0%
ADL Summary Score	$2,507	$1,863	74.3%
Behavior Summary Score	$2,507	$1,342	53.5%
Cognitive Impairment Summary Score	$2,507	$1,411	56.3%

Source: The Lewin Group analyses.

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

C. Impact of Net New Enrollees

While the analysis of existing enrollees indicated that the change in payments for existing CMO enrollees was not significantly different from the comparison groups during program start-up, the analysis did not account for the greater number of recipients of community care through the CMO. By design, Family Care expands the population eligible to receive home and community-based services by making the CMO benefit an entitlement. During March 2003, the CMO counties served 7,163 individuals, 6,908 of whom were Medicaid eligible. In theory, the program also has the potential to reduce nursing home use.

In order to estimate how many of the CMO members in March 2003 would not have received long-term care services in the absence of Family Care, we relied on: 1) the Department's estimate that 4.2 percent of CMO enrollees in 2001 were "new to Medicaid" and would not have entered the Medical Assistance system; 2) remainder of the state enrollment trends (1.6 percent net increase in monthly enrollment) applied to the number of CMO enrollees in the month following wait list elimination ; and 3) alternative assumptions regarding how much of the decline in nursing home use should be attributable to the CMOs based on accounting for the remainder of the state trend and county-specific trends in Medicaid nursing home use. See ***Appendix H*** for additional information.

Exhibit XII-10 shows the results of the analyses. Using the remainder of the state trends in Medicaid nursing home use to estimate the change in Medicaid nursing home users attributable to the CMOs resulted in an estimated of $572,506 less per month spent in March 2003 as a result of the decline in Medicaid nursing home users. However, these assumptions give the Milwaukee CMO "credit" for an over 15 percent decline in Medicaid nursing home since

December 1999 and estimates 596 fewer older frail adults receiving long-term care services in that county. Rather than using the state trend since CMO operations began, and instead using the Milwaukee-specific trend relative to the remainder of the state during the two years prior to the CMO, suggests Medicaid nursing home use might have continued to decline nearly ten percent in the absence of the CMO. Using the more conservative county-specific trends prior to the CMOs in Medicaid nursing home use to estimate the change in Medicaid nursing home users attributable to the CMOs resulted in an estimate of 339 new users in March 2003, with CMO payments of $675,105 per month. Finally, accounting for the reduced spending associated with the Medicaid nursing home users in the county-specific trend brings the average monthly spending increase associated with additional home and community-based users to $580,800, or about $81 per member per month across the whole CMO enrollment.

Exhibit XII-10
Additional Users and Associated Monthly CMO Payments

	Estimated Net New Users in March 2003	Monthly 2003 CMO Payments Associated with New Users
Remainder of the State Trend in Medicaid Nursing Home Use		
Fond du Lac	36	$69,592
La Crosse	108	$195,395
Milwaukee	-596	-$1,054,007
Portage	96	$228,240
Richland	-6	-$11,725
All CMO Counties	-362	-$572,506
County Specific Trend in Medicaid Nursing Home Use Prior to CMO		
Fond du Lac	36	$69,592
La Crosse	129	$232,221
Milwaukee	75	$132,775
Portage	111	$263,023
Richland	-11	-$22,506
All CMO Counties	339	$675,105

Source: The Lewin Group analyses.

PART FOUR:
CONCLUSIONS

XIII. CONCLUSIONS

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

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

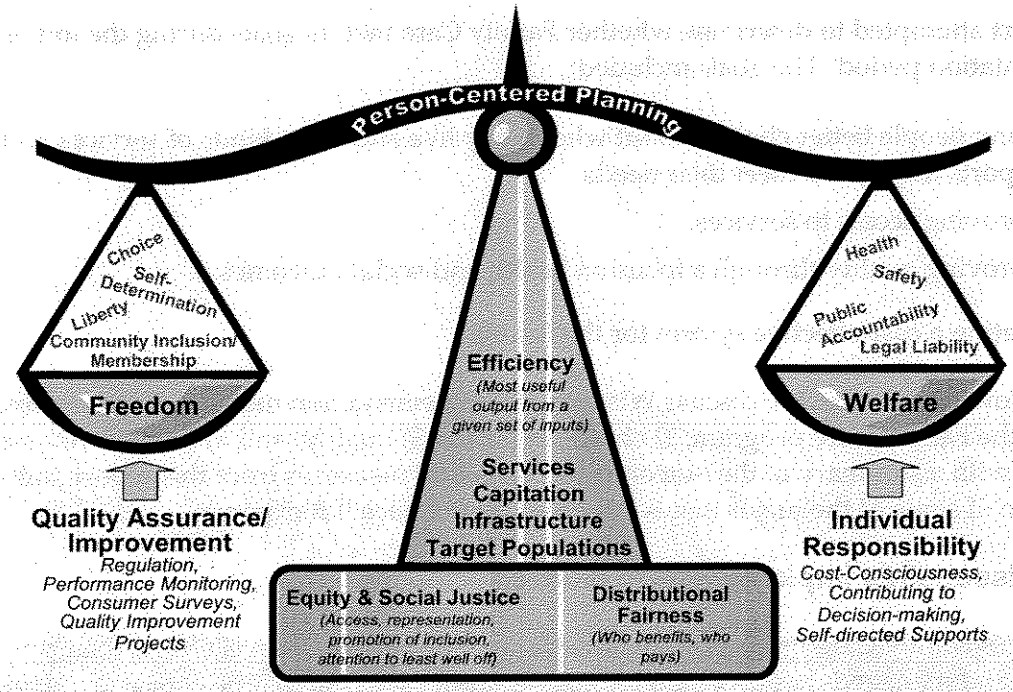
In the following sections, we discuss Wisconsin's implementation model and the the four major tenets of the Family Care program: 1) choice; 2) access; 3) quality; and 4) cost-effectiveness. We conclude with a summary of the outcome and spending measures from this report and a discussion of some of the major issues the program will face if it expands.

A. Wisconsin's Implementation Model

Wisconsin's Family Care program constitutes one of the few state-level efforts to apply a capitated and managed model of care to the long-term care system. The choice of a managed care model as the method of organizing, arranging, coordinating, supervising, and financing long-term care service provision entails certain strategies, structures, processes, functions, and capabilities. Further, applying managed care to home and community-based services also requires a thorough understanding of the populations, services, and underlying philosophies associated with providing alternatives to institutionalization. The combination of limiting freedom of choice of providers, capitating payments for services, and promoting consumer focus for home and community-based services requires a balancing act of potentially conflicting goals on the part of the state, the resource centers, the care management organizations, and the consumers (***Exhibit XIII-1***).

Home and community-based systems strive to build from a base of equity, social justice and distributional fairness. At the core of the new managed care system are the infrastructure (access points, care management organizations, provider networks, IT systems), target populations, services included (acute and LTC or carve outs "specialty" services) and the capitated amounts paid. Family Care's person-centered planning approach needs to weigh ensuring health, safety and accountability against allowing consumers choice in determining when, where, how and from whom they prefer to receive services. At the fulcrum, it also must balance individual desires with available resources and desired outcomes (efficiency). Ensuring accountability and system integrity are the oversight roles of: 1) the state and external quality review organizations (EQRO) that monitor process and outcomes, and enforce regulations; and 2) individual consumers participating in and taking responsibility for decision making regarding their support plans and the managed care plan's governance, as well as vigilance against fraud and abuse.

Exhibit XIII-1
Balancing the Family Care Philosophy



In addition to balancing potentially competing goals of welfare, freedom and cost, another challenge for Family Care was the use of the Medicaid 1915(b) and 1915(c) waiver authority. The 1915(b) aspects of the Family Care initiative prevented the unified one-stop shopping for information and assistance and enrollment into the capitated care management organizations because CMS required a separation between the organization advising about an individual's choices and the managed care organization. Since the resource centers that facilitate eligibility determination and the care management organizations are both county government entities, CMS required a third party to play the role of enrollment broker. Also, the state must negotiate a strategy for complying with the CMS requirement to introduce competition in the next couple of years. DHFS has submitted a proposal that continues reliance on the counties, but CMS approval is pending.

B. Choice

Defining choice within the context of Family Care has been evolutionary and could be exercised in a number of ways:

- what services to receive
- who provides the services
- where to live and receive services
- how services are delivered, including when and individual preferences regarding aspects of service delivery (e.g., no smoking, Kosher menu)

In order to exercise choice, individuals need information regarding basic service availability and detailed information about those who might provide those services. The resource centers provide a foundation for allowing individuals of all income levels to make informed choices. The CMOs must struggle with some of the more delicate balancing among an individual's preferences, safety considerations and cost. Given an unlimited budget, most choices could be accommodated, however, choice can be a difficult concept to implement when those involved have differing views of the limits of choice and available resources are constrained.

DHFS' goals statement has evolved to reflect both the choice and resource aspects of the program and the challenge presented in ***Exhibit XIII-1***:

> The redesigned system will provide individuals and families with meaningful choices of supports, services, providers, and residential settings, as long as such care or support is necessary, meets an adequate level of quality, is cost-effective, is consistent with the individual's values and preferences, and can be provided within available resources.[26]

State staff also emphasized the need to educate advocates, providers, county staff, and consumers about what choice means in Family Care. They plan to conduct education through RAD method training, consultation with the local LTC Councils, ongoing communication with advocates and state LTC Council reports and meetings. DHFS will also continue to collect consumer outcomes as a means of monitoring choice.

The member outcome interviews from 2001 indicated that approximately one-half of CMO members indicated that they could choose their services. While only half may seem low for a program that emphasizes choice, the outcome interviews occurred early in the program's implementation. At that point, case managers primarily focused on getting the same or similar benefit packages in place for the high volume of waiver rollovers. Also one-half was higher than the one-third in the waiver program in the remainder of the state that indicated they could choose their own services. A higher percent (80 percent) of CMO members indicated that they could change their daily routines.

In the future, Family Care faces several issues related to choice:

- **Loss of the independent advocate** – Advocates for the disability community, in particular, indicated that without an independent advocate, members lack an important voice for expressing their choices and ensuring the program's responsiveness. They lamented that, without a dedicated function, they lacked the necessary time and resources to be able to devote a proactive focus on Family Care members. To address several consumer involvement issues, we suggest that stakeholders consider a multi-function, consumer-oriented position that encompasses the activities of the independent advocate, enrollment consultant and staff support for the local LTC council.

[26] http://www.dhfs.state.wi.us/LTCare/History/VISION.HTM last revised 7-29-02.

- **Full realization of a self-directed supports option** – The ultimate manifestation of self-directed supports occurs when the consumer receives a budget allocation to be spent as desired. If pursued, the CMOs must take on the difficult task of devising a method for setting budgets consistently, fairly, and adequately, without exceeding available resources.

C. Access

As indicated earlier, individuals in need of long-term care services can access a wealth of information through the Resource Centers. The presence of the CMOs with guaranteed entitlement in Fond du Lac, La Crosse, Milwaukee, Portage and Richland has meant the elimination of wait lists and the ability to serve even more individuals. For many services, the CMOs have successfully expanded the number of providers available and also recruited new providers for services not previously available under the Medicaid program (e.g., some forms of transportation). CMO network managers identified selected services, particularly accessible housing, community-based residential facilities, and supported employment, for which they would like to see further expansion. Use of residential alternatives, transportation, and vocational services have increased more among existing enrollees in the CMO counties than the remainder of the state. Also, the entitlement has lifted categorical restrictions on the number of individuals in different disability populations that can receive services, resulting in greater access to services for younger individuals with physical disabilities without crowding out the other disability groups.

In the future, Family Care faces several issues related to access:

- **Increased enrollment** – As Family Care enrollment continues to expand, the CMOs face the challenge of hiring and training additional staff, while maintaining a consistent culture and application of care management principles. This will require the continuation of ongoing initial training as well as refresher courses for not only care managers, but fiscal and management staff.
- **Selective Contracting** – As of spring 2003, the CMOs had narrowed the number of contracted providers in only a few instances. As the CMOs gather additional information about provider performance and member satisfaction, they may face the politically sensitive task of excluding some traditional providers from their networks. CMOs will need to ensure that decision processes are well-documented and that standardized provider appeals procedures are in place.
- **Expanding the use of non-traditional providers** – The CMOs have just begun to explore alternative providers and encourage existing providers to offer new and/or more responsive services. In order to meet the full range of member needs, CMO will need to continue these efforts, especially in rural areas where the pool of traditional providers has been limited. This may also require creative contracting arrangements between the CMOs and providers.

D. Quality

Compared to individuals in the other waivers, higher percentages of CMO members indicated having each of the 14 outcomes met that constitute the three major domains of choice and self-determination, community integration, and health and safety. However, claims-based measures, including residential use, nursing facility use, hospital use, emergency room use, decubitis ulcers, and death found no differences between the two groups among existing enrollees from January 2001 through June 2001.

In the future, Family Care faces several issues related to quality:

- **Transitioning quality assurance/improvement to a contracted organization** – As of July 2002, in accordance with CMS requirements related to the 1915(b) waiver, DHFS contracted with MetaStar to serve as Family Care's external quality review organization (EQRO). MetaStar assumed many of the activities that DHFS staff had previously conducted with the assistance of other contractors. Different roles may be required for some DHFS staff, and new relationships so county staff necessitate continued effective and frequent communication.
- **Benchmarking the Member Outcome Tool results** – DHFS has conducted two rounds of member outcome interviews with Family Care members and one round each with Partnership members, PACE enrollees, and "regular" 1915(c)waiver recipients. State staff discourage the comparison of the Family Care Round I and II interviews because they implemented some process changes in the second round. Staff hope to use the data collected to develop benchmarks. Comparing the Family Care results to the others could be particularly difficult given the differences in the populations and the many environmental factors that cannot be considered. DHFS will need to continue to take care in presenting results and may want to consider developing mechanisms for case mix adjusting results.
- **Continuing education** – Implicit in the continuous quality improvement approach adopted by DHFS is the need for continuing education of DHFS, EQRO and county staff regarding the goals and measures. In addition to these entities, consumers, families and providers will also need continuing education to both further the program goals and manage expectations.

E. Spending and Cost-Effectiveness

Our spending analyses indicated that among existing enrollees, the differences in the increase in long-term care spending for CMO covered services from prior to the CMOs (October 1999 through March 2000) to early in the CMO's implementation (January 2001 through June 2001) for CMO members compared to waiver enrollees in relevant comparison areas were not significant. In addition, new CMO enrollees had spending generally 60 percent or less of the existing enrollees. However, the increased enrollment in the CMOs relative to the growth in enrollment in the remainder of the state means that aggregate spending for the Family Care program increased relative to if it had not been implemented because more individuals are receiving a broader service package.

In the future, Family Care faces several issues related to cost-effectiveness:

- **Measuring cost-effectiveness over the long term** - DHFS and the Legislature will want to continue to measure the program's costs and outcomes. The issues outlined previously regarding how to measure costs and what to compare will likely continue and, in addition, as the system continues to transform, it could get more difficult to standardize costs prior to and subsequent to the program. Given the uncertainty, DHFS may need to pursue different methods in order to triangulate results.

- **Instituting a functionally-based payment system** - As DHFS continues to incorporate information from the functional screens into its payment methodology, staff will have to: 1) continue to rely on self-reported data from the CMOs regarding service use and costs until transactions can be directly reported and audited; 2) contend with the incentives for the CMOs that conduct their own recertifications to report higher needs for members on the functional screen in order to receive a higher payment; and 3) continue to assess whether the functional screen adequately captures functional need, particularly for aspects related to mental health. The Department and its actuaries continue to break new ground in the payment for long-term care services.

F. Summary of Outcome Analyses Results

Exhibit XIII-2 provides a summary of the findings of our outcome analyses. Based on the result of these analyses, our assessment of the Family Care's progress toward meeting its goals is that:

- The program has substantially met the goal of increasing choice and access and improving quality through a focus on social outcomes.

- The program has yet to demonstrate improved quality related to an individual's health using claims-based measures, in part due to the time period of our analyses, and the need for more time to fulfill the promise of better care management.

- Existing enrollees did not experience a decline in service levels during the first year of the program.

- It is too early to draw conclusions regarding the program's ability to create a cost-effective system for the future.

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

Exhibit XIII-2
Summary Results of Key Outcomes and Cost Analyses Conducted

Indicator		Result
Access		
Information		
RC Outreach Activities	+	Numerous & varied efforts by counties
Resource Center Contacts	+	Met contract standard by county except Marathon and Kenosha for DD
Benefits		
Wait Lists	+	CMO counties no wait lists; rest of state increasing
CMO Enrollment	+	Enrollment continues to Increase
Choice of Providers	+	Number of contracted providers increased
Service Use by Type	+	Use of alternative residential, transportation and vocational services increased among existing enrollees
Quality of Life/Care		
Choice and Self-Determination		
Treated fairly	+	CMO favorable compared to waiver
Privacy	+	CMO favorable compared to waiver
Personal dignity & respect	+	CMO favorable compared to waiver
Choose services	+	CMO favorable compared to waiver
Choose daily routine	+	CMO favorable compared to waiver
Achieve their employment objectives	+	CMO favorable compared to waiver
Satisfied with services	+	CMO favorable compared to waiver
Community Integration		
Choose where and with whom they live	+	CMO favorable compared to waiver
Participate in the life of the community	+	CMO favorable compared to waiver
Informal support networks connection	+	CMO favorable compared to waiver
Residential care use	o	No difference compared to rest of state
Nursing home use	o	No difference compared to rest of state
Health and Safety		
Free from abuse and neglect	+	CMO favorable compared to waiver
Best possible health	+	CMO favorable compared to waiver
Safety	+	CMO favorable compared to waiver
Continuity and security	+	CMO favorable compared to waiver
Decubitis ulcer	o	No difference compared to rest of state
Hospital use	o	No difference compared to rest of state
Emergency Room use	o	No difference compared to rest of state
Death	o	No difference compared to rest of state
Spending		
LTC Medicaid & state spending	o	Mixed dependent upon comparison area
Spending on new enrollees	o	Spending for new enrollees less than existing
Nursing Facility versus Community	o	Mixed dependent upon assumptions
Additional Spending on Net New Users	o	Mixed dependent upon assumptions

+ Indicates Family Care had a positive outcome for the indicator.

o Indicates Family Care had neither a positive nor a negative outcome

- Indicates Family Care had a negative outcome for the indicator.

G. Expanding Family Care

Wisconsin, like most other states, faced a budget shortfall as it entered state fiscal year 2003. As a result, Family Care did not expand to any new counties. The Legislature is faced with this issue again this fiscal year. In addition, counties not implementing Family Care have begun to question the relatively high level of state funding flowing to the current Family Care counties while they face reductions in services. Although, while there is currently no discussion about pilot counties reverting back to the pre-Family Care system, it is notable that CMO staff unanimously expressed a preference for Family Care over the old system. It is in this environment that DHFS has begun to plan for the possibility of additional CMO counties.

Aside from political considerations, the major issues for DHFS include the scope, configuration and timing of any expansions, along with technical assistance that would need to be provided.

Scope -- The scope could range from one additional county, as was initially planned, to the rest of the entire state (another 67 counties). If Family Care is expanded to multiple counties, issues of timing and the ability to meet the technical assistance needs of the new counties become important considerations.

Configuration -- The configuration could continue to be county-based, or like Michigan, DHFS may determine that the organizational economies of scale warrant a minimum number of covered lives which would argue for a more regional approach for counties with smaller populations. In its 2002 solicitation for contracting organizations for its 1915(b)/(c) combination waiver, Michigan required a minimum of 20,000 Medicaid beneficiaries in their catchment area, of which a fraction might be expected to access covered services. DHFS wishes to contract exclusively with county governments and has submitted a proposal to CMS for its waiver renewal process. DHFS is also exploring whether partnership arrangements with providers or other organizations might meet CMS competition requirements, as well as play to the counties' strengths, primarily clinical functions, and shore-up areas in which they are weaker, primarily operational and fiscal systems. Milwaukee's CMO operates in this manner with Keylink Solutions for the fiscal operations related to claims payment and contracts with private entities for additional Care Management Units (CMUs).

Timing – The experience of the pilot counties suggests a gradual phase-in and possibly staggered roll-out of additional CMO counties. This may help reduce the level of technical assistance required.

Technical Assistance -- DHFS has taken advantage of the knowledge gained from implementing the pilot to develop protocols and aspects of the program that can be used in the rest of the state even without the full capitated model. The web-based functional screen is being used in non-Family Care counties. The Resource Allocation Decision (RAD) method was being introduced to supervisors in the waiver counties and Bureaus of Developmental Disability Services and Aging, Disability and Long-term Care have begun to train care managers for the waivers in the rest of the state. Familiarity with the member outcome tool is being developed, as DHFS conducted member outcome interviews with waiver recipients in the Summer of 2002. These early efforts should ease any transitions to Family Care. In addition, the draft Medicaid waiver concept paper being circulated by the Secretary includes pre-Family Care pre-paid health plans to ready future counties.

If the state continues to write sole-source contracts with local public entities that had population and HCBS experience to act as the managed care organizations, this will still require the build-up of managed care expertise and infrastructure at the public entities. DHFS will still need to provide technical assistance so that local governments can learn how to install and implement the operational, clinical, and fiscal mechanisms necessary to become managed care organizations. In recognizing this, DHFS has begun to consider the infrastructure elements that it may require of counties prior to implementing Family Care. For example, having the necessary information technology in place should accelerate the implementation process. DHFS has drafted a readiness assessment to aid in evaluating any future Family Care care management organizations because one of the lessons of the pilot was that the basic infrastructure needs to function smoothly in order to devote the necessary resources to organizational culture and philosophical changes.

Keys to the pilot's success that would be important to foster in any expansion include:

Commitment – The state and the county staff have demonstrated a high level of personal investment and pride in the program. They are committed to its success and do not even consider the possibility of reverting back to the old system because they see the advantages of the new system. It is this commitment that motivated the continuous learning process and spirit of cooperation. The current CMO staff and DHFS support the expansion of Family Care because they think it will provide other counties the opportunity to improve their long-term care systems.

Cooperation – All of the parties involved have been willing to work through problems and cooperate to build the new program. Not everyone agrees on everything, but cooperation is evident in: 1) the work groups established by DHFS where counties share information and bring up issues with the state staff; 2) the governing bodies, LTC councils and work groups established at the state and county level to advise on operations and policy; 3) the inter-departmental cooperation between DHFS and the Department of Workforce Development at the state level and the RCs, CMOs and the Economic Support Units at the county level to resolve the eligibility processes; and 4) the advocacy groups' efforts to improve the program and keep everyone focused on the member.

Trust – State staff had to trust the competency of county staff to implement the program. County staff had to trust that the state staff would support them and work with them. Members had to trust that they would continue to receive high quality, appropriate services. The pilot counties tread in uncharted territory. During one of our site visits, a CMO director commented "We didn't know what we didn't know." As a result, all parties had to have sufficient trust and willingness to make mistakes and learn from them without finger pointing.

Appendix A
Family Care CMO Benefit Definitions

I. FAMILY CARE CMO BENEFIT DEFINITIONS

The following definitions of the Family Care CMO benefits for Aged/Physical Disabilities Waiver can be found at http://www.dhfs.state.wi.us/LTCre/Waiver/c/AgedPD/appxB.pdf and for the Developmental Disabilities Waiver at http://dhfs.state.wi.us/LTCare/Waiver/c/MRDD/appxB.pdf:

1. **Care/Case Management:** The care manager initiates and oversees the initial comprehensive assessment process and reassessment process, the results of which are used by the care management team, participant and his/her informal supports in identifying the service needs of the participant and developing the individual's plan of care. The care manager also carries out activities that help participants and their families identify their needs and manage and gain access to necessary medical, social, rehabilitation, vocational, educational and other services.

2. **Supportive Home Care Service:** Supportive home care services are services to provide necessary assistance for eligible persons in order to meet their daily living needs and to insure adequate functioning at home, in small integrated alternate care settings and in the community. Supportive home care services differ from the State plan services in that they are supervised by case managers and provide services as indicated in a plan of care. Services include personal care, chore services, routine home care/maintenance, and supervision. Personal care services under the waiver provide necessary assistance with personal maintenance (grooming, bathing, dressing etc.). Home maintenance services and activities such as cleaning, changing storm windows and yard work. Providers may be members of the individual's family other than a spouse or parent of a minor child. Family members must meet the same standards as other supportive home care providers. Costs and utilization of the component services bundled under Supportive Home Care will continue to be tracked and computed separately in cost-effectiveness and cost-neutrality calculations.

3. **Respite Care:** Respite care services are services provided to a waiver eligible recipient on a short term basis to relieve the person's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility and may include payment for room and board. Respite care may also be provided in a residential facility such as a certified or licensed Adult Family Home, licensed CBRF, Child Caring Institution, children's foster home, children's treatment foster home, children's group home, certified Residential Care Apartment Complex, in the participant's own home or the home of a certified respite care provider. The cost of room and board is excluded if the service is received in a residential care apartment complex, the recipients own home or the home of a certified respite care provider.

4. **Adult Day Care:** Adult day care services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, transportation to and from the day care site. Transportation between the individual's place

of residence and the adult day health center may be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

5. **Habilitation:** Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The costs and utilization of the component services bundled under Habilitation will continue to be tracked and computed separately in cost-effectiveness and cost-neutrality calculations. Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services. This service includes:

   - **Day Center Service/Treatment:** Day services are the provision of regularly scheduled activities in a non-residential setting (day center) to enhance social development and to develop skills in performing activities of daily living and community living. Day services include services primarily intended for disabled adults. Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

   - **Prevocational Services:** Prevocational services are aimed at preparing an individual for paid or unpaid employment but which are not job task oriented. Services include teaching an individual such concepts as following directions, attending to tasks, task completion problem solving, safety and mobility training. Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Transportation may be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

   - **Supported Employment Services:** Supported Employment services are paid, competitive employment in an integrated work setting for individuals who because of their disabilities need intensive on-going support to perform in a work setting. Supported employment services include supervision, training, transportation services needed to provide intensive ongoing support, and any activity needed to sustain paid work by the participant, i.e., supported employment assessment, supported employment job placement, supported employment training, and supported employment follow-up. Supported employment services furnished under the waiver

are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

- **Daily Living Skills Training:** Daily living skills training provides training in activities of daily living such as child-rearing skills, money management, home care maintenance, food preparation and accessing and using community resources. Daily living skills training are provided in a residential setting and are intended to improve the participant's ability to perform routine daily living tasks, improve ability to utilize greater independence by either training the participant or the caregiver to perform activities with greater independence.

- **Counseling and Therapeutic Resources:** Counseling and therapeutic services are services that are needed to treat a personal, social, behavioral, cognitive, mental or alcohol or drug abuse disorder. Services are usually provided in a natural setting or service office. Services include: counseling to assist in understanding capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships, recreational therapy, music therapy, nutritional counseling, medical and legal counseling, and grief counseling.

6. **Home Modifications:** Home modifications are services and items that assess the need for, arrange for, and provide modifications and or improvements to a participant's living quarters. It allows for community living, provide safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, allow the individual to perform more ADLs with less assistance and decrease reliance on paid staff. Examples are ramps, lifts, kitchen/bathroom modifications, specialized accessibility/safety adaptations additions, voice activated, light activated, motion activated and electronic devices.

7. **Specialized Transportation:** Specialized transportation services assist in improving an individual's general mobility and ability to perform tasks independently and to gain access to waiver and other community services, activities and resources. Services can consist of material benefits such as tickets or other fare medium needed as well as direct conveyance of participants and their attendants to destinations.

8. **Specialized Medical Equipment and Supplies**: Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation.

9. **Personal Emergency Response System:** Personal emergency response system (PERS) is a device which provides a direct telephonic or other electronic communications link

between someone living in the community and health professionals to secure immediate assistance in the event of a physical, emotional or environmental emergency.

10. **Residential Services:** Nursing services under any of the following residential services are provided only in accordance with the standards of Wisconsin's Nurse Practice Act.

- Children's foster homes and Children's treatment foster hones are settings licensed to provide care for up to 4 children who are not related to the operator. Services provided include care, supervision, treatment, and training as needed for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation when transportation is part of providing the service. Services may include several hours per week of nursing care per child. Room and board costs are not included in the services the child receives.

- Adult family homes for 1-2 beds means a residence in which care and maintenance above the level of room and board, but not including nursing care are provided to one and two residents.

- Adult family homes for 3-4 beds means a small congregate care setting where 3-4 adults, who are not related to the operator, reside and receive care, treatment, support, supervision and training. The services are provided, as needed, for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training and transportation when transportation is part of providing the services and that may include several hours per week of nursing care per resident. Room and board costs are not included in the services the person receives.

- Community-based residential facilities (CBRF) are larger congregate care settings where 5 or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training that is provided as needed for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training and transportation when transportation is part of providing the services and that may include several hours per week of nursing care per resident. Room and board costs are not included in the services the person receives.

  For individuals with developmental disabilities, a variance must be obtained from the Department of Health and Family Services for the individuals on the waiver to live in a CBRF. For older frail individuals and those with physical disabilities, although bed size has historically been used as a proxy for whether a facility is really "community-based" or more institutional in nature, the definition of a community-based residential facility for these groups does not include a size limit. The bed size limit is not imposed here because the HFS Executive Team has determined that for elders and persons with physical disabilities the interdisciplinary case management team which includes the consumer can more effectively monitor the nature and quality of these facilities, rather than continuing to administratively impose bed size limits. Among the factors to be

considered in such monitoring is the importance of privacy to the individual consumer and in larger facilities the extent to which the consumer's "residence" is physically separated from that of others (e.g. separate lockable door, bathroom, kitchen facilities etc.). Each CMO network is required to include facilities which offer such physical separateness in various residential service settings including CBRF's, adult family homes, RCAC's and nursing homes.

- Residential care apartment complexes (RCAC) are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services, personal assistance, nursing services, and assistance in the event of an emergency.

11. **Adaptive Aids:** Adaptive aids are controls or appliances that cannot be obtained through Wisconsin's approved MA State Plan. They are aids that enable persons to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable individuals to access, participate, and function in their community. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc. that allow the vehicle to be used by the participant to access the community), or those costs associated with the maintenance of these items.

12. **Communication Aids**: Communication aids are devices or services needed to assist with hearing, speech or vision impairments in order to access and deliver services. These services assist the individual to effectively communicate with service providers, family, friends and the general public, decrease reliance on paid staff, increase personal safety, enhance independence, and improve social and emotional well-being. Communication aids include: communicators, speech amplifiers, aids and assistive devices, interpreters, and cognitive retraining aids, (including repair) and are items not covered under the Medicaid state plan.

13. **Home Delivered Meals**: Home delivered meals or "meals on wheels" include the costs associated with the purchase and planning of food. supplies, equipment, labor and transportation to deliver one or two meals a day to recipients who are unable to prepare or obtain nourishing meals without assistance. This service will be provided to persons in natural or supportive service settings to promote socialization and adequate nutrition.

14. **Consumer-directed Supports** (also called Self-directed Supports): Consumer-directed supports are services which provide support, care and assistance to an individual with a disability, prevent the person's institutionalization and allow the person to live an inclusive life. Consumer-directed supports are designed to build, strengthen, or maintain informal networks of community support for the person. Consumer-directed supports include the following specific activities at the request and direction of the consumer or his/her legal representative:

(a) Provision of services and supports, which assist the person, family or friends to: identify and access formal and informal support systems; develop a meaningful consumer support plan; or increase and/or maintain the capacity to direct formal and informal resources.

(b) Completion of activities which assist the person, his/her family, or his/her friends to determine his/her own future.

(c) Development and implementation of person-centered support plans which provide the direction, assistance and support to allow the person with a disability to live in the community, establish meaningful community.

(d) Ongoing consultation, community support, training, problem-solving, technical assistance and financial management assistance to assure successful implementation of his/her person-centered plan.

(e) Development and implementation of community support strategies which aid and strengthen the involvement of community members who assist the person to live in the community.

(f) Services provided under a plan for consumer-directed supports may not duplicate any other services provided to the person. Components of the consumer-directed supports will be documented as necessary to prevent the person's institutionalization in the individual service plan/personal support plan. Additionally, the local agency shall document how the community support services enable the person to lead an inclusive community life, build a viable network of support, and result in outcomes specified by the consumer or his/her legal guardian.

Payment parameters for consumer directed supports. Wisconsin will cover consumer-directed supports when local agencies have memorandums of understanding with the state agency to demonstrate the feasibility and effectiveness of consumer-directed community supports, or are Family Care CMOs. Each local agency offering consumer-directed support services will develop a written plan to implement consumer-directed community support options, which will:

(a) Specify how consumers, families, and other natural supports were involved in developing the plan and will be involved in ongoing oversight of the plan.

(b) Specify how the local agency will provide information about consumer-directed support options to consumers, families and other natural supports, guardians, and providers.

(c) Specify how participating consumers and their families, guardians and other natural supports will be supported: to know their rights as citizens and consumers; to learn about the methods provided by the consumer-directed supports plan to take greater control of decision-making; and to develop skills to be more effective in identifying and implementing personal goals.

(d) Establish support for development of person-centered support plans which are based on individual goals and preferences and which allow the person with a disability to live in the community, establish meaningful community associations, and make valued contributions to his/her community.

(e) Provide for mechanisms for consultation, problem-solving, technical assistance and financial management assistance to assist consumers in accessing and developing the desired support(s), and to assist in securing administrative and financial management assistance to implement the supports(s).

(f) Establish a mechanism for allocating resources to individuals for the purpose of purchasing consumer-directed community support services based upon identified factors. These factors may include the person's functional skills, his/her environment, the supports available to the person, and the specialized support needs of the person.

(g) Describe how the local agency will promote use of informal and generic sources of support.

(h) Describe how the local agency will promote availability of a flexible array of services that is able to provide supports to meet identified needs and that is able to provide consumer choice as to nature, level, and location of services.

(i) Describe how the local agency will assure that consumer-directed community supports meet the person's health and safety needs.

(j) Provide for outcome-based quality assurance methods.

Provider qualifications for consumer-directed supports: Consumer-directed supports will be provided by entities which meet the unique recipient needs and preferences of the consumer as specified in the person's individual service plan or personal support plan. Local agencies are responsible to work with the consumer and his/her legal guardian to assure that the consumer-directed supports meet the consumer's health and safety needs and preferences, and are directed at the desired consumer outcomes.

In addition, for individuals with developmental disabilities, these services are included:

15. **Consumer Education and Training:** Consumer education and training services are designed to help a person with a disability develop self advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. CMO's will assure that the consumer and legal guardian receive necessary information on training and educational opportunities related to identified goals.

16. **Housing Counseling:** Housing counseling is a service which provides assistance to a recipient when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of the housing counseling is to promote consumer choice and control of housing and access to housing that is affordable and promotes community inclusion. Housing counseling includes exploring both home

ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family. Services include counseling and assistance in identifying housing options, identifying financial resources and determining affordability, identifying preferences of location and type of housing, identifying accessibility and modification needs, locating available housing, identifying and assisting in access to housing financing, and planning for ongoing management and maintenance.

Medicaid State Plan Services in the Family Care Benefit Package include:

Alcohol and Other Drug Abuse Day Treatment Services (in all settings) as defined in HFS 107.11

Alcohol and Other Drug Abuse Services as defined in HFS 107.11 (except those provided by a physician or on an inpatient basis)

Case Management (including Assessment and Case Planning) as defined in HFS 107.32

Community Support Program as defined in HFS 107.11 (6)

Durable Medical Equipment, except for hearing aids and prosthetics (in all settings) as defined in HFS 107.24

Home Health as defined in HFS 107.11

Medical Supplies as defined in HFS 107.24

Mental Health Day Treatment Services (in all settings) as defined in HFS 107.11

Mental Health Services as defined in HFS 107.11 (except those provided by a physician or on an inpatient basis)

Nursing Facility as defined in HFS 107.09 (all stays) including ICF/MR, and IMD

Nursing Services (including respiratory care, intermittent and private duty nursing) as defined in HFS 107.11, HFS 107.113 and HFS 107.12

Occupational Therapy as defined in HFS 107.17 (in all settings except for inpatient hospital)

Personal Care as defined in HFS 107.112

Physical Therapy as defined in HFS 107.16 (in all settings except for inpatient hospital)

Speech and Language Pathology Services as defined in HFS 107.18 (in all settings except for inpatient hospital)

Transportation Services as defined in HFS 107.23 (except Ambulance and transportation by common carrier)

Appendix B
Sample Characteristics

Appendix B: Sample Characteristics

The tables presented in this appendix provide information about the sample sizes of the different analysis samples used, as well as whether the analysis sample differs from the comparison group based on a T test for significance. The tables present information for the sample frame, which included individuals for whom we had eligibility and either MMIS or HSRS claims information, the analysis sample which included individuals for whom we had COP, DD or electronic functional screens, and the weighted sample, which adjusted the analysis samples to reflect the relevant enrollment for CMO members from our original sampling information.

In general, for the existing enrollee samples, with the exception of Milwaukee, the matched counties and the remainder of the state comparisons are similar on the key characteristics of age, sex, Medicare status, target group, impairments in activities of daily living (ADL) and instrumental activities of daily living (IADL) if two or more impairments are considered, home as the residential setting total Medicaid and COP spending, and long-term care spending (***Exhibits B-1*** to ***B-3***). For all of the comparisons, length of time on program tended to be different with those in the comparison areas having been on the waiver program longer than the CMO members. This reflects the pre-CMO efforts in the CMO counties to reduce their wait lists. Other notable differences based on the weighted samples include:

- Portage and Pierce 1999 average monthly long-term care spending;
- The age distribution for those over age 60 for the Family Care sample versus remainder of the state comparison; and
- Milwaukee compared to Rock and even to non-CMO Milwaukee waiver recipients. Milwaukee's CMO had been operating only six months at the time period for the sample draw. The differences between the CMO sample of existing enrollees and Rock and the non-CMO Milwaukee sample suggests that the CMO enrolled lower cost individuals during this initial period, further complicating comparisons.

We relied on 1999 characteristics for the comparison because pre-CMO the same screening tool was used for both the CMO and the comparison areas and an apples-to-apples comparison could be made between the groups for functional impairment. However, this precluded comparing the analyses samples to the sample frame on the measures for functional impairment because screens were not available for the sample frame, only those that were abstracted for our analyses. Therefore, we confirmed that, for at least the CMO sample frame and analyses samples, functional status was similar based on the electronic functional screens available for all CMO members (***Exhibit B-2***).

Finally, ***Exhibit B-4*** provides information about the characteristics of new enrollees (those not on the waiver during December 1999) into the CMOs.

Exhibit B-1: CMO and Matched Comparison County Existing Enrollees 1999 Sample Characteristics

	Fond du Lac			Waupaca		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	313	237	237	158	140	140
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age						
18-44	30.7%	28.7%	26.0%	31.7%	35.7%	29.4%
45-59	17.9%	19.8%	18.4%	15.8%	15.0%	14.7%
60-74	22.4%	24.5%	25.6%	20.9%	20.0%	20.6%
75+	29.1%	27.0%	30.0%	31.7%	29.3%	35.4%
Average Age	58.4	59.0	60.8	59.9	57.7	61.1
Sex						
Male	36.4%	35.0%	34.7%	43.7%	42.1%	38.8%
Female	63.6%	65.0%	65.3%	56.3%	57.9%	61.2%
Dual Eligible						
Medicare & Medicaid	83.4%	85.7%	87.0%	81.7%	80.0%	82.8%
Medicaid Only	16.6%	14.4%	13.0%	18.4%	20.0%	17.2%
Target Group						
Elderly	43.5%	41.4%	46.3%	43.0%	37.1%	46.3%
Physically Disabled	17.9%	19.0%	18.1%	13.9%	12.9%	18.1%
Developmentally Disabled	38.7%	39.7%	35.6%	43.0%	50.0%	35.6%
Impairment in Activities of Daily Living						
0-1	NA	23.2%	22.6%	NA	25.0%	20.9%
2	NA	32.9%	34.2%	NA	20.0%	21.0%*
3+	NA	24.1%	22.8%	NA	40.7%	39.6%*
Severe Medical	NA	19.8%	20.5%	NA	14.3%	18.6%
Impairments in Instrumental Activities of Daily Living						
0-1	NA	3.0%	3.2%	NA	1.4%	1.4%
2	NA	15.2%	15.4%	NA	5.7%	7.5%*
3+	NA	62.0%	60.9%	NA	78.6%	72.5%*
Severe Medical	NA	19.8%	20.5%	NA	14.3%	18.6%
Residential Setting						
Other/Unknown	11.8%	11.4%	10.6%	15.2%	16.4%	13.1%
Own Home	67.7%	66.2%	68.1%	61.4%	60.0%	67.4%
Nursing Home	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CBRF	15.7%	17.3%	15.8%	23.4%*	23.6%	19.6%
Residential Care Apartment Complex	4.8%	5.1%	5.5%	N/A	0.0%	0.0%
Length of Time on Program						
12-17 months	32.6%	20.3%	20.6%	8.9%*	7.1%*	9.0%*
18-23 months	11.8%	13.1%	13.7%	10.8%	11.4%	11.8%
24-29 months	9.6%	11.8%	12.3%	12.0%	11.4%	11.4%
30+ months	46.0%	54.9%	53.4%	68.4%*	70.0%*	67.8%*
Average Monthly Spending						
1999	$2,237	$2,218	$2,219	$1,911	$1,923	$1,927
Average Monthly LTC Spending						
1999	$1,811	$1,826	$1,827	$1,649	$1,674	$1,677

* Significant at the 0.05 level

Exhibit B-1: CMO and Matched Comparison County Existing Enrollees
1999 Sample Characteristics, continued

	La Crosse			Manitowoc		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	445	355	355	228	220	220
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age						
18-44	32.4%	35.8%	32.5%	29.0%	26.8%*	28.6%
45-59	18.2%	19.4%	17.9%	21.9%	21.8%	22.0%
0-74	17.5%	15.8%	16.8%	19.3%	20.5%	19.7%
75+	31.9%	29.0%	32.8%	29.8%	30.9%	29.7%
Average Age	58.3	56.4	58.5	58.4	59.3	58.
Sex						
Male	37.5%	39.4%	37.6%	39.0%	38.6%	39.6%
Female	62.5%	60.6%	62.4%	61.0%	61.4%	60.4%
Dual Eligible						
Medicare & Medicaid	79.1%	78.3%	80.0%	83.3%	83.6%	82.9%
Medicaid Only	20.9%	21.7%	20.0%	16.7%	16.4%	17.1%
Target Group						
Elderly	44.3%	39.7%	45.0%	45.2%	46.8%	45.0%
Physically Disabled	18.4%	18.3%	17.3%	19.3%	18.6%	17.3%
Developmentally Disabled	37.3%	42.0%	37.7%	35.5%	34.6%	37.7%
Impairment in Activities of Daily Living						
0-1	NA	19.2%	18.3%	NA	16.8%	17.4%
2	NA	23.1%	23.8%	NA	23.6%	23.1%
3+	NA	34.4%	33.0%	NA	45.5%*	46.2%*
Severe Medical	NA	23.4%	24.9%	NA	14.1%*	13.3%*
Impairments in Instrumental Activities of Daily Living						
0-1	NA	4.5%	4.7%	NA	3.6%	3.6%
2	NA	14.7%	14.8%	NA	10.9%	10.6%
3+	NA	57.5%	55.6%	NA	71.4%*	72.5%*
Severe Medical	NA	23.4%	24.9%	NA	14.1%*	13.3%*
Residential Setting						
Other/Unknown	21.4%	21.1%	19.8%	9.2%*	8.6%*	9.2%*
Own Home	71.9%	71.3%	73.0%	77.2%	77.7%	76.7%
Nursing Home	0.2%	0.3%	0.3%	0.0%	N/A	N/A
CBRF	6.1%	6.8%	6.2%	12.3%*	12.7%*	13.2%*
Residential Care Apartment Complex	0.5%	0.6%	0.6%	1.3%	0.9%	0.9%
Length of Time on Program						
12-17 months	24.3%	16.3%	16.5%	7.9%*	7.3%*	7.2%*
18-23 months	9.7%	11.8%	12.5%	11.0%	11.4%	11.0%
24-29 months	9.9%	9.3%	9.5%	7.5%	6.8%	6.7%
30+ months	56.2%	62.5%	61.4%	73.7%*	74.6%*	75.1%*
Average Monthly Spending						
1999	$1,885	$1,834	$1,834	$1,789	$1,809	$1,808
Average Monthly LTC Spending						
1999	$1,550	$1,549	$1,549	$1,485	$1,501	$1,501

* Significant at the 0.05 level

Exhibit B-1: CMO and Matched Comparison County Existing Enrollees
1999 Sample Characteristics, continued

	Milwaukee			Rock		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	444	186	NA	236	189	NA
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age						
18-44	0.0%	0.0%	NA	0.0%	0.0%	NA
45-59	0.0%	0.0%	NA	0.0%	0.0%	NA
60-74	47.5%	49.5%	NA	52.1%	51.9%	NA
75+	52.5%	50.5%	NA	47.9%	48.2%	NA
Average Age	75.8	75.6	NA	74.4*	74.6	NA
Sex						
Male	20.7%	19.4%	NA	30.1%*	29.6%*	NA
Female	79.3%	80.7%	NA	69.9%*	70.4%*	NA
Dual Eligible						
Medicare & Medicaid	95.3%	95.7%	NA	92.4%	94.7%	NA
Medicaid Only	4.7%	4.3%	NA	7.6%	5.3%	NA
Target Group						
Elderly	100.0%	100.0%	NA	100.0%	100.0%	NA
Physically Disabled	0.0%	0.0%	NA	0.0%	0.0%	NA
Developmentally Disabled	0.0%	0.0%	NA	0.0%	0.0%	NA
Impairment in Activities of Daily Living						
0-1	NA	3.8%	NA	NA	15.9%*	NA
2	NA	43.6%	NA	NA	23.8%*	NA
3+	NA	21.0%	NA	NA	45.0%*	NA
Severe Medical	NA	31.7%	NA	NA	15.3%*	NA
Impairments in Instrumental Activities of Daily Living						
0-1	NA	16.7%	NA	NA	10.6%	NA
2	NA	12.9%	NA	NA	12.7%	NA
3+	NA	38.7%	NA	NA	61.4%*	NA
Severe Medical	NA	31.7%	NA	NA	15.3%*	NA
Residential Setting						
Other/Unknown	6.1%	4.8%	NA	11.9%*	12.2%*	NA
Own Home	90.1%	91.9%	NA	75.0%*	75.1%*	NA
Nursing Home	0.0%	0.0%	NA	0.0%	0.0%	NA
CBRF	3.8%	3.2%	NA	13.1%*	12.7%*	NA
Residential Care Apartment Complex	0.0%	0.0%	NA	0.0%	0.0%	NA
Length of Time on Program						
12-17 months	25.2%	19.9%	NA	8.5%*	10.1%*	NA
18-23 months	29.5%	30.1%	NA	11.4%*	12.2%*	NA
24-29 months	2.3%	2.7%	NA	8.9%*	10.1%*	NA
30+ months	43.0%	47.3%	NA	71.2%*	67.7%*	NA
Average Monthly Spending						
1999	$1,484	$1,460	NA	$1,744*	$1,827*	NA
Average Monthly LTC Spending						
1999	$1,109	$1,123	NA	$1,383*	$1,460*	NA

* Significant at the 0.05 level

Exhibit B-1: CMO and Matched Comparison County Existing Enrollees
1999 Sample Characteristics, continued

	Portage			Pierce		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	249	194	194	126	108	108
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age						
18-44	35.3%	38.7%	32.8%	34.9%	38.0%	27.6%
45-59	18.9%	20.6%	17.9%	30.2%*	29.6%	24.0%
60-74	16.5%	15.0%	15.8%	18.3%	16.7%	21.2%
75+	29.3%	25.8%	33.6%	16.7%*	15.7%*	27.2%
Average Age	56.8	54.3	58.2	53.5	52.8	59.4
Sex						
Male	40.6%	43.3%	40.9%	35.7%	31.5%*	31.2%
Female	59.4%	56.7%	59.1%	64.3%	68.5%*	68.8%
Dual Eligible						
Medicare & Medicaid	83.1%	82.0%	84.4%	77.0%	80.6%	85.9%
Medicaid Only	16.9%	18.0%	15.6%	23.0%	19.4%	14.1%
Target Group						
Elderly	38.2%	32.0%	41.6%	26.2%*	24.1%	41.6%
Physically Disabled	15.7%	16.0%	16.3%	14.3%	12.0%	16.3%
Developmentally Disabled	46.2%	52.1%	42.0%	59.5%*	63.9%*	42.0%
Impairment in Activities of Daily Living						
0-1	NA	20.6%	18.7%	NA	28.7%	23.9%
2	NA	18.6%	20.2%	NA	19.4%	18.8%
3+	NA	40.7%	36.4%	NA	41.7%	42.6%
Severe Medical	NA	20.1%	24.7%	NA	10.2%*	14.9%
Impairments in Instrumental Activities of Daily Living						
0-1	NA	3.1%	3.3%	NA	4.6%	7.0%
2	NA	11.9%	11.8%	NA	7.4%	8.8%
3+	NA	65.0%	60.2%	NA	77.8%*	69.3%
Severe Medical	NA	20.1%	24.7%	NA	10.2%*	14.9%
Residential Setting						
Other/Unknown	18.1%	16.5%	14.5%	15.9%	16.7%	11.0%
Own Home	73.9%	77.3%	80.6%	57.1%*	55.6%*	66.8%*
Nursing Home	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CBRF	8.0%	6.2%	5.0%	27.0%*	27.8%*	22.3%*
Residential Care Apartment Complex	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Length of Time on Program						
12-17 months	20.1%	11.3%	12.9%	1.6%*	2.8%*	3.8%*
18-23 months	14.9%	17.0%	19.3%	9.5%	10.2%	12.3%
24-29 months	8.0%	8.8%	9.3%	7.9%	6.5%	8.5%
30+ months	57.0%	62.9%	58.6%	81.0%*	80.6%*	75.4%*
Average Monthly Spending						
1999	$2,125	$2,408	$2,409	$2,447	$2,558	$1,927
Average Monthly LTC Spending						
1999	100.0%	$2,142	$2,143	$2,221	$2,330	$1,677*

* Significant at the 0.05 level

Exhibit B-1: CMO and Matched Comparison County Existing Enrollees 1999 Sample Characteristics, continued

	Family Care			Remainder of the State		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	1,451	972	972	12,758	482	482
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age						
18-44	22.6%	27.8%	25.6%	35.9%*	25.1%	24.2%
45-59	12.7%	16.1%	15.1%	20.2%*	15.6%	14.1%
60-74	27.6%	24.2%	25.3%	18.5%*	18.1%*	18.0%*
75+	37.2%	32.0%	34.0%	25.5%*	41.3%*	43.7%*
Average Age	63.4	60.3	61.6	55.9*	63.0	63.9
Sex						
Male	32.7%	35.3%	34.6%	42.0%*	34.4%	33.8%
Female	67.3%	64.7%	65.4%	58.0%*	65.6%	66.2%
Dual Eligible						
Medicare & Medicaid	85.7%	84.2%	85.3%	79.8%*	86.1%	86.9%
Medicaid Only	14.3%	15.8%	14.8%	20.2%*	13.9%	13.1%
Target Group						
Elderly	60.1%	50.1%	53.5%	40.6%*	50.4%	53.5%
Physically Disabled	12.2%	14.5%	14.4%	13.4%	17.2%	14.5%
Developmentally Disabled	27.7%	35.4%	32.2%	46.0%*	32.4%	32.0%
Impairment in Activities of Daily Living						
0-1	NA	17.5%	16.9%	NA	20.1%	20.1%
2	NA	28.5%	29.4%	NA	28.8%	29.4%
3+	NA	30.6%	29.3%	NA	34.7%	34.8%*
Severe Medical	NA	23.5%	24.5%	NA	16.4%*	15.7%*
Impairments in Instrumental Activities of Daily Living						
0-1	NA	6.2%	6.5%	NA	6.0%	6.1%
2	NA	13.9%	14.1%	NA	15.4%	15.5%
3+	NA	56.5%	54.9%	NA	62.2%*	62.7%*
Severe Medical	NA	23.5%	24.5%	NA	16.4%*	15.7%*
Residential Setting						
Other/Unknown	14.1%	14.7%	14.0%	23.3%*	15.4%	15.1%
Own Home	76.9%	75.2%	76.4%	62.2%*	72.6%	72.7%
Nursing Home	0.1%	0.1%	0.1%	N/A	N/A	N/A
CBRF	7.8%	8.5%	8.0%	14.0%*	12.0%*	12.3%*
Residential Care Apartment Complex	1.2%	1.4%	1.5%	0.5%*	N/A	N/A
Length of Time on Program						
12-17 months	25.6%	17.0%	17.4%	7.4%*	8.3%*	8.3%*
18-23 months	17.1%	16.7%	17.2%	11.1%*	12.7%*	12.8%*
24-29 months	7.2%	8.5%	8.6%	9.0%*	10.2%	10.2%
30+ months	50.1%	57.8%	56.8%	72.6%*	68.9%*	68.6%*
Average Monthly Spending						
1999	$1,919	$1,970	$1,993	$2,524*	$2,147	$2,148
Average Monthly LTC Spending						
1999	$1,564	$1,653	$1,673	$2,214*	$1,790	$1,790

* Significant at the 0.05 level

Exhibit B-2: Family Care CMO Existing Enrollees
Functional Limitations Based on 2000/2001 Screens

	Fond du Lac			La Crosse			Milwaukee			Portage			All Family Care		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
N	314	237	237	454	355	355	897	186		242	194	194	1,907	972	972
Impairment in Activities of Daily Living															
0-1	31.5%	28.3%	27.5%	20.3%	21.4%	20.7%	19.2%	17.7%	NA	20.3%	23.7%	22.4%	21.6%	22.8%	22.5%
2	21.3%	26.6%	27.0%	20.9%	20.0%	20.5%	19.6%	16.7%	NA	19.8%	17.0%	18.2%	20.2%	20.4%	20.4%
3+	47.1%	45.2%	45.5%	58.8%	58.6%	58.8%	61.2%	65.6%	NA	59.9%	59.3%	59.4%	58.2%	56.8%	57.1%
Impairments in Instrumental Activities of Daily Living															
0-1	9.2%	8.4%	8.8%	9.5%	8.2%	8.6%	11.0%	12.9%	NA	8.3%	7.7%	8.9%	10.0%	9.1%	9.5%
2	12.7%	17.3%	17.3%	14.8%	18.6%	18.6%	13.7%	14.5%	NA	12.0%	14.4%	15.0%	13.6%	16.7%	16.8%
3+	78.0%	74.3%	73.9%	75.8%	73.2%	72.8%	75.3%	72.6%	NA	79.8%	77.8%	76.1%	76.4%	74.3%	73.7%

Exhibit B-3: CMO and Alternative Milwaukee Comparison Group Existing Enrollees 1999 Sample Characteristics

	Milwaukee Family Care			Milwaukee Non-Family Care		
	Sample Frame	Analysis Sample	Weighted Analysis Sample	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	908	186	NA	1330	120	NA
Percent	100.0%	100.0%	NA	100.0%	100.0%	NA
Age						
8-44	0.0%	0.0%	NA	0.0%	0.0%	NA
45-59	0.0%	0.0%	NA	0.0%	0.0%	NA
60-74	44.2%	49.5%	NA	47.6%	38.3%	NA
75+	55.8%	50.5%	NA	52.4%	61.7%	NA
Average Age	74.4	75.6	NA	75.6%	77.5%	NA
Sex						
Male	22.0%	19.4%	NA	25.9%*	20.8%	NA
Female	78.0%	80.7%	NA	74.1%*	79.2%	NA
Dual Eligible						
Medicare & Medicaid	94.2%	95.7%	NA	92.3%	95.0%	NA
Medicaid Only	5.8%	4.3%	NA	7.7%	5.0%	NA
Target Group						
Elderly	100.0%	100.0%	NA	100.0%	100.0%	NA
Physically Disabled	0.0%	0.0%	NA	0.0%	0.0%	NA
Developmentally Disabled	0.0%	0.0%	NA	0.0%	0.0%	NA
Impairment in Activities of Daily Living						
0-1	NA	3.8%	NA	NA	14.2%*	NA
2	NA	43.6%	NA	NA	40.8%	NA
3+	NA	21.0%	NA	NA	24.2%	NA
Severe Medical	NA	31.7%	NA	NA	20.8%*	NA
Impairments in Instrumental Activities of Daily Living						
0-1	NA	16.7%	NA	NA	15.0%	NA
2	NA	12.9%	NA	NA	15.0%	NA
3+	NA	38.7%	NA	NA	49.2%	NA
Severe Medical	NA	31.7%	NA	NA	20.8%*	NA
Residential Setting						
Other/Unknown	5.5%	4.8%	NA	7.1%*	6.7%	NA
Own Home	85.2%	91.9%	NA	79.2%*	83.3%*	NA
Nursing Home	0.0%	0.0%	NA	0.1%	0.0%	NA
CBRF	9.3%	3.2%	NA	13.5%	10.0%*	NA
Residential Care Apartment Complex	0.0%	0.0%	NA	0.1%	0.0%	NA
Length of Time on Program						
12-17 months	22.6%	19.9%	NA	6.2%*	5.8%*	NA
18-23 months	26.8%	30.1%	NA	26.7%	28.3%	NA
24-29 months	2.8%	2.7%	NA	7.0%	1.7%	NA
30+ months	47.9%	47.3%	NA	60.1%*	64.2%*	NA
Average Monthly Spending						
1999	$1,637	$1,460	NA	$1,763*	$2,013*	NA
Average Monthly LTC Spending						
1999	$1,241	$1,123	NA	$1,368*	$1,683*	NA

* Significant at the 0.05 level

Exhibit B-4: CMO New Enrollees
1999 Sample Characteristics

Fond du Lac			
	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	NA	274	274
Percent	NA	100.0%	100.0%
Age			
18-44	NA	40.9%	33.0%
45-59	NA	12.8%	15.3%
60-74	NA	12.8%	14.1%
75+	NA	33.6%	37.5%
Average Age	NA	56.4%	59.6%
Sex			
Male	NA	40.5%	37.4%
Female	NA	59.5%	62.6%
Dual Eligible			
Medicare & Medicaid	NA	80.3%	78.3%
Medicaid Only	NA	19.7%	21.7%
Target Group			
Elderly	NA	40.9%	46.3%
Physically Disabled	NA	8.0%	18.1%
Developmentally Disabled	NA	51.1%	35.6%
Impairment in Activities of Daily Living			
0-1	NA	44.9%	39.8%
2	NA	26.6%	26.6%
3+	NA	28.5%	33.6%
Severe Medical	NA	NA	NA
Impairments in Instrumental Activities of Daily Living			
0-1	NA	5.1%	6.5%
2	NA	11.3%	11.8%
3+	NA	83.6%	81.7%
Severe Medical	NA	NA	NA
Residential Setting			
Other/Unknown	NA	8.4%	8.4%
Own Home	NA	76.6%	79.6%
Nursing Home	NA	0.0%	0.0%
CBRF	NA	12.4%	9.3%
Residential Care Apartment Complex		2.6%	2.7%
Length of Time on Program			
0-5 months	NA	77.0%	76.1%
6-11 months	NA	23.0%	23.9%
Average Monthly Spending 2000			
	NA	$1,492	$1,503
Average Monthly LTC Spending 2000			
	NA	$1,249	$1,258