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July 15, 2003

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

Dear Senator Roessler and Representative Jeskewitz:

As required by 1999 Wisconsin Act 9, the Legislative Audit Bureau contracted with The Lewin Group, Inc., in 1999 to conduct an evaluation of the Family Care pilot program. This report is the final document in a series of reports prepared under the terms of the contract.

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

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

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

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

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

Sincerely,

Janice Mueller
State Auditor

JM/KW/bm

Enclosures

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

FAMILY CARE PILOT PROGRAM

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

The Family Care model creates two new community organizations:

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

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

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

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

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

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

Access to Services and Information

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

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

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

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

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

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

Infrastructure Development

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

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

Quality of Life and Quality of Care

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

other community-based waiver programs. Family Care participants reported more positive outcomes than the others surveyed in three broad areas:

- choice and self-determination, including fairness, privacy, choice in one's daily routine, and satisfaction with services;

- community integration, including choosing where and with whom to live, participating in the life of the community, and remaining connected to informal support networks; and

- health and safety, including freedom from abuse and neglect, attainment of the best possible health, and continuity and security in one's life.

Lewin compared the incidence of four traditional indicators of quality of care for CMO enrollees with the incidence of those indicators in the remainder of the state during the first six months of 2001. The report notes slightly lower levels of hospital and emergency room use, diagnosis of decubitis ulcers, and death for Family Care recipients, but no statistically significant differences.

Expenditures

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

- the Family Care CMO counties;

- a matched "comparison" county for each Family Care CMO county; and

- the remainder of the state.

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

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

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

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

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

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

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

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

Comparison of Community and Nursing Facility Costs

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

Lewin found that expenditures were lower for community care services under Family Care than for nursing home care. When functional status was considered, average spending for long-term care services in the community was 74.3 percent of nursing home spending. However, if level of care was considered, the difference diminished as the level of care increased. At the intermediate level of care, average community costs were 53.6 percent of nursing home costs: $1,128 per person per month in the community, compared to $2,104 in a nursing home. At the skilled nursing level, average community costs were 75.4 percent of nursing home costs: $1,913 per person per month in the community, compared to $2,538 in a nursing home. Finally, at the intensive skilled nursing level of care, average community costs per month were higher than the average nursing home costs: per person per month costs of $3,218 in the community were 108.1 percent of the $2,976 average monthly costs in a nursing home.

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Wisconsin Family Care Final Evaluation Report

Prepared for:

Wisconsin Legislative Audit Bureau

Prepared by:

The Lewin Group

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June 30, 2003
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PART ONE:
INTRODUCTION

I. PROGRAM OVERVIEW

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

In 1999, the Governor and Legislature authorized the Department of Health and Family Services (DHFS) to pilot the Family Care Program in a limited number of counties. Fond du Lac, Portage, La Crosse and Milwaukee Counties began operating RCs in 1999 and implementing Family Care CMOs during CY 2000, while Richland began its CMO in 2001. Jackson, Kenosha, Marathon and Trempealeau are currently piloting the RCs.[1] The goals of Family Care include:

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

If the program achieves its goals, Family Care will provide frail older adults and younger adults with physical or developmental disabilities with greater access to flexible services that promote independence and facilitate a higher quality of life. Family Care involves several innovations:

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

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

A. Eligibility

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

Exhibit I-1
Eligibility for Family Care Benefits

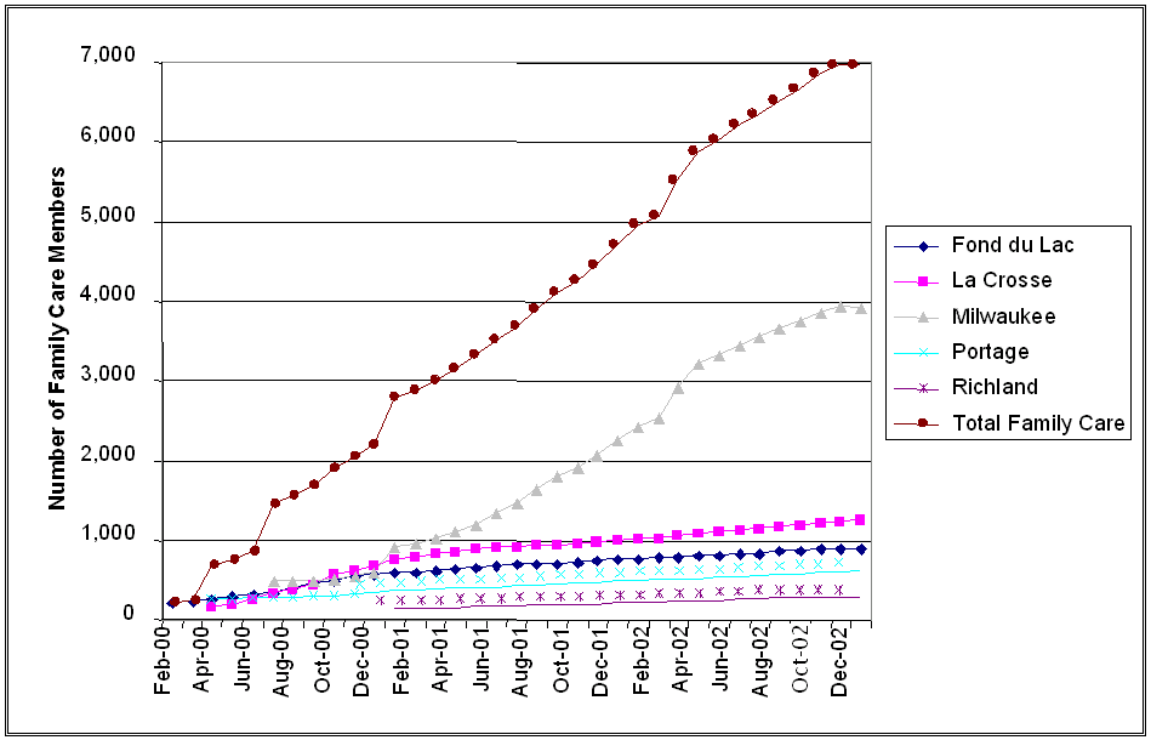
Target Population	**Frail Older Adults**	**Adults with Physical Disabilities**	**Adults with Developmental Disabilities**
	Age 65+, except Milwaukee age 60+	Age 17 years and 9 months and older	Age 17 years and 9 months and older
Resource Center (RC) Services			
Eligibility	Individuals of all income and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

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

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

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

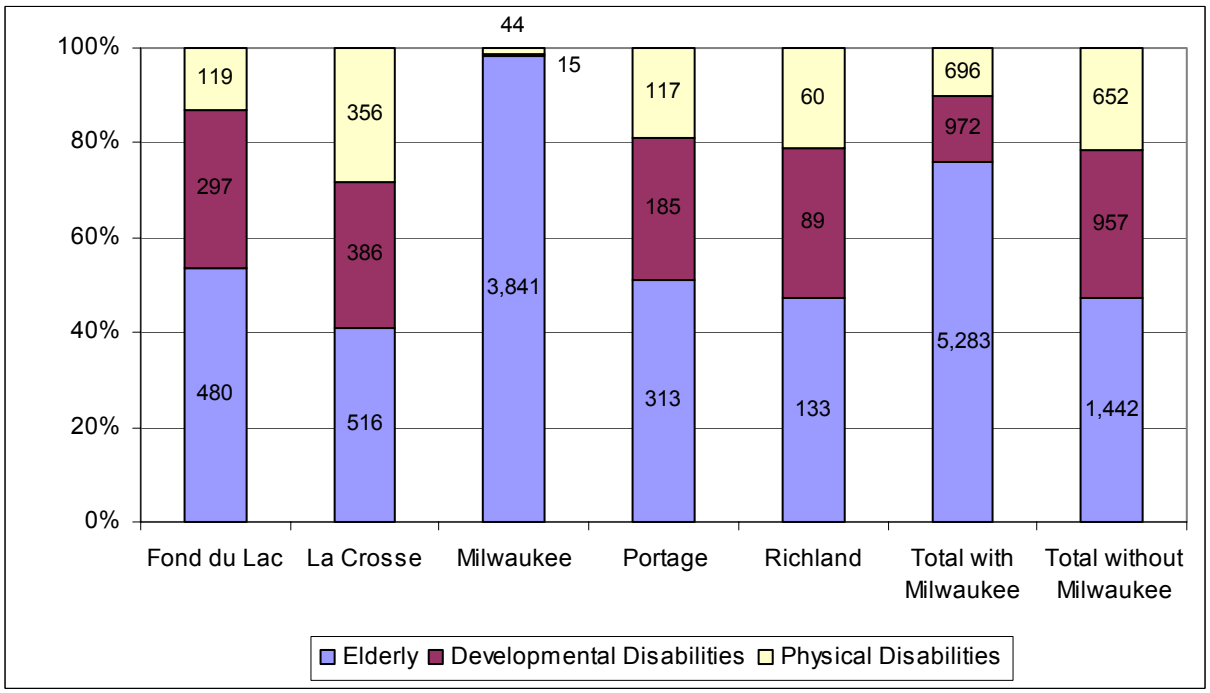
Exhibit I-2
Family Care CMO Enrollment through December 2002



Note: Enrollment data since January 2001 reflect totals presented in the most recent Family Care Activity Report. Revised data for 2000 were not available, possibly affecting the curve of data presented.

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

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



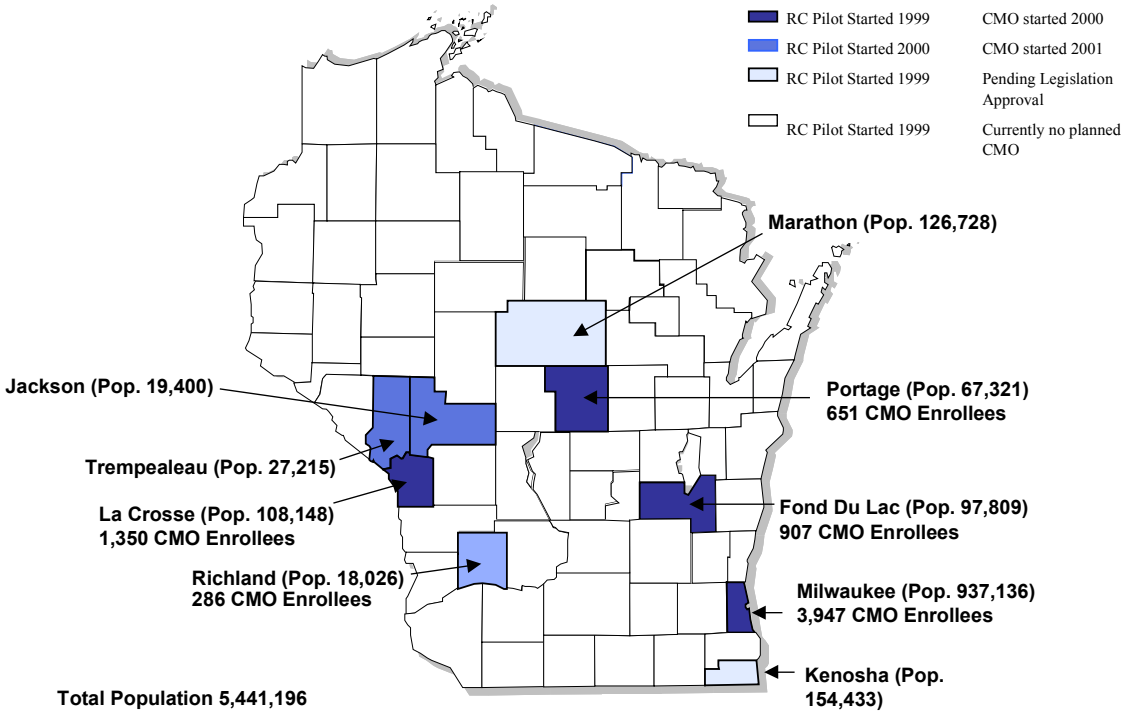
Note: These distributions exclude the 15 enrollees (12 in Milwaukee) that did not have the target population identified because CMO members' enrollment records in the Medicaid Management Information System (MMIS) cannot yet be matched with Target Group data from the Functional Screen, due to different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

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

B. Infrastructure

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

Exhibit I-4
Family Care Sites



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

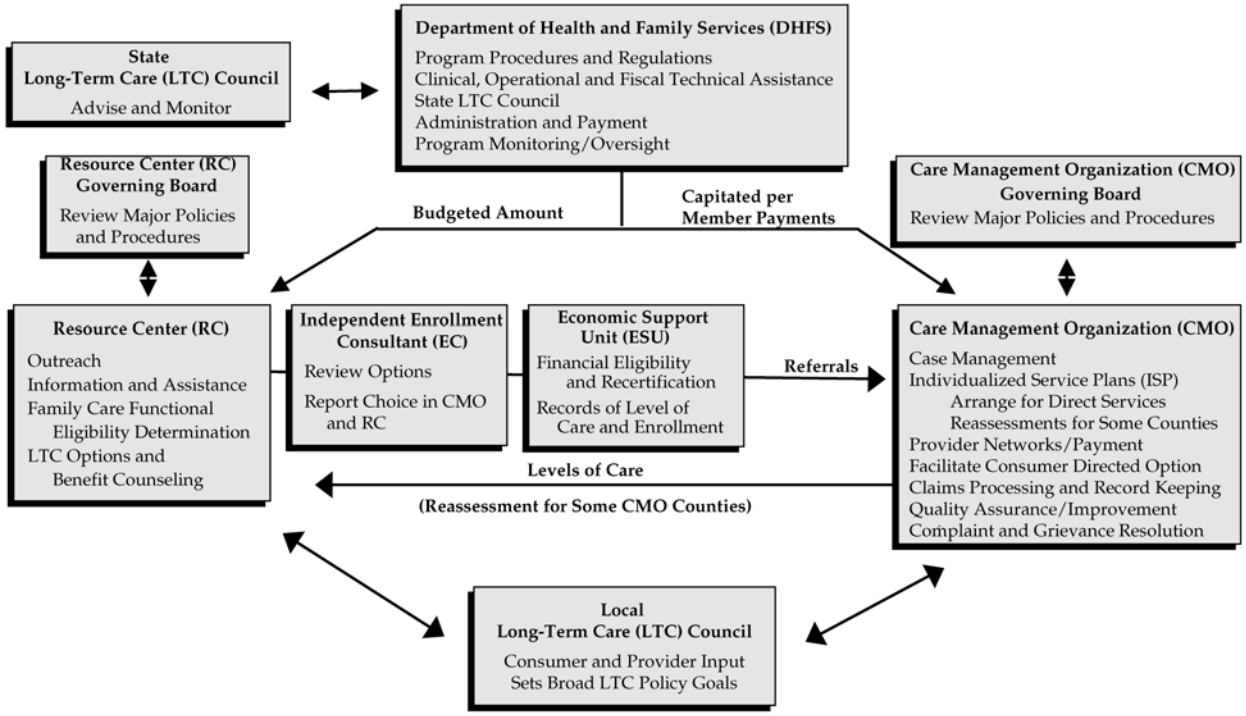
Family Care involves the partnership and interaction among a number of entities at both the state and local level (***Exhibit I-5***). Similar to programs prior to Family Care, the long term care counseling and the provision of benefits occurs at the local level, primarily through the Resource Centers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

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

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

Exhibit I-5

Wisconsin Family Care (FC) Functions and Roles



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

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

Resource Centers

Resource Centers provide assistance to individuals seeking information about long-term care services and service personnel working with populations in need of long-term care services. They offer a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers that are

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

Care Management Organizations

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

Independent Enrollment Consultant

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

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

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

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

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

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

Economic Support Unit

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

C. Benefits

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

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

D. Quality Assurance/Improvement

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

Family Care relies on a consumer-centered approach that includes process measures, such as CMO contract compliance and quality site reviews, but more heavily relies on consumer-defined outcomes captured by the Member Outcome Tool, developed in partnership with the Council for Quality and Leadership (the Council). The tool measures consumers' perceptions of outcomes and whether or not supports exist to achieve those outcomes in several areas: privacy, the ability to choose services, housing, safety, the degree to which members are respected, and experience continuity, and satisfaction with services (***Exhibit I-9***).

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

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

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

Exhibit I-8
DHFS' Multi-Level Quality Plan

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

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

Exhibit I-9
Member Outcome Tool Domains and Measures

Domain	Choice And Self-Determination	Community Integration	Health And Safety
Outcomes Measured	• People are treated fairly • People have privacy • People have personal dignity and respect • People choose their services • People choose their daily routine • People achieve their employment objectives • People are satisfied with services	• People choose where and with whom they live • People participate in the life of the community • People remain connected to informal support networks	• People are free from abuse and neglect • People have the best possible health • People are safe • People experience continuity and security

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

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

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

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

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

E. Financing

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

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

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

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

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

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

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

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

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

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

Exhibit I-11
Funding for Family Care

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

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

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

Exhibit I-12
Prospective CY 2003 Monthly Capitation Rates

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

Source: DHFS provided information.

II. OVERVIEW OF THE EVALUATION

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

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

This report incorporates revisions to the *Draft Outcome and Cost-Effectiveness Evaluation Report* and also provides a summary of the implementation of Family Care through May 2003, as well as major conclusions and future considerations for the program. The information in this report provides some preliminary indications of the results of the Family Care program. It is important to note that the data available for the pre/post comparison for the outcome analysis generally reflect only the first year of the program's implementation, and, as a result, does not capture the ultimate impact of the program. In addition, our prior implementation reports indicated that the CMOs were focused on start-up issues and were not yet able to fully realize the potential advantages of the new care management structures and other aspects of the program during this period. Impacts of the program would not be expected to be realized until three to four years following start-up, and the data for an analysis of this timeframe would be available four to five years after start-up, or 2004-05. In addition, ultimate impacts, particularly on nursing home use, may not be realized for some time to come. This report also updates the baseline fidelity measure (see ***Appendix C***), a measure of program progress outlined in the previous report, with information as of May 2003.

A. Phase I

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

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

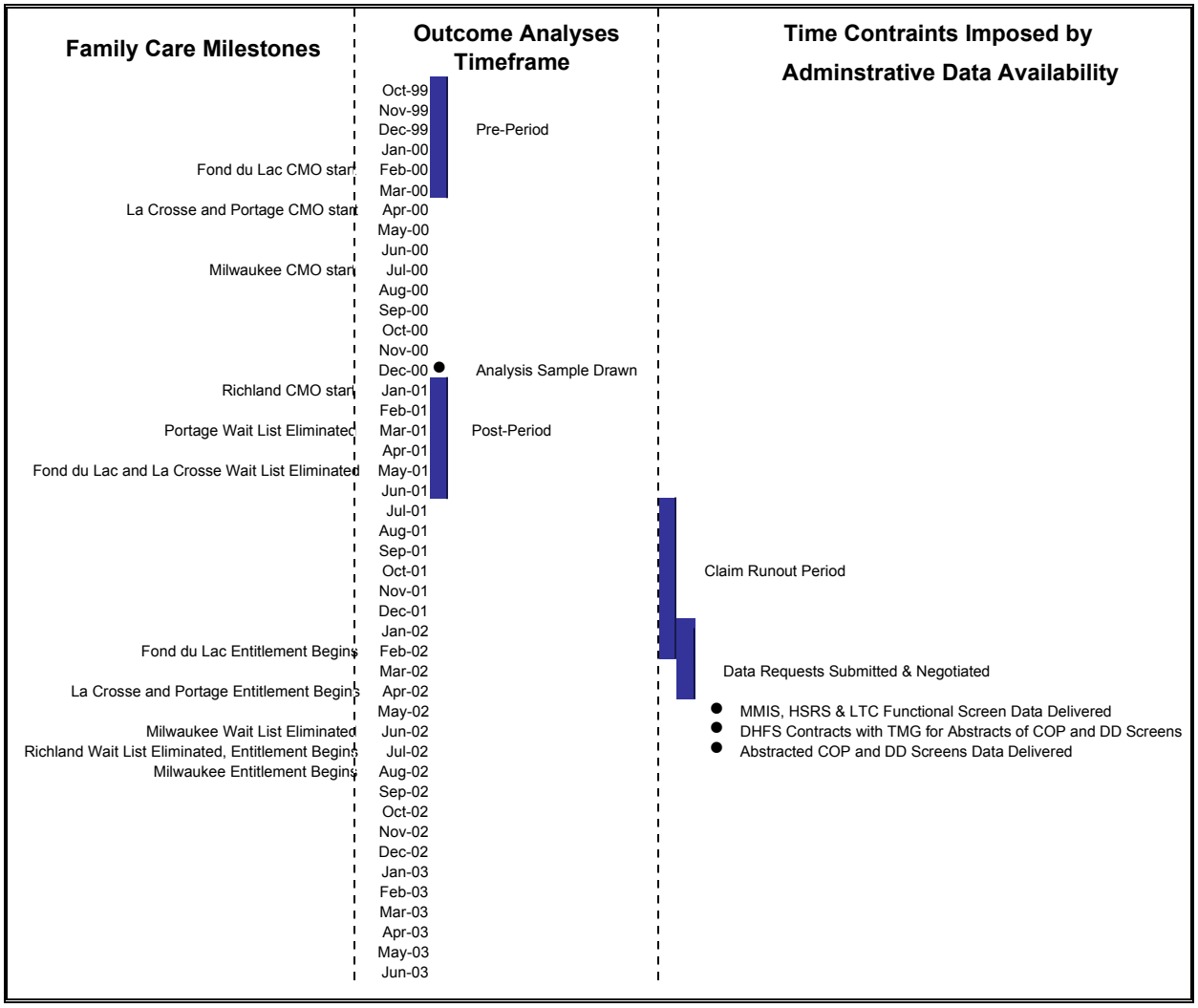
B. Phase II

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

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

Exhibit II-1 indicates the time period for most of the outcome analyses that focus on spending within the context of the evolution of Family Care. Data availability dictated the analysis timeframe. A request for data was made in January 2002 for data through the end of June 2001. This time period was necessary due to the time lag between service provision and when a claim is entered and recognized into the data systems (particularly the Medicaid claims system). DHFS provided information regarding lag factors associated with different types of services in the Medicaid Management Information System (MMIS). We used a goal of capturing 90 percent of claims for the most critical services (inpatient, prescription drugs, home health, personal care, and therapies). Among these services, inpatient hospital had the longest time period to capture close to 90 percent -- 89.16 percent at eight months following the service date. Working eight months backwards from February 2002, established June 2001 as the last month for the analysis and requiring six months of experience in the CMO brought us to December 2000 for the analysis samples. This also limited the analyses to the four initial CMO counties. In conducting the analyses, we did not adjust for the up to 10 percent of unobserved spending because the analyses were carried out at the individual level and it would not be possible to accurately predict which individuals would incur the unobserved spending.

Exhibit II-1
Family Care Outcome Analyses Timeframe



III. METHODOLOGY

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

DHFS Monthly Activity Reports and Quarterly Family Care Activity Reports;

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

Pilot County Quarterly Narrative Reports.

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

The outcome and cost-effectiveness portions of the report required selection of comparison groups, development of analysis files, and measurement of selected program outcomes and costs.

A. Comparison Groups for Family Care CMO Members

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

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

To assess whether the Family Care CMOs had an effect on outcomes and costs, we examined changes in selected outcomes and costs for CMO members from prior to implementation of the CMOs to a period following implementation. We then compared these changes to changes among comparison groups. This combined pre/post and comparison group non-experimental design is called a difference-in-difference (DID) analysis. The approach accounts for changes over time unrelated to the Family Care program by adjusting for the change experienced by a

similar group not subject to Family Care (comparison areas). The underlying assumption is that the time trend in the control group is an adequate proxy for the time trend that would have occurred in the Family Care CMO counties in the absence of Family Care. The simple difference-in-difference estimator is represented by the following formula:

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

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

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

1. **Matched Non-Family Care Counties** – For each of the four CMO counties included in the analysis, we identified comparison counties that have similar community long-term care systems characteristics to the CMO counties (***Exhibit III-1***). Data availability dictated an analysis timeframe that required most analyses to focus on the initial four CMO counties and therefore many of the analyses exclude Richland. The matched county approach strives to measure the incremental effect of the system and reimbursement changes as a result of Family Care, holding constant the "generosity" of the county prior to the program. The matched counties were chosen based on similarity for four main criteria related to the combination of COP-W, CIP II and COP-R. These criteria focus on the elderly and non-elderly adults with physical disabilities which constitute two-thirds of the CMO enrollment in Fond du Lac, La Crosse, and Portage. The criteria included:
    - Service spending per capita for the county;
    - Service recipient per 1,000 county residents;
    - Service spending per recipient; and
    - The percent of spending for alternative residential care.

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

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

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

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

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

2. **A Sample of the Remainder of the State** – A random sample of individuals receiving Medicaid home and community-based waiver services in counties other than Fond du Lac, La Crosse, Milwaukee, Portage and Richland was drawn.[5] The random sample approach has the advantage of diversifying the comparison area and precluding the possibility of selecting a county that looks well-matched based on available information but a poor match for other reasons. The random sample approach, however, does not account for any fundamental differences between the CMO counties and the rest of the state in the number of potentially eligible individuals served, the funding level per recipient, and the range of services available.

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

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

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

Exhibit III-2
Analysis Groups

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

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

Exhibit III-3
Nursing Facility Information for CMO Counties

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

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

The analyses of those in institutions exclude individuals who qualify for Family Care based on a developmental disability because: 1) we did not have access to an electronic functional status measure for this population (the MDS, which is required in skilled nursing facilities certified for Medicare and Medicaid residents, is not required among residents of ICF-MRs); and 2) the CMO counties that serve the DD population have limited numbers of, or no, individuals in ICF-MRs within their county (***Exhibit III-4***).

Exhibit III-4
ICF-MRs in CMO Counties Serving Individuals with Developmental Disabilities

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

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

B. Data Analysis

The data for the outcome and cost-effectiveness analyses included a number of sources to capture the range of outcomes and relevant individual characteristics. Most of the data sources constitute administrative data systems used for payment and reporting purposes. In working with administrative data, it is important to be cognizant that data are only as complete and reliable as the incentives to enter it. This means that fields that affect payment tend to be the most reliable. Required fields not used for payment determination that include intelligent edits to prevent poor data entry would be the next most reliable. Required fields without edits would be expected to be completed but may not include reliable data. Optional fields would be expected to have the most missing data.

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

Exhibit III-5
Key Characteristics of Outcome and Cost-Effectiveness Data Sources

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

As noted earlier, the analyses primarily focused on the change from just prior to the implementation of Family Care (October 1999 to March 2000) compared to the first half of the first full calendar year of operation (January 2001 to June 2001) for:

- The first four CMO counties (Fond du Lac, La Crosse, Milwaukee, and Portage);
- Matched comparison counties (Waupaca, Manitowoc, Rock, and Pierce);
- Milwaukee non-Family Care enrollees; and
- A sample of the remainder of the state.

In addition, individuals residing in a nursing home in CMO counties in December 2000 were also examined.

1. Samples and Analysis Files

The need to abstract level of care screens for the pre-period in the Family Care CMO counties, the pre- and post-period for the comparison areas, and the resources available for the abstracting, precluded using the universe of individuals for the analyses. DHFS contracted with The Management Group (TMG) to abstract nearly 4,000 screens for approximately 2,800 individuals. The Lewin Group developed two Access input forms – one for the COP screens for the elderly and those with physical disabilities, and one for the screens for those with developmental disabilities. ***Exhibit III-6*** outlines the sampling strategy, including:

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

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

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

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

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

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

Exhibit III-7
Sample Frame and Analysis Sample Sizes

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

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

C. Caveats and Limitations

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

- **Time period for analysis** – As noted earlier, the period for analyses was early in the implementation of the CMOs and as a result reflect only initial outcomes of the program. Given the major start-up activities that had to be accomplished, impacts of the program would not be expected to be realized until three to four years following start-up, and the data for an analysis of this timeframe would be four to five years after start-up, or 2004-05. In addition, ultimate impacts, particularly on nursing home use, may not be realized for some time to come.
- **Data reliability** – Also, as noted earlier, the primary data sources for the analyses were administrative files that can be subject to data entry error and misreporting, particularly if payment is not dependent upon the reported data. However, we focused on those items

that would be considered more highly reliable and well reported for our measures (e.g., based on cautions made by DHFS, we did not examine units from the HSRS data).

- **Lack of Medicare claims data –** The analyses do not include Medicare data for individuals who were eligible for both Medicare and Medicaid. This group represents approximately 70 percent of the analysis sample. This means that measures that relied upon the availability of acute care claims (e.g., hospitalization and emergency room visits) are captured only to the extent that Medicaid paid a portion of the bill (i.e., deductibles and co-payments) and may not fully capture use and certainly does not reflect total health care spending for dual eligibles. Although, to the extent that readers are interested only in the state's liability, the spending information does capture state benefit payments. In order to obtain the Medicare data, a special request to the Centers for Medicare and Medicaid Services (CMS) would have been required and the timeframe for completion of the analysis did not permit submission of such a request.
- **Comparability of measures for institutional and community settings –** In the cost-effectiveness analyses of CMO members and nursing facility residents, both the functional impairment measures and the cost measures were not fully comparable. The MDS impairment measures for nursing facility residents are subject to some degree of setting bias (i.e., staff are more likely to indicate impairment because individuals are more likely to receive assistance with some activities of daily living simply because they are in the nursing facility) which increases the proportion of individuals with more severe disabilities. Also, the per diem payment system for nursing facility care means that costs cannot be associated with individuals based on their reported level of functioning. Therefore, we were only able to compare the level of functioning in the community relative to the nursing facility and focus on individuals in the community with a comparable level of impairment to compare average spending.

PART TWO:
PROGRAM PROGRESS

IV. OVERVIEW OF PROGRAM PROGRESS

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

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

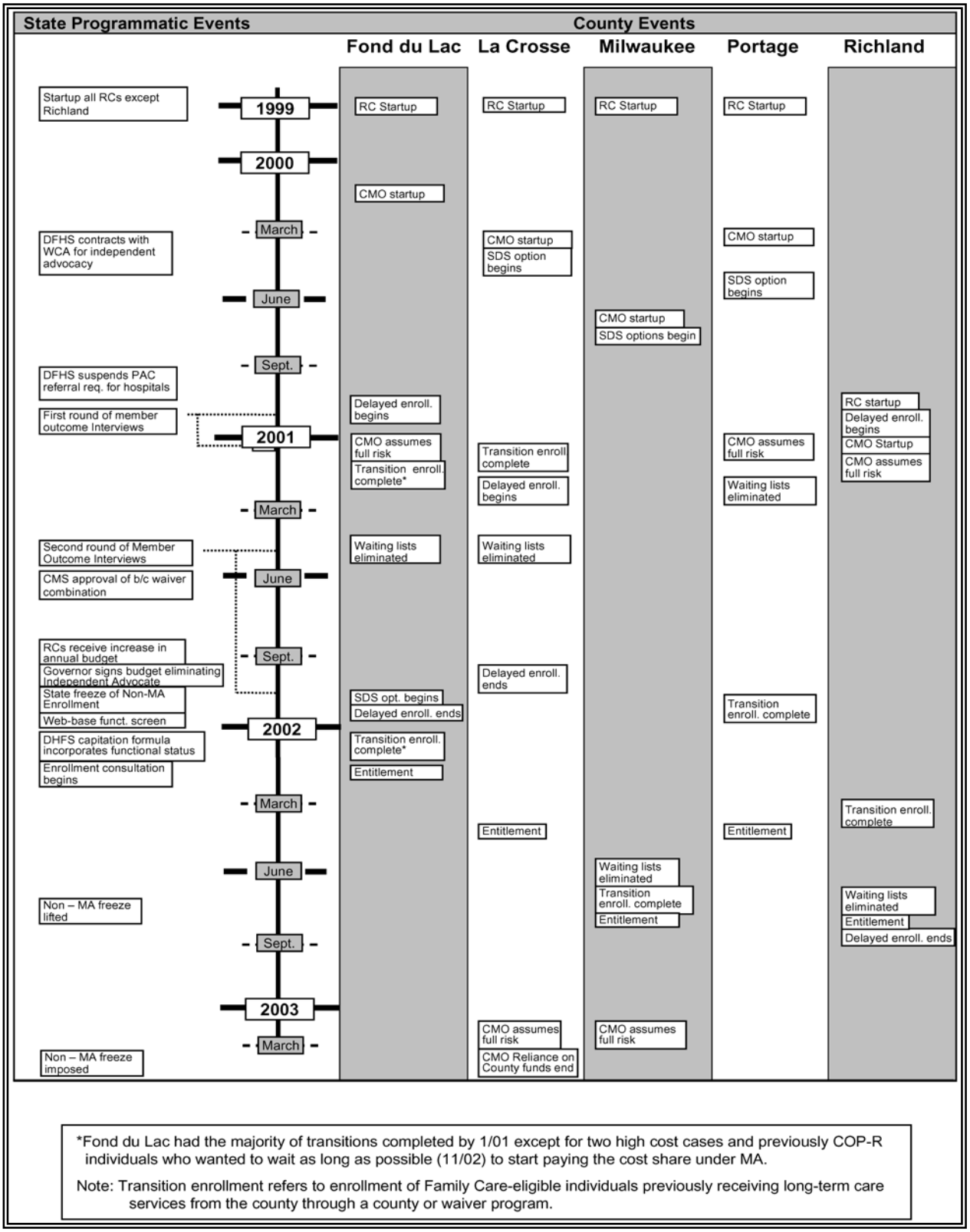
- Infrastructure development;
- Governance;
- Access to services and information; and
- Care management, consumer direction and quality.

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

Achievements of particular note include:

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

Exhibit IV-1
Family Care Timeline



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

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

- Increased consumer involvement through a self-directed supports option at the CMOs, active participation of consumers in the care management process, governing boards for the RCs and CMOs, and state and local long-term care councils.
- Development of an innovative quality assurance and improvement system that improves upon the traditional process measures by seeking direct input from members through the Member Outcome Tool.

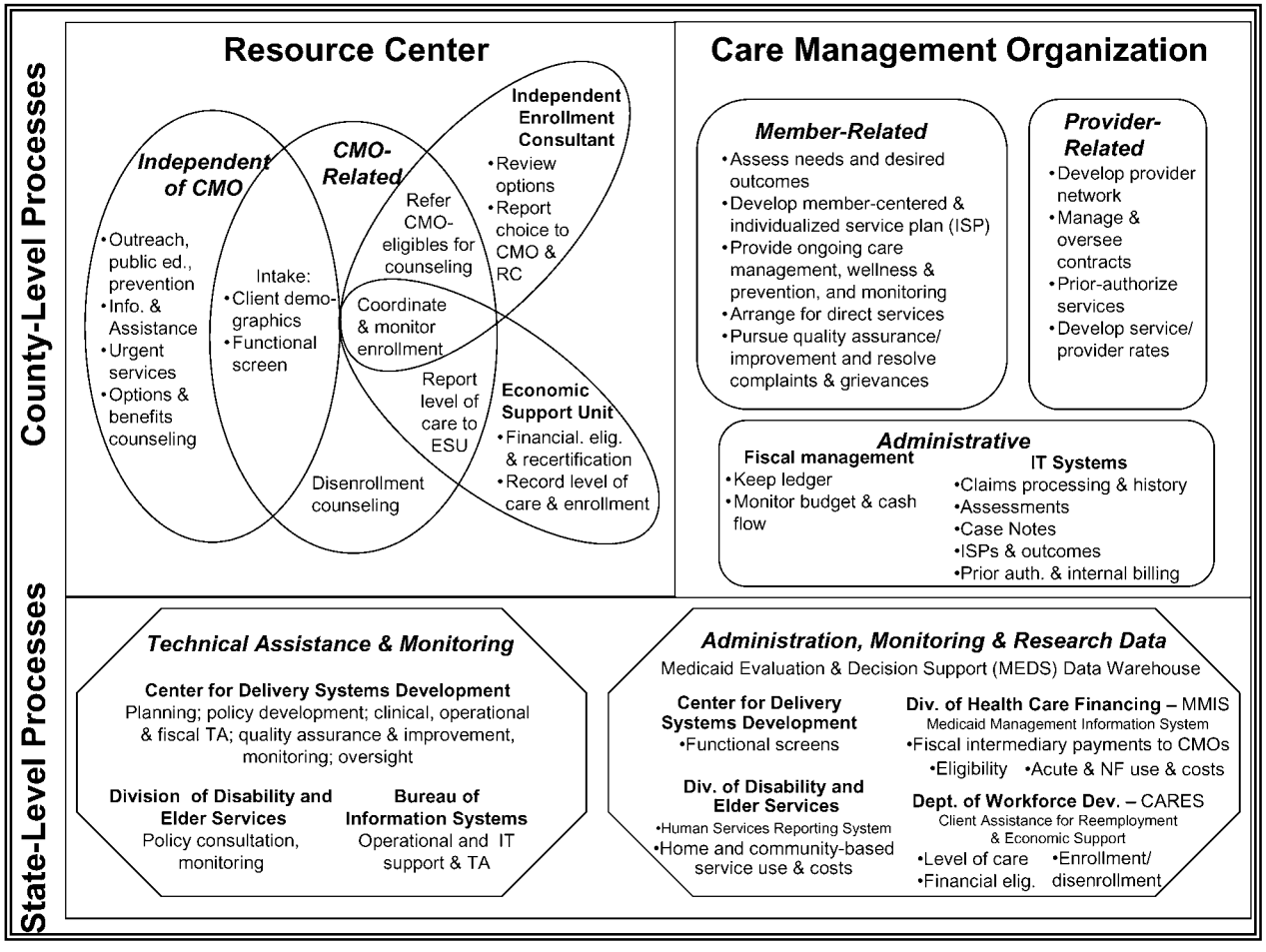
Issues encountered of particular note include:

- Delays in the approval of the initial Medicaid waivers to establish the mandatory enrollment and limit the allowable providers to the CMOs due to federal concerns regarding potential conflict of interest involved in the enrollment process because the RCs and CMOs are both county entities.
- Failure to involve the staff of Economic Support Units, which determine financial eligibility for CMO enrollment, calculate cost-share requirements, and enter enrollment information into the administrative systems, in the planning of the CMO enrollment process. As a result, ESUs were inadequately staffed for the initial conversion of existing waiver enrollees to the CMOs.
- Disparate information technology (IT) systems at the county and the state level, making automation of some functions difficult and electronic transfer of data cumbersome.
- CMO struggles to hire ahead of member enrollment due to uncertainty regarding enrollment trends and some County Boards' reluctance to permit additional staff, particularly while other county agencies had hiring freezes.
- Loss of the independent advocates in the fall of 2001 due to budget cuts, thereby eliminating a formal, independent avenue to address CMO member issues and grievances.
- Freezes on non-Medical Assistance CMO enrollment also due to budget situations which restricts new enrollment to those functionally eligible with limited financial resources.

V. INFRASTRUCTURE DEVELOPMENT

As indicated in the ***Program Overview*** section, in order to establish the Family Care program, several new organizations and processes needed to be established. ***Exhibit V-1***, an adaptation of a DHFS framework, depicts the major clinical, operational, and fiscal processes and responsible entities of the Family Care model. The clinical processes include those involving direct service to consumers. Traditionally, such service delivery has been a staple of local long-term support programs. They include intake, eligibility screening, options and benefit counseling, provider resources, prevention and outreach activities, assessment, care planning, and service authorization. Operational processes refer to those necessary to operate the CMO as a managed care organization including provider contracting, pricing, claims processing, claims history, benefit codes, and information technology (IT) development and management. Fiscal processes include budget management, coordination of benefits, accounting, reimbursement, financial reporting, and forecasting.

Exhibit V-1
Family Care Function and Process Model



Source: Lewin adaptation of DHFS Family Care Business Process Model 5/02 and Family Care Organizations and Functions 11/02.

In order to carry out these processes in Family Care, infrastructure had to be developed. In this section, we highlight the infrastructure development over the last three years by focusing on major events and issues related to: Resource Centers, the CMO enrollment process, Care Management Organizations, and Information Technology systems.

A. Resource Centers

With the exception of Richland, all of the Resources Centers had been operating at least one year prior to the start of the evaluation period. The RCs' clinical tasks include providing information and assistance (I & A), conducting community outreach and prevention activities, administering the LTC functional screen, providing options counseling[6], and tracking demographic information about callers. Pilot county staff had extensive experience in these areas prior to Family Care. During the initial start-up of the RCs, staff focused on establishing initial outreach and information materials and distribution points and activities for the materials. RCs provided consumers with basic information about long-term care providers in their area including: the name of the business, the type of service offered, its location, and phone number. Most RCs initially did not have a contact name and direct telephone number for most providers and there was substantial variance in the amount of additional information available (brochures, smoking allowed, etc).

Over the course of 2000 to 2003, the RCs continued to add provider information, often automating and making it available to consumers directly. Every RC provided outreach in the form of literature, such as pamphlets and brochures, which were often distributed at health fairs and other community presentations. RCs also pursued active outreach strategies. For example, the Marathon web-site provides information, linked to other service providers, online information requests, online PAC referral, a chat room, and a discussion board, thus enabling isolated persons access to information and services provided by the RC. In La Crosse, the RC served as the central contact for Neighbor Care, a program that aids businesses in identifying potential RC customers. Fond du Lac provided brochures to individuals receiving home-delivered meals, and Kenosha sent 5,000 brochures to retirees through a United Way mailing. The RCs also used the media where five RCs (Jackson, La Crosse, Portage, Richland, and Trempealeau) advertised in local newspapers, four RCs (La Crosse, Jackson, Milwaukee and Trempealeau) developed and aired television ads about the RCs services, and two RCs (Portage and Trempealeau) included radio advertisements.

Counties also experimented with different outreach strategies. Staff in Fond du Lac, for example, initiated an effort in 2002 to offer information and assistance at two senior centers on one day each month in rural areas - Ripon Senior Center and Waupun Senior Center. However, they determined that demand was insufficient and suspended the Senior Center effort. Fond du Lac and Richland also partnered with paramedics to identify potentially eligible persons.

During 2000 and 2001, the RCs in the CMO counties also had to adapt to their new role of conducting the functional screens and coordinating the CMO enrollment process. RC functional screen staff were initially backlogged by the volume of waiver conversion participants that had

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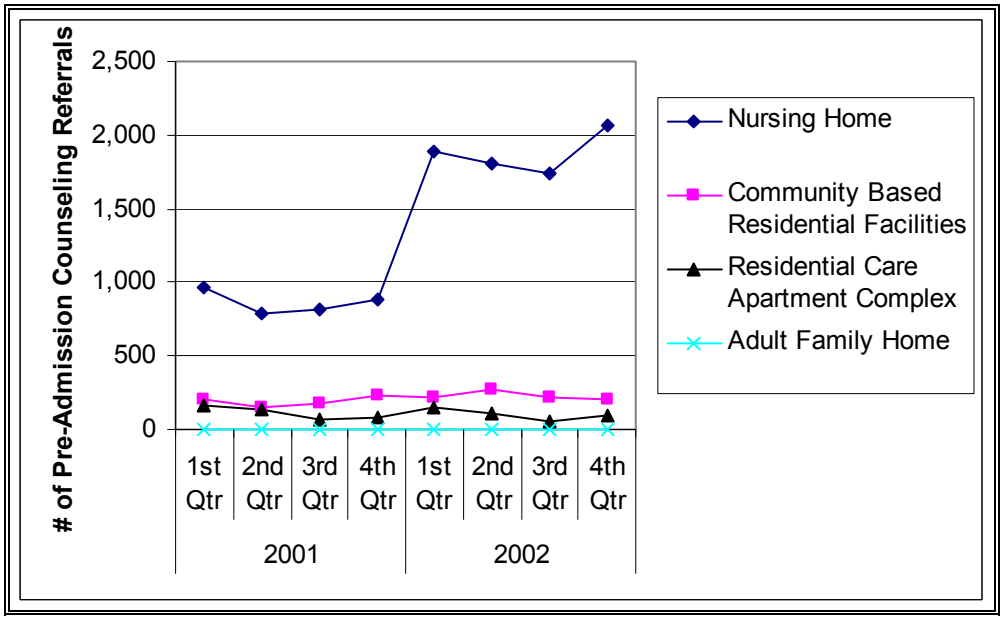
[6] Options counseling differs from enrollment counseling provided by the ECs. See definition of "options counseling" in ***Appendix D: Acronyms and Glossary of Terms***.

to be screened. Aggressive outreach efforts were halted by some RCs due to the overwhelming staff resources needed to respond to functional screen requests. During this period, RC staff in CMO counties raised concerns about their ability to provide sufficient attention to RC functions other than CMO intake. This prompted some CMO counties to shift the responsibility for the annual re-certification screens to the CMOs. By 2002, the RCs reported less difficulty completing screens in a timely fashion due to reduced workload from a combination of factors that varied across county, including increased staffing, responsibilities shifted to the CMOs, and reduced volume.

During the same CMO start-up period, in addition to functional screen workload, the CMO county RCs implemented mandatory pre-admission consultation (PAC) referrals from hospitals, nursing homes, and community-based residential facilities (CBRFs). The RCs reported being overwhelmed by the number of referrals to which they had to respond, primarily from the hospitals. The RCs reported that the majority of the hospital referrals were inappropriate, in that the individuals being referred did not have a long-term care need of 90 days or more. In response, DHFS' suspended the requirement for mandatory referrals from hospitals only in the fall of 2000.

Exhibit V-2 shows a significant increase in PAC referrals from nursing homes during the first quarter of 2002. In late 2001, the Department increased its efforts to educate nursing homes about the potential enforcement of the PAC requirement. Additionally, the state Bureau of Quality Assurance (BQA) began enforcing the rule by asking facilities about PAC during site-reviews. Milwaukee dominated the increase in PAC referrals from nursing homes.

Exhibit V-2
Quarterly PAC Referrals, by Facility Source,
First Quarter 2001 to Fourth Quarter 2002



Source: DHFS Quarterly Family Care Activity report, 4th Quarter 2001 and 2002.

More recently, during the six months following full entitlement in accordance with s. 46.283 (4)(e), Wis. Stats., pilot county RCs conducted outreach to inform residents of long-term care facilities about Family Care and assisted them in applying for the Family Care CMO benefit. The counties have been timely in instituting this outreach to residents of long-term care facilities. Fond du Lac began resident outreach activities in March 2002, La Crosse and Portage in April 2002. Milwaukee's outreach efforts began even before the county reached entitlement in August 2002. Richland is currently conducting their outreach. Outreach to institutionalized residents will be evaluated by DHFS and the RCs. They plan to examine the effectiveness of the outreach in providing information to residents and in enrolling consumers in a CMO by measuring cost, number of contacts, and number of enrollments.

B. CMO Enrollment Process

The CMO enrollment process became progressively more complicated during the course of Family Care's implementation. The original plan was to develop one-stop shopping through the RCs, keeping things as simple as possible for the consumers. Practical and policy considerations prevented a true one-stop shop. The RCs provide information about the CMO, its benefits and alternatives to CMO membership, and determine functional eligibility. However, local Economic Support Units need to determine financial eligibility and any cost-share amounts. Federal requirements instituted an Independent Enrollment Consultant.

Initially, ESUs did not participate in the development of the Family Care enrollment process. Once the oversight was identified, the CMO counties established regular meeting times with their ESUs to work on issues surrounding the enrollment process. All counties now have ES workers specializing in Family Care-related eligibility to increase productivity and improve communication; Fond du Lac county offices two ES workers dedicated to CMO enrollment. However, as of May 2003, despite the addition of an ESU supervisor, Milwaukee continued to experience problems in obtaining timely eligibility determination through the ESU.

Federal requirements related to governance issues, taken up in the next section, resulted in the introduction of an Independent Enrolment Consultant in January of 2002 (April 2002 in Milwaukee). The EC must be independent of the county and functions to provide unbiased information to the consumer about his or her choices. DHFS provided requirements and guidance on the roles and responsibilities of the enrollment consultant, and the RCs, ESUs, and ECs in each county developed slightly different processes to incorporate the ECs and complete enrollments. The ECs note that if the program were to be instituted statewide, 72 different processes would be unwieldy. In 2002, shortly after the ECs first started, staff in the CMO counties noted that the enrollment consultation process had not delayed enrollment by more than two or three days, with the exception of Milwaukee, which experienced an increase of approximately one week. Milwaukee's longer time frame with the addition of the ECs had more to do with another step to coordinate with the ES staff, not the EC consultation process.

C. Care Management Organizations

DHFS' decision to contract with counties to serve as Care Management Organizations (CMOs) required the state and the counties to work together to build managed care expertise and

infrastructure at the counties. Essentially, county government agencies had to learn how to become managed care organizations in terms of the operational, clinical and fiscal management. While the counties had ample experience with the clinical aspects under the prior system, county human service entities had less experience with managed-care-oriented operational and fiscal processes. One CMO director stated, "We didn't know what we didn't know." In implementing the Family Care program, pilot counties have continued to build capacity in business practices, staffing, and information technology (IT) to carry out all of the processes. The evolution of IT, care management, and provider networks at the CMOs are taken up in subsequent sections.

Prior-authorization provides an example of evolving business practices. Initially, prior authorization procedures for services delivered by providers under the Family Care benefit were time intensive for both the CMO care managers, who authorized services, and the providers, who delivered the services. CMOs struggled to develop a consistent and timely process to ensure that providers receive authorization before delivering services (i.e., prior authorization procedures). However, over time these processes became more routine or adapted to become less cumbersome. For example, prior authorization for small durable medical equipment or disposable medical supplies (DME/DMS), such as cottonballs and gauze pads, exceeded the monetary costs for these items. In an attempt to streamline the process, Portage used the service plan to pre-authorize these types of items and the interdisciplinary team reviews the authorization every six months. Other counties provided a monthly allowance for such purchases.

The CMOs have experienced some difficulty staffing ahead of enrollment and retaining experienced staff as a result of county politics and collective bargaining agreements. The relationship between the local Family Care agencies and the county boards had an impact on hiring practices. Even though capitated payments increase commensurate with enrollment, some county boards still held the RC and CMO at their discretion for approval to hire. The county board in Fond du Lac tabled a request for new staff from February to May 2002, delaying necessary hiring. Other pilot counties developed agreements with the county board to hire staff as needed, without coming to the board for approval. However, in these counties, Family Care staff reported that there was resentment from other county departments placed under a hiring freeze due to the State's budget deficit.

Issues with unions in Milwaukee and Fond du Lac had an impact on the staffing composition during 2001 and 2002. In Milwaukee, as a result of seniority, Child Welfare workers replaced 45% of the combined CMO and RC county workforce when the Child Welfare Program was terminated in Milwaukee County. Much staff time and energy was devoted to this major transition. The new workers had to be trained in the field of aging as well as the processes of the CMO. This change did not affect the Care Management Units (CMUs)—private agencies Milwaukee County contracts with to provide care management which constitute over half of the total care management teams in Milwaukee. In Fond du Lac, the CMO could offer contracted entry-level workers a higher salary than the entry level pay for union-represented social workers. Thus, the Fond du Lac CMO tried to hire care managers outside the union in order to offer more competitive salaries to assure quality and improve staff retention. As they grow, the CMOs continue to specialize positions. The Milwaukee CMO recently added a fiscal

analyst to process member obligations based on the cost-share calculations and La Crosse added a quality assurance position in the past year.

D. Information Technology

IT system development is central to building an effective program in the Family Care model, particularly for the CMOs. Without basic, nearly real-time information about the members and their service use and costs, CMOs may find it difficult to manage the capitated payments and coordinate care. Integration of the core CMO functions permits the generation of management reports that can assist staff in understanding the consequences of decisions. The ability of counties to share information electronically among the RC, ES, EC, and the CMO might also create efficiencies since electronic transmission of information generally reduces the need for re-keying of information.

IT systems continue to evolve to support RC and CMO functions. Each county has taken its own approach to developing IT systems that support the Family Care model. The use of different systems makes instituting new automation requirements (such as those mandated by the Health Insurance Purchase and Portability Act (HIPPA)) and integration across systems challenging. ***Exhibit V-3*** shows the current status of automation and integration of the major functions for the RCs and CMOs.

The main RC functions, information and referral, outcome tracking, and conducting functional screens, have all been computerized. The Resource Centers either added to information and referral software they had in place prior to Family Care or purchased software from vendors designed specifically for this activity. The state provided the functional screen software application because it generates the level-of-care determination required for the MA waiver eligibility, which must be applied uniformly across the state. The state moved from a PC-based, dial-in upload for the functional screen, to the Web-based screen in October 2001. DHFS noted that the Web-based screen increases screener reliability by subjecting the information to cross-edits and other checks as it is entered. In addition, DHFS staff review automated system-generated reports to identify patterns of screening that might indicate questionable screening practices, such as numerous screens recorded on one person during a short time period. As a result, manipulating the screen for eligibility purposes is less likely to occur with this system.

More variation in information technology exists at the CMO level with different systems and different degrees of integration across the systems. The systems listed in ***Exhibit V-3*** are not required to be integrated, although there are some advantages to being able to tie them together for reporting, planning, and management functions. Each of the CMOs has taken their own approach to IT, some choosing to build their own systems, some contracting out major functions, and others purchasing existing software packages and adapting the applications as necessary.

Exhibit V-3
Development of County Information Technology Systems, May 2003 Status

	Resource Center		Care Management Organization					
	I&R and Outcomes	**Functional Screens**	**Assessment**	**Case Notes**	**ISPs & Outcomes**	**Prior-Authorization**	**Billing Internal**	**Provider Claims Processing**
Fond du Lac	Packaged software (CMHC)	State provided	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)	Packaged software (CMHC)
LaCrosse	County developed – customized software (DRI)	State provided	Manual process	Manual process	County developed – customized software (DRI)	County developed – customized software (DRI)	County developed – customized software (DRI) *(pending)*	County developed – customized software (DRI) *(pending)*
Milwaukee	County developed – customized software	State provided	County developed – customized software (Keane)	County developed – customized software (Keane)	Contracted system (Keylink)	Contracted system (Keylink)	County developed – customized software	Contracted system and services (Keylink)
Portage	Packaged software (IRIS)	State provided	County developed – customized software (Schenk) *(testing)*	County developed – customized software (Schenk) *(testing)*	County developed – customized software (Schenk) *(partially implemented)*	County developed – customized software (Schenk)	County developed – customized software (Schenk)	County developed – customized software (Schenk)
Richland	Packaged software (IRIS)	State provided	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage *(pending)*	Transferred system from Portage	Transferred system from Portage	Transferred system from Portage

Note: I&R is "Information and Referral" and ISPs are "Individual Service Plans."

Source: DHFS provided information and site visit interviews.

All of the clinical processes in Milwaukee and Fond du Lac are computerized with the exception of prevention and outreach activities. Milwaukee also integrated most of its clinical functions. La Crosse computerized their Individual Service Plan (ISP)[7] and is considering adopting Milwaukee's Web-based system for assessments and case notes; however, in May 2003, an office move was expected to delay any IT updates. Portage computerized its ISP, but the CMO continues to test the assessment, case notes, and outcome functions, and the plan is to have them all integrated. Richland has adapted components of the Portage system for fiscal functions and still plans to automate both the assessment and the Member-Centered Plan but progress has been delayed due to lack of sufficient staff time. All of the counties have operational and fiscal procedures computerized with the exception of La Crosse. La Crosse is still in the planning stages of automating claims processing.

The counties' diverse approaches to IT systems have presented challenges for both the counties and the state. The state provided funds within the counties' start-up grants for IT development. To build their respective systems, the counties allocated more than $1 million of these state start-up funds, plus some of their own funds. In addition, state IT staff served as consultants to the counties. The counties' different approaches to developing their systems has resulted in a different customized system for each county, which reduces potential economies of scale that could be achieved with greater sharing of common systems. This also means that each CMO has different capabilities regarding the integration of its IT functions and, thus, management of the CMO's finances.

State funding to provide start-up grants and IT staff consultants will diminish and, therefore, if future counties implement Family Care, they will need to take greater advantage of leveraging software developed and lessons learned with the existing systems, rather than developing new ones. The State encourages the sharing and transfer of system technology between counties to promote efficiency. Richland's CMO capitalized on the experience of another CMO, Portage, and transferred the Portage IT system for a fraction of the actual cost of the systems.

The current IT challenges for the CMOs are the switch to an electronic submission of encounter data and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. Encounter data are records of individual health care services provided to CMO members. This information is currently manually entered into HSRS. The switch to electronic encounter reporting will occur in two phases. As of May 2003, the DHFS and the CMOs had completed Phase I, which essentially mimicked the current HSRS manual process in an electronic format. Phase II will incorporate more stringent guidelines regarding data requirements as well as logical edits and a "feedback loop".

On the HIPAA front, DHFS has made considerable efforts assisting the pilot counties in preparation for compliance with the Act's requirements. The Act offers improved portability and continuity of health insurance coverage and regulations to guarantee patient rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information. DHFS health programs and the CMOs, which operate as health

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[7] The Member-Centered Plan (MCP), developed by CMO staff and the Family Care member, outlines the member's preferences and personal outcomes. The plan should inform the Individual Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.

plans, must comply with HIPAA privacy (effective April 14, 2003), security, and transaction rules (effective October 16, 2003). The Bureau of Information Systems offered technical assistance of approximately .5 to 1 FTE staff to the counties to help them become HIPAA compliant. In May 2003, Portage, Fond du Lac, Milwaukee, and Richland reported that they experienced strain on staff due to the increased time obtaining records for members as well as training on HIPAA rules, especially in the months leading up to April 14, 2003. The Human Service Department in La Crosse County provided most of the preparation for HIPAA alleviating the burden from RC and CMO staff directly.

An ongoing issue for the counties is the maintenance and upkeep of their systems. IT systems require annual resource commitments to maintain both the hardware and software. In 2002, the counties contended that these types of costs were not adequately accounted for in the capitated rates. In 2003, the CMO capitated rates included 12 percent for administrative functions and other non-benefit expenses.

VI. GOVERNANCE

For Family Care, governance encompasses conflict of interest issues and consumer participation in the development of the Family Care model that is, in part, manifested in governing boards and advisory bodies. As discussed in the ***Program Overview*** section, each RC and CMO has a separate governing board and each CMO county has a Local Long-term Care Council and the DHFS supports a State Long Term Care Council.

A. Conflict of Interest

Two conflict of interest of interest issues arose during the evaluation period: 1) the separation of enrollment and service provision; and 2) the recertification functional screens. At the beginning of the program, in approving the b/c waiver combination, the Centers for Medicare and Medicaid Services (CMS) raised concerns about the potential for conflict of interest as a result of the same entity (the county) being ultimately responsible for intake, enrollment, and service delivery. Specifically, as a result of the capitated rate, the CMO has a financial interest in who is eligible and at what rate. If the county controls both the CMO and the RC, and the CMO faced a shortfall in funds, the county could pressure the RC to unduly influence individuals to enroll in the CMO if their costs were expected to be less than the capitated rate or not to enroll if costs would be expected to be higher than the capitated rate.

In response to these concerns, DHFS originally required that CMOs and RCs to have separate governing boards. However, since the RC and CMO governing boards are advisory to the county boards and the RC and CMO also both report to the elected county board, CMS required the inclusion of an enrollment consultant independent of the county to ensure that consumers receive objective and complete information before their enrollment in a CMO.

In 2002, stakeholders had reservations about the effect of the enrollment consultant (EC) on consumers who must now be channeled through yet another person before receiving services. Despite the added steps and additional person involved in the consumer's life, the enrollment consultant process was generally viewed as an opportunity to review the Family Care benefit package and answer questions. The ECs noted they frequently answered questions about estate recovery, type of benefits possible, and cost-share amounts.

In our 2002 Implementation Report, The Lewin Group raised concerns about conflict of interest related to the annual recertification process. The Economic Support Units complete annual recertification of financial eligibility in all counties. The original plan was for the RCs to conduct all functional screens for recertification. However, as noted earlier, in some counties, Fond du Lac, Milwaukee, and Richland, CMOs assumed this responsibility. In these counties, CMO conduct of recertification functional screens relieved RCs with limited staff of this duty, capitalized on the CMO's long-term relationship with the client, offering maximum continuity for the consumer, and provided the potential to more accurately assess the individual based on continuing contact versus a snapshot assessment each year by RC staff.

However, a potential conflict of interest emerges if the CMO performs the annual functional recertifications. For example, incentives exist for the CMO to adjust level of functioning to keep low-cost consumers in the program. Consumers requiring a less costly array of services

subsidize the cost of those requiring a more costly array of services. Also, as DHFS' rate setting methodology evolves to correspond to functional status, CMOs could have the incentive to screen individuals into higher functional impairment levels. However, DHFS remains confident that the functional screen cannot be manipulated and has automatic review mechanisms for changes from the previous level of care. In addition, each CMO complies with requirements for on-going testing for inter-rater reliability for the CMO, as well as the RC, screeners. Also, in Richland, the RC now reviews re-certification completed by the CMO if the level of care changes.

B. Consumer Participation

Several opportunities exist for consumers to be involved in the development of the Family Care model. The following avenues have been used by the pilot counties to date:

- State and Local Long-Term Care Councils;
- RC and CMO Governing Bodies; and
- CMO and RC Committees.

The State Long-Term Care Council is administratively attached to DHFS and includes a majority of consumers or consumer representative members. After the Council lost statutory status in July of 2001 due to sunset legislation, former DHFS Secretary Phyllis Dube´ kept the membership intact as a council that would advise the DHFS, and added two additional members to represent the interests of children and individuals with mental illness.

Local Long-Term Care Councils (LLTCCs), by contract, must provide general planning and oversight to the Family Care pilots. They serve as advisory bodies only. According to s. 46.282 (2)(b)(1), Wis. Stats, each Council must be comprised of 17 members, nine of whom represent consumers in the three Family Care target populations proportional with the number of people in those target populations receiving long-term care in the state as determined by DHFS. The counties all report that they have achieved this membership. As the program evolves, the LLTCC will make recommendations to DHFS regarding the need for additional CMOs.

County staff noted that maintaining a productive, informed, and consumer-driven LLTCC represented a challenge. In most counties, CMO staff coordinated the LLTCC because they have the most knowledge about the program in the county. The CMO contract simply notes that the CMO must assist the LLTCCs in their duties. Staff reported that the CMO contract does not clearly state coordinating responsibilities of the Council, such as setting the agenda and providing administrative support. Therefore, CMO staff assumed coordinating responsibilities, diverting resources from the more defined CMO activities.

Although the LLTCCs offer an avenue of consumer participation, some advocates expressed concern that the definition of consumer representation on the LLTCCs, as well as on the State Long-Term Care Council, was too loose and should more appropriately represent the consumer level. The statutory definition of consumer representative reads, "….[O]lder persons or persons with physical or developmental disabilities or their immediate family members or other representatives", s. 46.282(2)(b)1, Wis. Stats. Advocates noted that the definition of "other

representative" did not ensure that the person chosen under that title had the ability to appropriately represent consumers of a particular target population. For example, advocates noted that a provider may not make an appropriate consumer representative.

DHFS received a Bridges to Work grant for $32,000 from the CMS for use in years 2002 and 2003, to support the development of LLTCCs. The grant examined effective strategies of involving consumers in the Family Care program. Through the grant, DHFS contracted for the development of: training materials to educate the LLTCCs on how to function as an effective advocacy and advisory group; a newsletter for LLTCCs; a video to train new members; and direct education and consultation on-site.

As of the end of 2001, all the RCs and CMOs had met contractual obligations in establishing separate governing boards comprising one-fourth consumer representation. RC boards provided oversight on the development of a mission statement for the Center, determined relevant structures, policies, and procedures of the Resource Center consistent with state requirements and guidelines, identified unmet needs, and proposed plans to address unmet needs. The CMO governing board is responsible for maintaining a plan for the CMO's separation from eligibility determination and enrollment counseling functions. Most counties reported that the governing board reviewed the plan, but, with the exception of Richland, did not assist with the development of the plan. In addition to the separation plans, staff from most CMOs reported presenting other program policies and procedures to the CMO board for review.

Another avenue for consumer participation has been the many committees formed by the RCs and CMOs. All of the CMOs and the Milwaukee RC had consumer representation on a Quality committee. The Portage CMO also had consumers involved in their Grievance and Operations committees; the Milwaukee CMO involved consumers in their Ethics and Grievance committees. A workgroup for prevention and wellness that included consumers existed in Richland. Fond du Lac CMO had consumers involved in the Self-Directed Support Option (SDS) committee and a Community-Based Residential Facility (CBRF) variance and will be starting a member grievance committee. As of May of 2003, Portage re-instated a SDS workgroup with consumer membership.

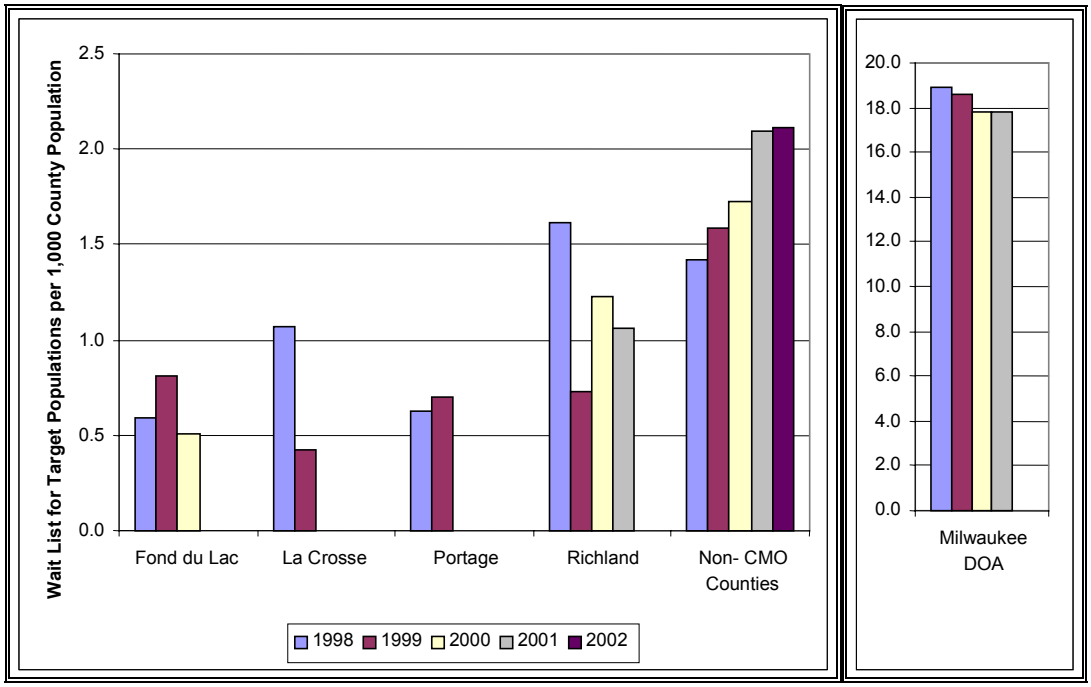
VII. ACCESS TO SERVICES AND INFORMATION

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

A. Elimination of Wait Lists

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

Exhibit VII-1
Wait List for Target Population per 1,000 County Population
December 31, 1998 - 2002



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

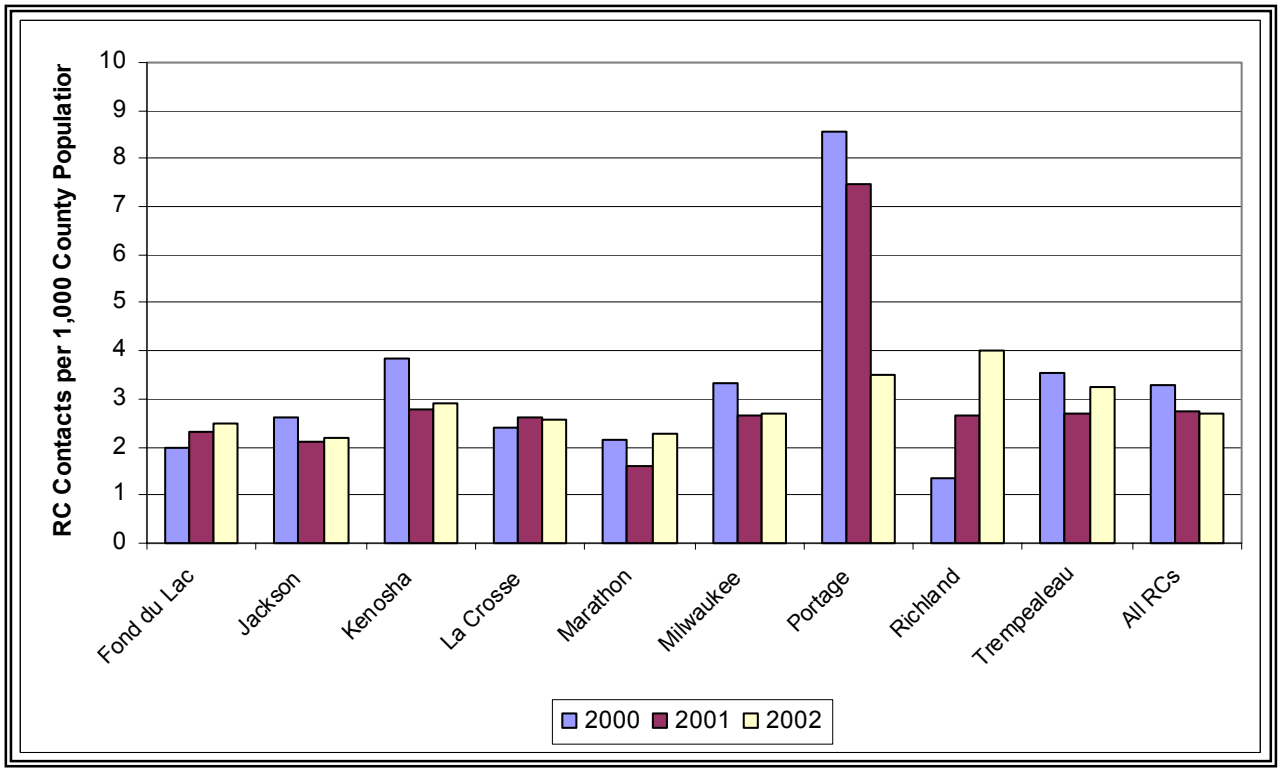
Source: The Lewin Group calculations based on DHFS provided wait list data.

B. Information and Outreach Activities

As noted earlier, Aging and Disability Resource Centers (RC) play a critical role for long-term care information and service seekers. Among the nine counties with RCs, all provide information, assistance and options counseling, while the five CMO counties are also involved in outreach and intake related to the CMO benefit.

Examining the average monthly RC contacts per 1,000 people in the counties provides an indication of the effectiveness of overall outreach. ***Exhibit VII-2*** shows that the average RC contacts per month for all of the RCs fluctuated over time with five of the nine RCs reporting the highest number of contacts per 1,000 county population in 2000 and all but Portage showing stability or increases between 2001 and 2002. Some of the fluctuation may represent reporting refinements over time as the RCs improved and standardized their tracking of contacts. For example, the apparent large decline in contacts in Portage resulted from the county adopting DHFS' convention for reporting that excludes pre-admission consultation referrals, whereas prior to 2002, they had included these as contacts. Richland's increase in contacts over time reflects its RC's later start-up (November 2000), compared to all the other RCs that had been operation for at least a year prior to 2000.

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



Note: Milwaukee's Resource Center focuses on individuals age 60 and older; however, the denominator used for county population includes all ages.

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

Resource Centers were designed to reach the general public and not just individuals seeking publicly-funded services. ***Exhibit VII-3*** indicates the primary outreach areas for the RCs and some of the more notable outreach activities were summarized in the ***Infrastructure Development*** section. The majority of information sought from RCs continued to be: 1) basic needs and general benefits, 2) disability and long-term care related services, and 3) long-term care living arrangements. Most consumers requesting information and assistance from the RCs were given information about long-term care services or resources, or referred to services or resources other than emergency, adult protective service, and long-term care.

Exhibit VII-3
Resource Center Outreach Activities,
April 2000 to March 2001 and April 2001 to March 2002

Outreach Strategy	Fond du Lac		Jackson		Kenosha		La Crosse		Marathon		Milwaukee		Portage		Richland		Trempealeau	
	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02	01	02
General Public																		
RC Literature	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Directory of Services			●	●	●	●			●	●								
Community Presentations	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Presence at Health Fairs	●	●				●		●	●	●		●		●		●		●
Gatekeepers – accountants, grocery, movies, paramedics		●						●		●		●		●				
Web site	●	●			●	●			●	●	●	●	●	●		●	●	●
University/ College						●						●		●				
Media																		
Radio		●	●	●										●	●	●		●
TV Ad/ Interview Show			●	●			●	●				●					●	●
Newspaper Ads			●	●			●	●						●		●		●
Newspaper Articles	●	●		●	●	●								●		●		●
Targeted Outreach																		
Flu Shots		●								●								●
Hmong Elders Focus Group							●	●										
School System	●					●	●	●								●		●
Provider Presentations (Group)		●	●					●		●					●	●	●	●
Provider Meetings (Individual)	●	●					●	●		●		●		●		●		●
Rural areas		●				●				●								

Source: Quarterly reports submitted by Resource Centers.

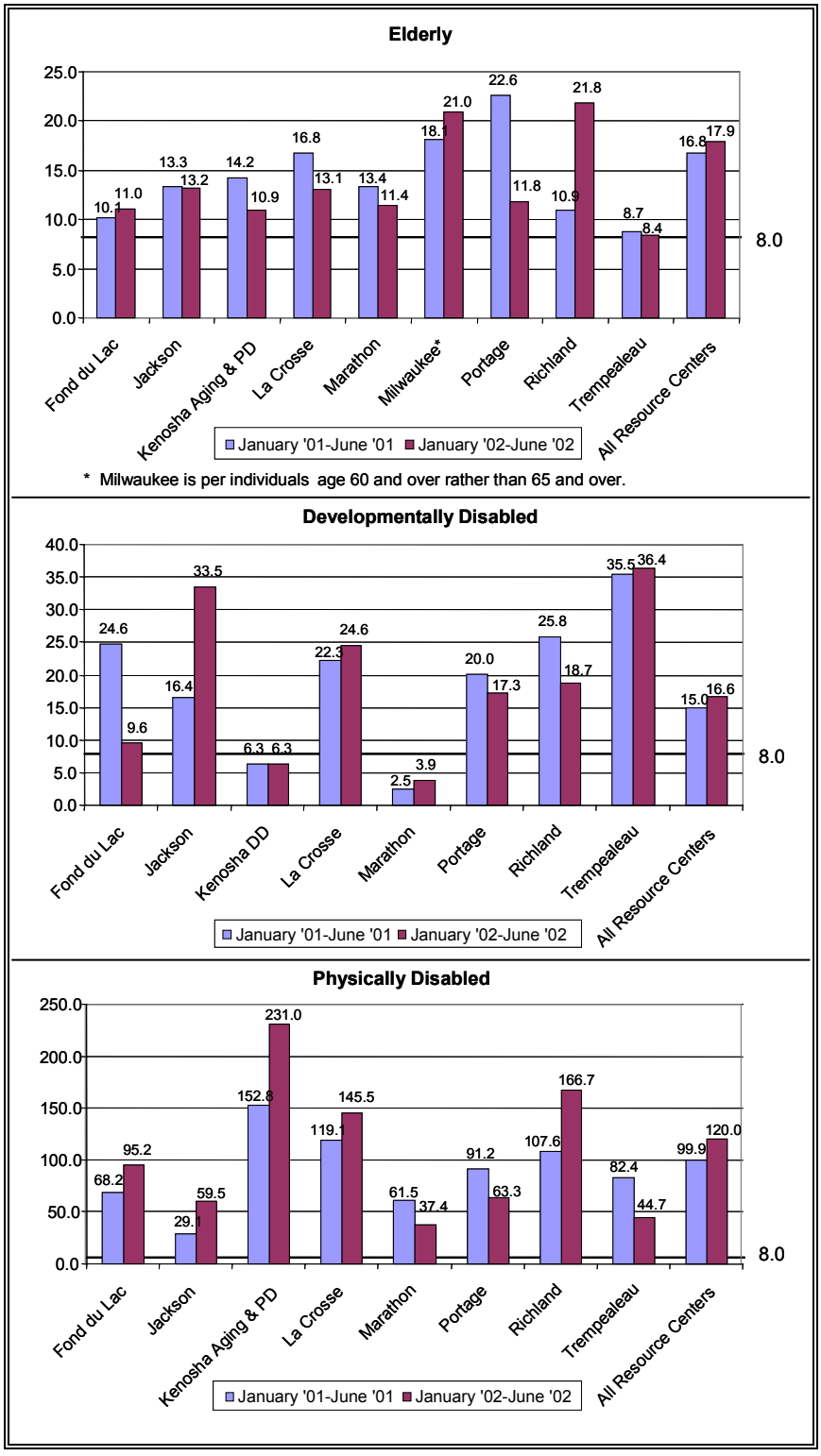
It has been argued that by receiving help with making effective long-term care choices, middle- and upper-income consumers and families will use their private resources more efficiently, thereby reducing the chances of exhausting all their resources and relying on publicly-funded services. By targeting non-Medical Assistance (non-MA) eligible individuals, the RCs play a critical role in shifting the point at which individuals receive timely information and potentially enter the service delivery system. No effective data collection means exist to capture the extent to which non-MA individuals use the RC. However, an indication of the breadth of the population using the RCs is that a minority of the contact outcomes focused on access to the COP, HCBS waiver, and CMO benefits. On average 15.3 percent of all of the RC's contacts were referred for a functional screen to assess eligibility for these benefits from October to December 2002, compared to 13.2 percent for the same period in 2001.[8] Also, in the last quarter of 2002, 178 or approximately one percent of RC contacts were referred to private long-term care services and this percentage has been fairly consistent over time.[9]

Over the course of program implementation, the Resource Centers have generally met or exceeded the DHFS established contract goal of eight contacts per 1,000 target population each month. As presented in ***Exhibit VII-4***, with the exception of Kenosha and Marathon for the DD population, during the first half of 2001 and 2002, all of the RCs met their goals of eight contacts per 1,000 target population. The lower contacts in these two counties may be due in part to the denominator used for the calculations. No direct measure of the number of individuals with developmental disabilities by county exists. Therefore, DHFS used a proxy of the percentage per 1,000 population based on a national average which may not accurately reflect a particular county's population in need. Also worth noting is the lack of the use of media as an outreach avenue in Marathon and the relatively limited use of media in Kenosha in comparison to the other counties with Resource Centers.

Overall, from 2001 to 2002, the number of contacts per 1,000 increased for each target population; however, besides Milwaukee, which only serves the elderly, no RCs increased the number of contacts per 1,000 for all of the target groups. The Kenosha Aging and Physically Disabled RC saw the greatest increase in contacts per 1,000 target population from 2001 to 2002 for the PD population, rising from 152.8 to 231.0. The contacts per 1,000 among the elderly in 2002 ranged from 8.4 in Trempealeau to 21.8 in Richland, while among the DD population, the range was from 3.9 in Marathon to 36.4 in Trempealeau. The largest number of contacts per 1,000 in 2002 was among the PD population, ranging from 37.4 in Marathon to 231.0 in Kenosha.

8 From Quarterly Family Care Activity Report: For periods ending December 2001 and December 2002.
9 From Quarterly Family Care Activity Report: For periods ending December 2002.

Exhibit VII-4
RC Contacts per 1,000 per Month
(January to June, 2001 and 2002)



Source: DHFS provided data based on County Resource Center reports.

C. CMO Enrollment Activity

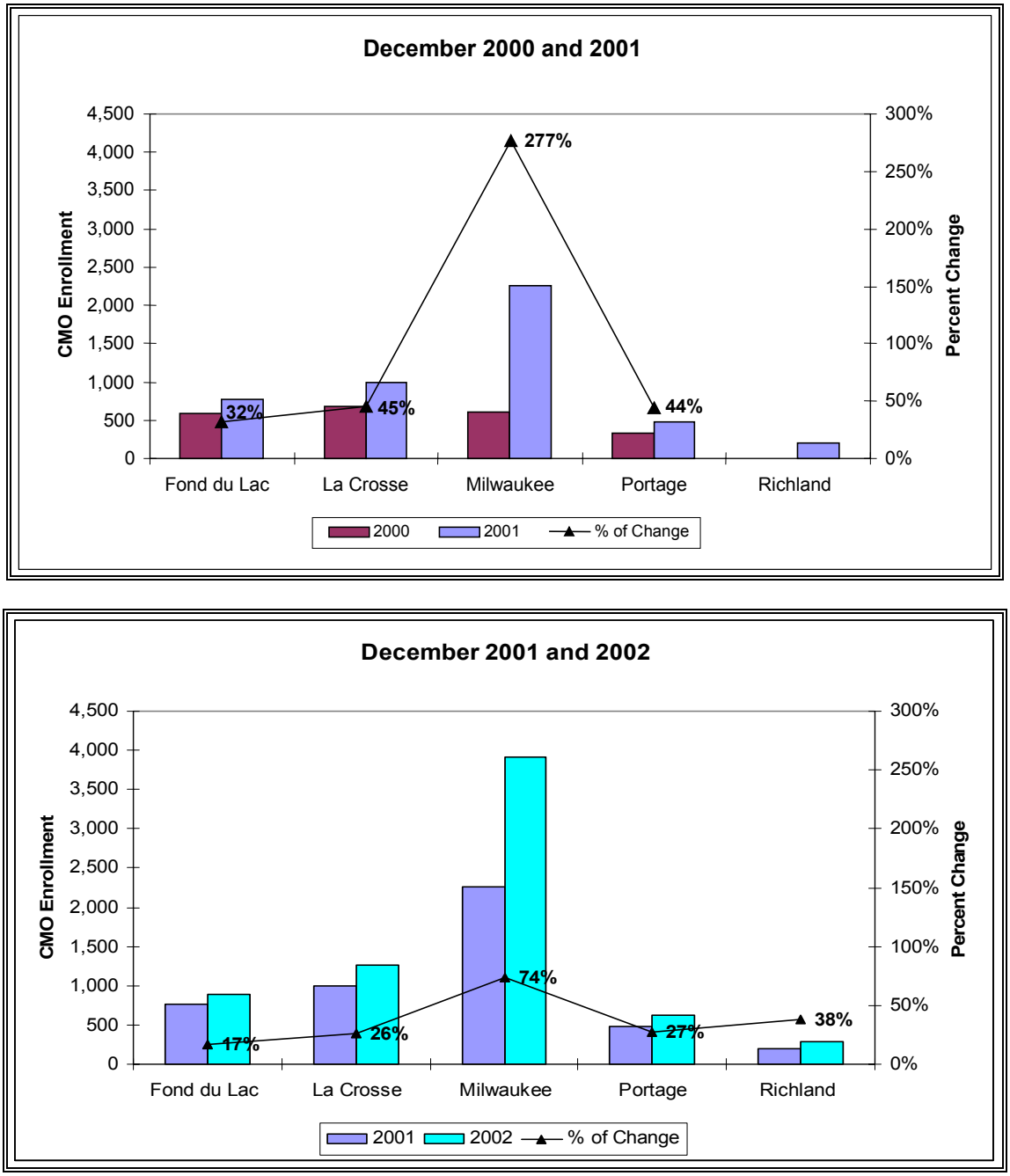
CMO enrollment continued to increase through the end of 2002. Generally, the CMOs enrolled existing Community Options Program (COP) and waiver program consumers during an initial enrollment phase during the first six to 12 months of operations followed by new enrollees, primarily from the wait lists, until the wait lists were eliminated in Spring 2001 for Fond du Lac, La Crosse and Portage and Summer 2002 for Milwaukee[10] and Richland. According to Family Care statutory language, CMOs must reach full entitlement after two years of operation. In order for CMO county to operate at entitlement, all persons financially and functionally eligible for Family Care must be offered the benefit, and enrollment in the CMO is required for individuals to receive home and community-based waiver services. Therefore, all pre-Family Care waiting lists and delayed enrollment lists must be eliminated to ensure timely access to the Family Care benefit for all eligible individuals, including institutionalized residents. Entitlement has never been required for non-MA individuals at the intermediate level of care without an adult protective service need. All five CMOs reached full entitlement during 2002.

As shown in ***Exhibit VII-5***, enrollment continued to grow in each county, with smaller percentage increases during 2002 and with Milwaukee continuing to experience the largest absolute and percentage increase. Possible implications of these trends are discussed in the ***Outcome and Cost-Effectiveness Analyses*** section.

The composition of CMO membership has shifted somewhat since their inception. During the initial transition of waiver program participants to Family Care, the composition of Family Care members mirrored the waiver programs. While the absolute numbers in all of the target groups continue to increase, the CMO counties other than Milwaukee experienced a faster rate of growth for younger individuals with physical disabilities. Excluding Milwaukee, 47 percent of CMO enrollees were elderly as of December 2002 compared to 46 percent in December 2000; 31 percent had developmentally disabilities (DD) compared to 35 percent; and 21 percent were younger individuals with physical disabilities (PD) compared to 19 percent (see ***Exhibit VII-6***). By including Milwaukee's primarily elderly membership in the total count of CMO enrollees, the proportion of elderly enrollees jumps to 76 percent in December 2002. The proportion of elderly members in all CMOs may continue to increase as targeted outreach to nursing facilities advances and the program responds to demographic shifts.

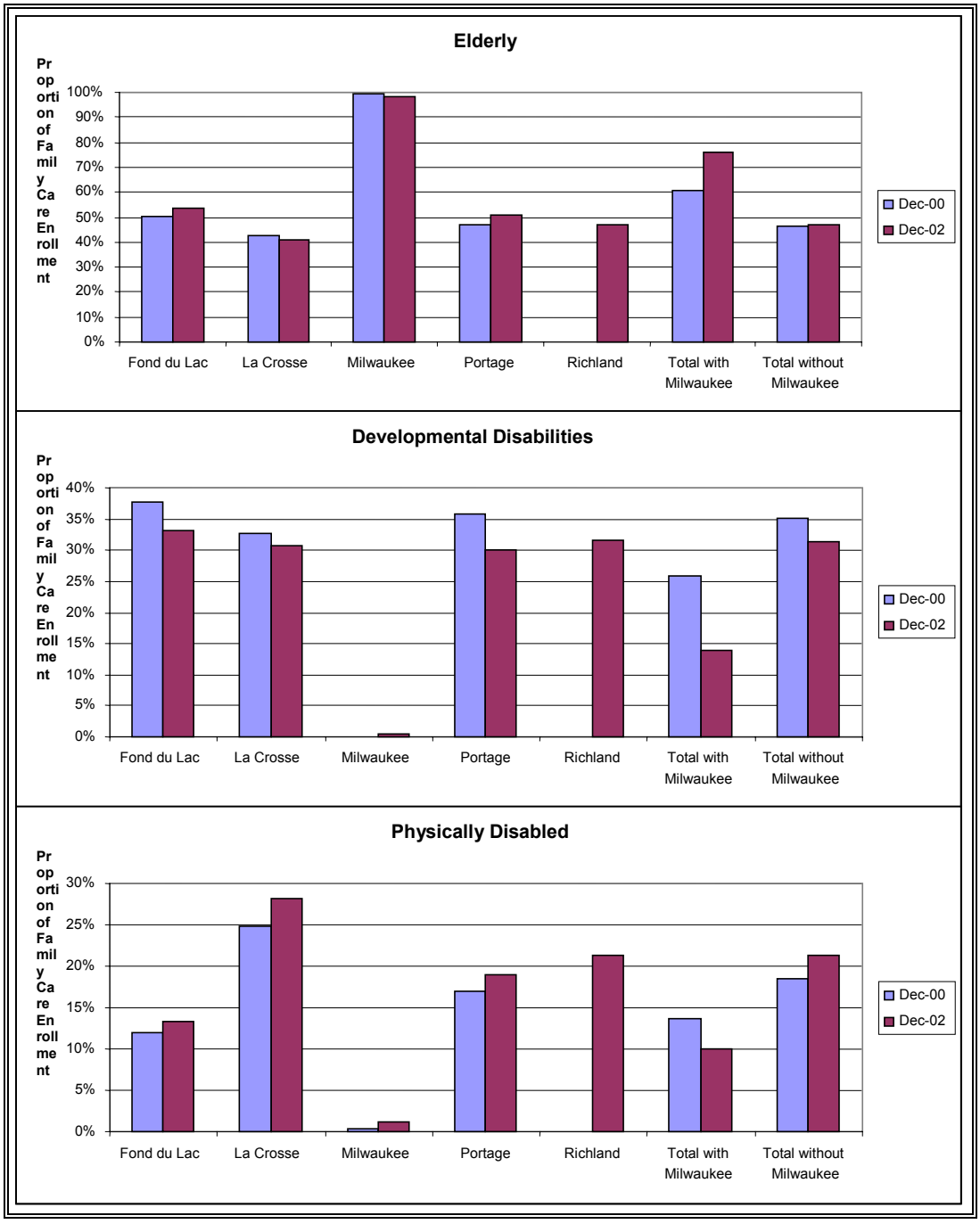
[10] Milwaukee was an exception in that existing enrollees and the wait list were processed in parallel over a two-year period.

Exhibit VII-5
Trends in Annual CMO Enrollment



Source: Family Care Monthly Monitoring Report from March 2001 and Quarterly Family Activity Report for the quarter ending December 2002.

Exhibit VII-6
Enrollees by Target Population as of December 31, 2000 and 2002



Source: The Lewin Group analysis of DHFS provided data.

1. Delayed Enrollment

As seen earlier in the timeline shown in ***Exhibit IV-1*** at the beginning of the Program Progress section, all counties, with the exception of Portage and Milwaukee, instituted "delayed enrollment" at different points in time and under different circumstances. Delayed enrollment, as it differs from a waiting list in definition, is an administrative status indicating that individuals will begin receiving services soon after they are found eligible, but not immediately; a waiting list refers to the individuals who were waiting for community-based long-term care prior to Family Care. The counties used delayed enrollment and waiting lists in two different ways including:

- eliminating the pre-Family Care waiting list and then instituting a delayed enrollment plan due to a lack of staff capacity at the CMO; and

- instituting a delayed enrollment plan while also working on eliminating pre-Family Care waiting lists in order to slow enrollment and allow the CMO to become accustomed to its new role.

La Crosse and Fond du Lac eliminated delayed enrollment by October and December of 2001, respectively. By October 2001, only institutionalized individuals remained on Fond du Lac's plan since the county prioritized service delivery to individuals in the community at high risk of institutionalization. From the beginning of Family Care until July of 2002, Richland operated using delayed enrollment.

CMO Disenrollment

A common measure of potential dissatisfaction with managed care is voluntary disenrollment rates. ***Exhibit VII-7*** shows that 348 or 9.9% of CMO members who were members on June 30, 2001 had disenrolled by June 30, 2002, primarily, and not unexpectedly with a frail and often older population, because they died. Portage had the highest rate of overall disenrollment with 14.0% and Richland had the lowest with 4.1%. Across the CMO counties, approximately two thirds of the disenrollments resulted from deaths, 21.8% voluntarily disenrolled, and the remaining 11.5% lost their eligibility primarily due to changes in their financial status.

The lost eligibility category may over-represent the number of people disenrolled. The Client Assistance for Re-Employment and Economic Support (CARES) system will disenroll individuals who have not been re-certified within a year of first enrollment.[11] When individuals are automatically disenrolled by the CARES system prior to re-certification, the CMO loses the capitated rate for the month causing accounting and cash flow challenges. The CMO continues to serve the member throughout these disruptions in recorded enrollment, and the CMO receives compensation for those months when the automatic disenrollments are corrected.

[11] This was the case in the waiver programs prior to Family Care as well.

Exhibit VII-7
CMO Disenrollment Among Members as of June 30, 2001 through June 30, 2002

CMO Counties	Percent Disenrolled	Deceased	Lost Eligibility	Voluntary Disenrollment
Fond du Lac	12.5% (84)	63.1% (53)	7.1% (6)	29.8% (25)
La Crosse	9.2% (84)	66.7% (56)	11.9% (10)	21.4% (18)
Milwaukee	8.6% (115)	66.1% (76)	14.8% (17)	19.1% (22)
Portage	14.0% (58)	70.7% (41)	10.3% (6)	19.0% (11)
Richland	4.1% (7)	85.7% (6)	14.3% (1)	0.0% (0)
Total	9.9% (348)	66.7% (232)	11.5% (40)	21.8% (76)

Source: DHFS provided data based on the MEDS database as of August 31, 2002.

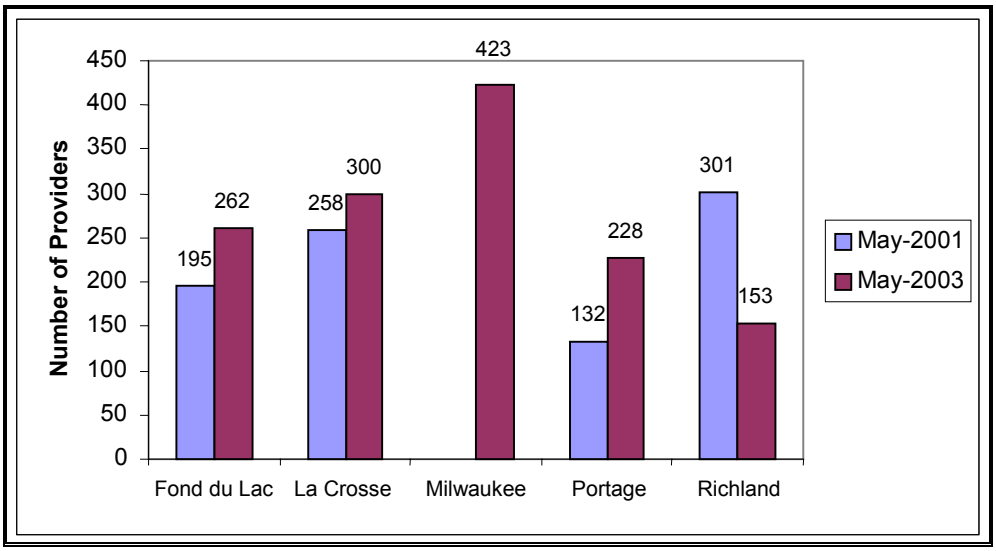
Among members as of June 30, 2001, 2.2%, or 76, chose to return to fee-for-service and forfeit services available through the waiver. These individuals were still able to access Medicaid-funded personal care services under the state plan or nursing facility care. Nursing facility representatives have claimed that Family Care members have been disenrolled when they indicate that they want to remain in the nursing home. A joint survey conducted in 2002 by the Wisconsin Association of Homes and Services for the Aging and the Wisconsin Health Care Association (the not-for-profit and for-profit nursing home associations) indicated that, "Nine facilities reported instances in which their residents were disenrolled by the CMO because they expressed a wish to remain in the facility."

The CMOs counter that there have been a few cases where an individual enters a nursing home for needed skilled care and subsequently the individual stabilizes to the point where the care management team develops a community-based service package that fulfills their care requirements. However, the nursing home resident or their family decides that they would prefer to remain in the nursing home. These disenrollments mean that individuals were able to exercise choice. However, they also mean that the CMO was no longer responsible for financing the individual's nursing home care. If these types of disenrollment constitute more than an anomaly, it would have implications for the program's ability to be cost-effective.

D. Service Availability

CMOs make providers available to their members by procuring formal contracts with providers to form the CMO provider network and by purchasing services without formal contracts with providers outside of the network. The number of providers under contract with the CMOs in Fond du Lac, La Crosse, and Portage increased by 34%, 16%, and 73% respectively, from May 2001 to May 2003 (see ***Exhibit VII-8*** and ***Appendix E***). Accurate change over time could not be calculated for Milwaukee and Richland due to the methods used for data collection and provider contracting practices.

Exhibit VII-8
Number of Providers Contracting with the CMO, 2001 and 2003



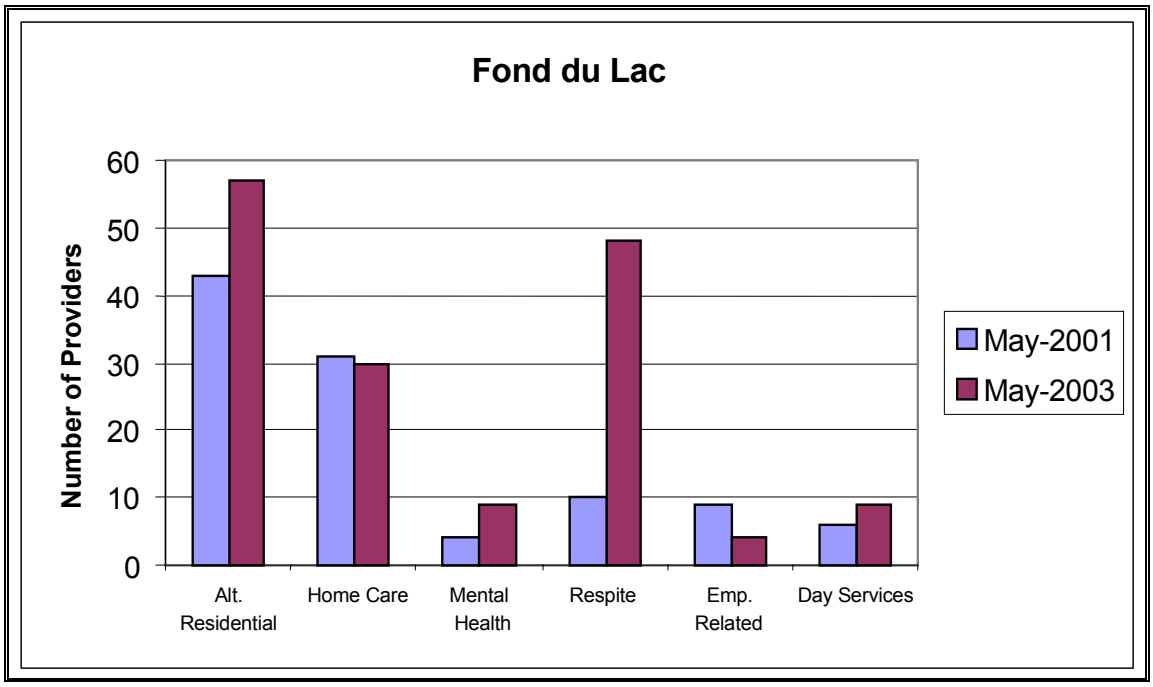
Note: The total number may not represent the total number of contracts that the CMO has because some providers may be counted twice if they provide more than one service type. Information for Milwaukee was not available for 2001. Declines in Richland are likely due to changes in CMO provider network staff and not the actual number of providers available.

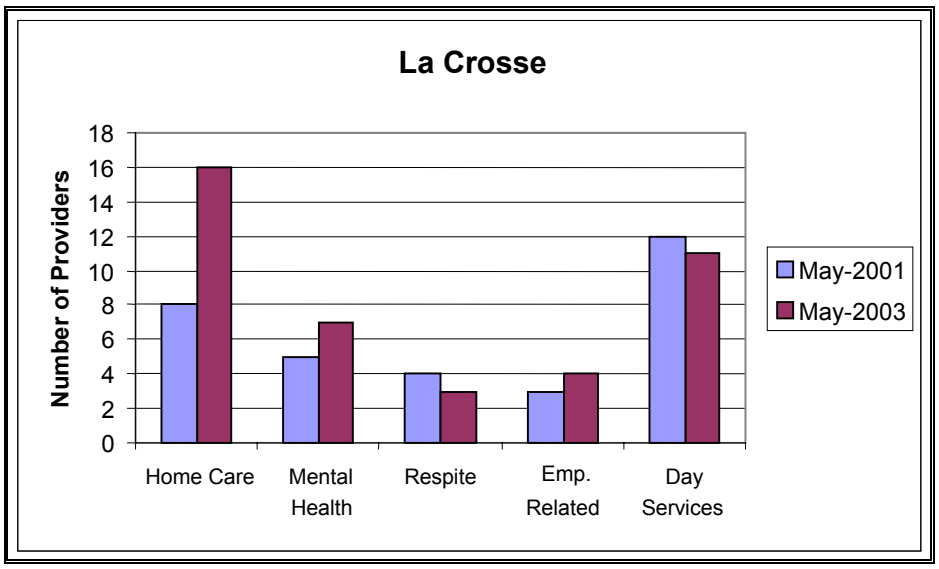
Source: Data provided to Lewin by counties in May 2001 and May 2003.

Milwaukee and Richland indicated that the number of providers they contract with does not fully reflect the options available to Family Care members. The data provided by Richland suggests the number of providers decreased by nearly 50 percent, even though Richland noted they did not experience a decrease in provider availability. Richland also indicated that they obtain services with providers outside of the formal network. Further, staff turnover in their provider network developer position prevented confirmation of 2001 or 2002 numbers. In Milwaukee, the provider network developer did not feel that the number of contracts reflected CMO capacity because the CMO will contract with providers selected by the consumer.

Exhibit VII-9 indicates that the expansion of provider networks varied among counties by the type of provider. Alternative residential facilities, which include community-based residential, adult family homes and assisted living, increased in the three counties that had data for 2001 and 2003. They also increased from 2002 to 2003 in Milwaukee (156 to 197). Contracted home care and mental health providers stayed about the same or increased. Respite care providers increased in both Fond du Lac and Portage. However, in 2003, the La Crosse CMO had to develop a new home health provider contract when their previous primary provider would no longer serve Medicaid long term care cases citing inadequate reimbursement and a desire to focus on severe acute cases.

Exhibit VII-9
Number of Providers Contracting with the CMO for Selected Services, 2001 and 2003





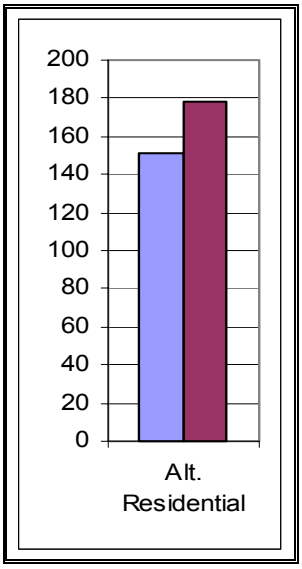
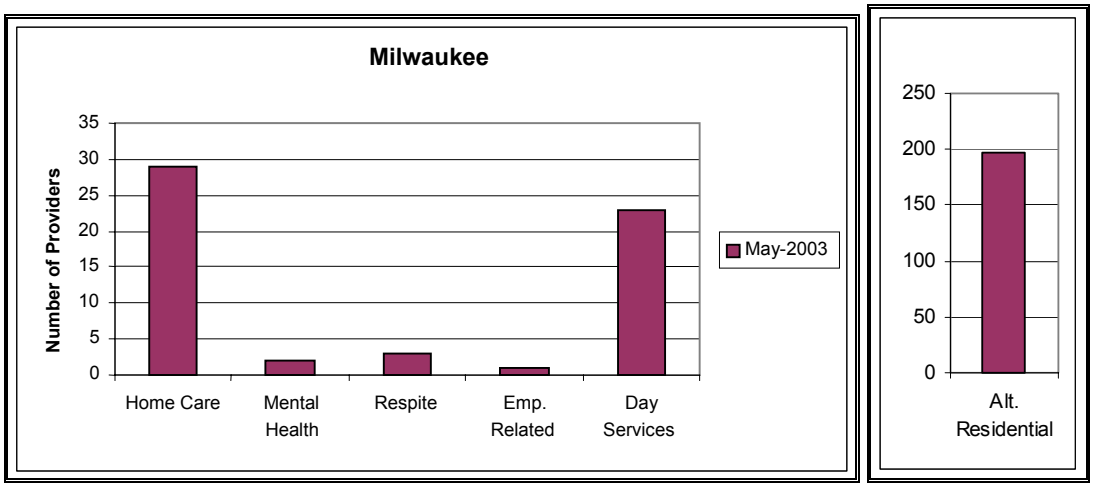
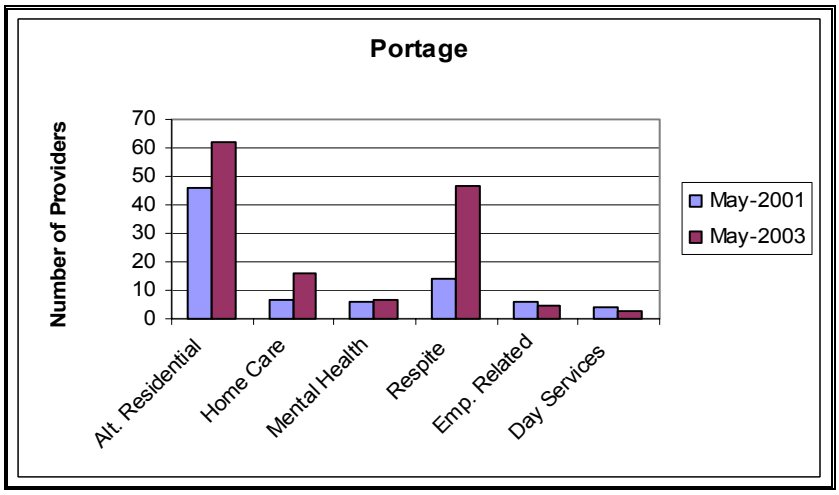
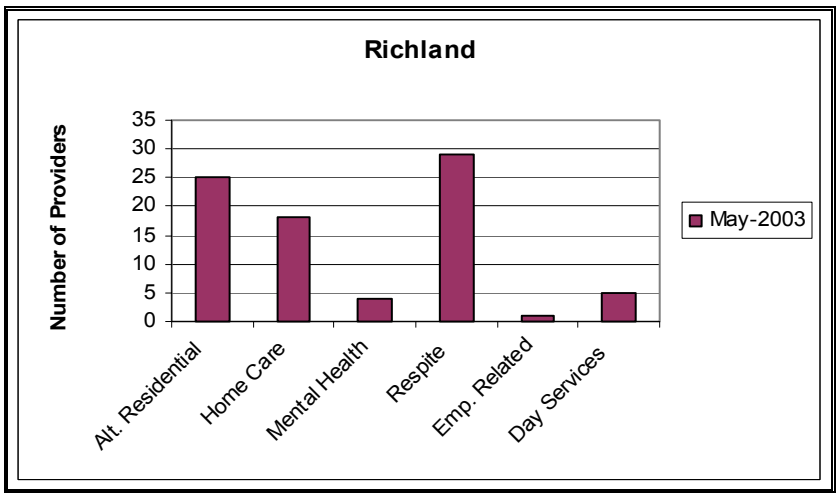


Exhibit VII-9 (cont.)
Number of Providers Contracting with the CMO for Selected Services, 2001and 2003







Note: Information for Milwaukee was not available for 2001. 2001 information for Richland not presented due to lack of comparability to information reported for 2003.

Source: Data provided by counties in May 2001 and May 2003.

Despite the general trend of expanding the number of providers in the network, some decreases in providers also occurred. For example, employment providers of related services in Fond du Lac decreased from nine to four providers. The CMO attributed this decrease to the transition of CMO members from outside the county back to Fond du Lac, eliminating the need to contract with additional providers outside the county.

In 2002, many of the providers interviewed felt that there was healthy market competition. Potentially as a result of this competition, most of the providers voiced disappointment in not receiving increased referrals. However, some providers felt that CMOs used "preferred providers" rather than giving consumers "a real choice." The few providers that experienced increased business under Family Care hired additional staff to meet the demand. All but one provider expressed interest in staying on as a provider under Family Care.

In May of 2003, all of the CMOs had procedures in place to identify unmet need ranging from monthly meetings between provider network developers and care management staff and on-going lists of out of network needs, to a task force in Milwaukee County formed to respond to loss of certification of many ICF/MRs which recently resulted in facility closings. La Crosse and Fond du Lac counties had also begun using utilization reports to project future need.

1. Community-Based Alternatives

In 2002, approximately five percent of Family Care members resided in nursing facilities. The CMO counties report institutional relocations to DHFS quarterly. Since the start of 2001, 252 CMO members were relocated from nursing facilities to alternative community settings (see ***Exhibit VII-10***). This count excludes Richland County because they did not begin tracking relocations until August 2002. However, the quality of the data collection and definition of a relocation differ by county. Some CMOs define a relocation as a move to a community setting by a CMO member residing in a nursing home for any length of time. Other CMOs expand the definition to include individuals new to Family Care who relocate upon enrollment into the program. Other counties consider all individuals enrolled in the CMO as institutional diversions, but do not report them as institutional relocations.

Facility closings do not appear to have a direct impact on the reported relocations, particularly in Milwaukee, so it is difficult to assess whether declining nursing home use in the CMO counties shown in ***Exhibit VII-11*** is attributable to the CMOs or to nursing facility closings independent of the CMO activities. In 2000, three facilities with a total of 684 beds closed in Milwaukee, but the CMO did not track relocations in 2000. Milwaukee lost 557 beds from four facility closings in 2001 and reported relocating 20 individuals. In 2002, Milwaukee County experienced three closings with a total of close to 300 beds and had only 34 relocations. Milwaukee CMO staff reported that they do not feel they have recorded the total number of relocations.

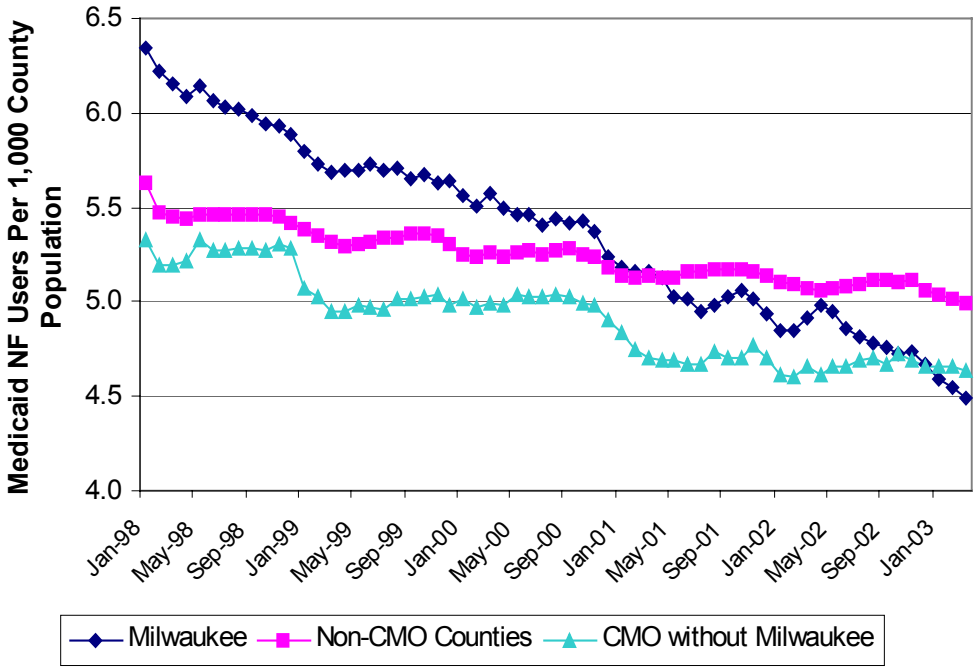
Exhibit VII-10
Institutional Relocations

Year	Quarter	Fond du Lac	La Crosse	Milwaukee	Portage	Total
2001	Jan - Mar	2	14	6	2	24
	Apr - Jun	3	20	14	1	38
	Jul - Sep	2	12	0	1	15
	Oct - Dec	2	18	0	9	29
2002	Jan - Mar	2	12	0	3	17
	Apr - Jun	2	30	11	unknown	43
	Jul - Sep	5	18	16	1	40
	Oct - Dec	2	12	7	3	24
2003	Jan - Mar	2	12	5	3	22
Total		**22**	**148**	**59**	**23**	**252**

Source: CMO Quarterly Narrative Reports and correspondence with pilot county staff.

Note: As of May 2003, Richland had not begun to track relocations.

Exhibit VII-11
Medicaid Nursing Facility Use per 1,000 County Population



Source: The Lewin Group calculations based data from the Department of Health and Family Services Medicaid statistics found at http://www.dhfs.state.wi.us/Medicaid1/caseload/intro.htm and 2000 Decennial Census population estimates.

Some providers, particularly nursing facility administrators, assert that Family Care has not significantly altered the existing trend to promote community living. They indicated that the nursing facility industry in Wisconsin remains focused on transitioning individuals into the community and that facilities continue to have a discharge plan in place for each resident. In a 2002 Wisconsin Association of Homes and Services for the Aging (WAHSA) and the Wisconsin Health Care Association (WHCA) survey of nursing facility administrators, and Family Care counties with a CMO, 33 administrators indicated that 115 residents were relocated. Of the relocations, the administrators reported only 21% occurred prior to the date originally posted by the facilities' discharge plan.

Family Care counties reported increased community residential options for members. The CMO in Fond du Lac reported a 25% increase in the number of residential beds for the elderly in the last year. In response to consumer requests for greater privacy, the size of CBRFs in Fond du Lac was reduced to four beds, allowing members to have private rooms. La Crosse added 28 adult family homes to their network. The CMO in La Crosse noted that at least 40 Hmong homes have been certified as adult family homes in the network so that Hmong families can care for their older members in a more culturally appropriate way.

VIII. CARE MANAGEMENT, CONSUMER DIRECTION, AND QUALITY

The care management, consumer direction, and quality components of the Family Care model all significantly altered prevailing practices prior to the establishment of the CMOs. The CMOs adopted an entirely new culture of care management practice that demanded the formation of care management interdisciplinary teams to carry out new practices and monitoring of caseload size and structure. The DHFS and CMO counties also instituted formal mechanisms for consumers to direct their own care and influence the program through advocacy. Finally, the Family Care pilots adapted to the new requirements of the quality initiatives described in the ***Program Overview*** section. While all of the counties have moved beyond the initial start-up phase, the process of realizing the full intention of the Family Care model will be a continual one.

A. Care Management

At first, the CMO counties faced the multiple challenges of expanding the number of people they served, expanding the scope of services they provided, adapting to new practices, such as including an RN on each care management team, and adapting to new information systems. During this initial implementation period, care managers had a number of extra burdens placed on their time, such as enrolling current clients in Family Care and learning new information systems and forms. At the same time, they were trying to develop expertise in providing services previously financed through the Medical Assistance Card. In addition, many workers were newly hired and, as a result, had limited institutional knowledge.

The counties have gradually begun to implement structural and procedural changes to adopt the care management philosophy of Family Care. As shown in ***Exhibit VIII-1***, adopting this new philosophy marked a major shift in county practice. Case management, as defined by previous county programs, involved the brokering of services by a single social worker. This approach centered on grouping consumer need into specific, pre-defined service categories. In contrast, care management or support coordination under Family Care is a strategy for balancing consumer preference and cost through addressing the core issues facing consumers. In this model, care management is an organizational approach to control costs, facilitate consumer direction, and consider acute and primary care needs. Family Care care management focuses on the unique needs of the individual and involves a holistic approach by the use of an interdisciplinary team, consisting of the CMO member (consumer), social workers, RNs, providers, and family members.

In order to implement the revised care management approach, CMOs reduced caseloads for social workers, relative to pre-Family Care levels. The average caseload size of about 30 to 50 is smaller than caseloads prior to Family Care. In the COP program in Milwaukee, caseloads were as high as 60 individuals per care manager and they now average 40 to 45. The pilot counties noted a significant reduction in the caseload size for social service coordinators caring for the DD population as compared to pre-Family Care arrangements. Portage reported that caseloads for the DD population averaged between 70-80 prior to Family Care and now run about 40 to 45.

Exhibit VIII-1
Comparison of Traditional Case Management with Care Management Philosophies under Family Care

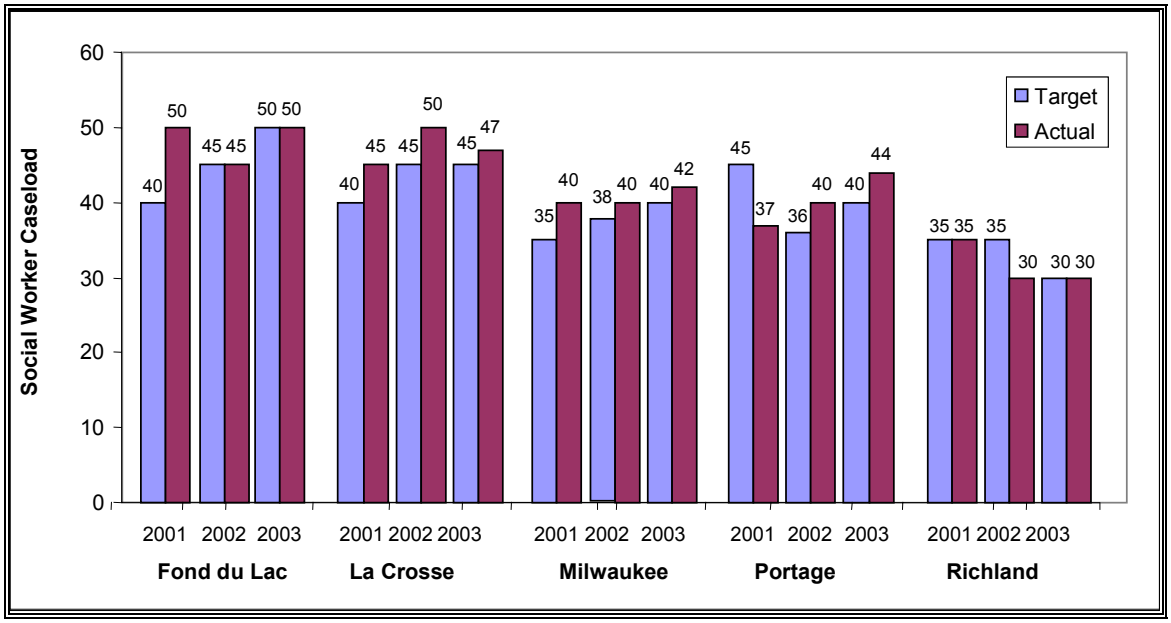
Old System/ Case Management	Family Care / Care Management
Service focused	Outcome focused
Primarily considers social and functional needs and finances	Considers the whole person, including preferences and physical health
Care decisions made at management level	Care decisions made at the consumer/care manager level
Groups consumer need into specific service categories	Services are person-centered
One social worker	Interdisciplinary team (consumer, provider, RN, family members, social worker, etc.)
Matches available services to consumers	Examines strategies about the most appropriate ways to meet consumer needs
More service = better service	More services are not always the best way to meet consumer need
Allows providers discretion over number of hours or amount of service	Exerts pressure on providers to provide only needed services
Does not consider prevention	Includes prevention activities

Source: Derived from DHFS Family Care Case Management Orientation Manual compiled by the Wisconsin Center for Excellence in Long-Term Care, University of Wisconsin School of Nursing, January 2002.

Exhibits VIII-2* and *VIII-3 indicate that caseload targets have adjusted as the CMOs gained more experience and the actual caseloads achieved changed over time with the ability to staff. More recently, some of the counties had specialized beyond/within target population. Milwaukee added a dementia team and a Spanish speaking team, while La Crosse created a mental health unit.

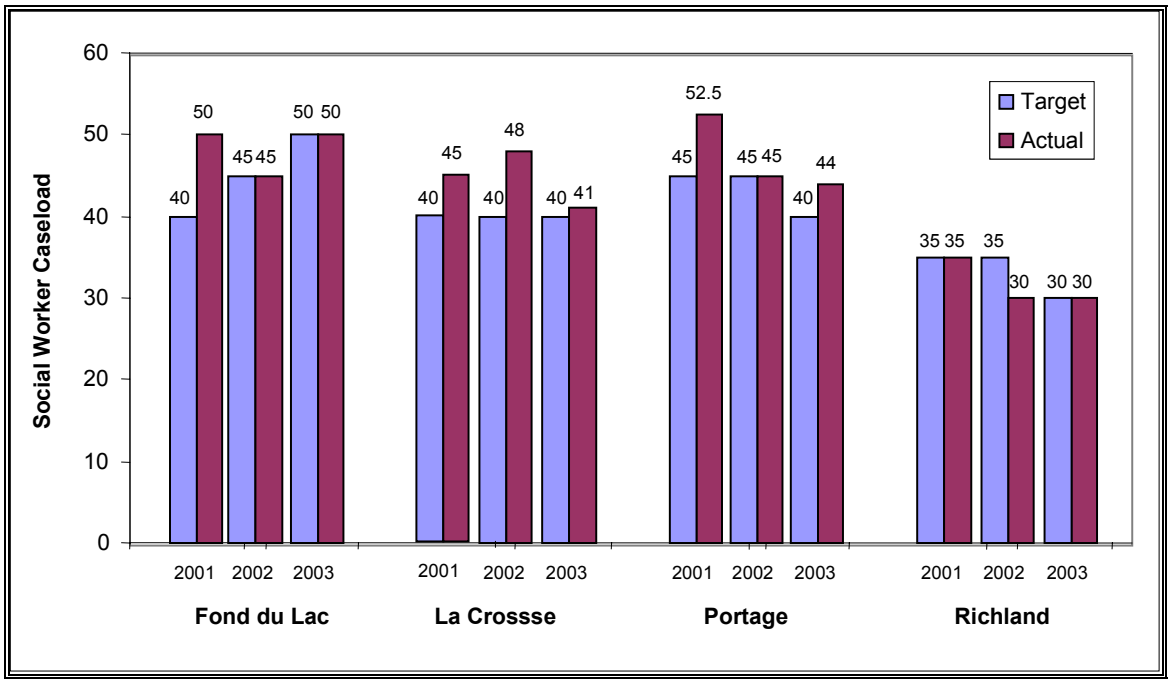
Under Family Care, RNs have an important role on the interdisciplinary teams assessing health needs, incorporating preventive measures, monitoring health, integrating social supports with medical needs, and coordinating care with other medical providers. Together with the social worker, they work to best meet consumers' preferences and medical, psychological, and social needs. The CMO staff felt that the addition of the RN ensured better quality care by providing a medical perspective in care planning and monitoring. In general, social workers viewed the RN as a valuable resource. However, some CMOs indicated that they encountered RN resistance to supervision from social workers and, as a result, appointed a RN supervisor. Also, the CMOs have had a difficult time hiring enough RNs to lower their caseloads to the targets they established (***Exhibit VIII-4***). In 2003, Portage received County Board approval to hire ahead of enrollment, making it possible for the CMO to finally meet its goal of 80 members per RN.

Exhibit VIII-2
Social Worker Caseload for Elderly and Physically Disabled Members, May 2001, 2002, and 2003



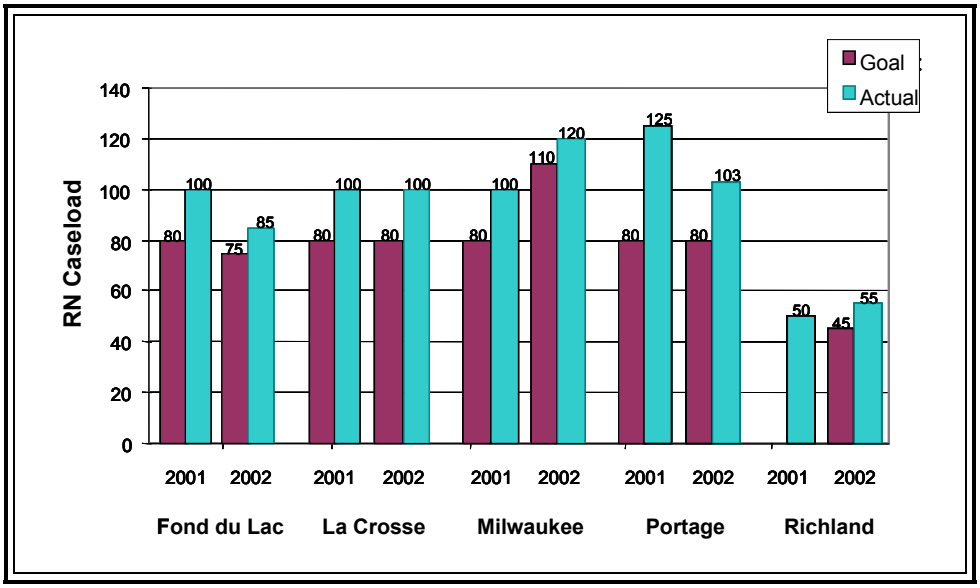
Source: Average caseloads reported by CMO staff in May 2001, May 2002, and May 2003.

Exhibit VIII-3
Social Worker (SW) Caseload for Developmentally Disabled Members, May 2001, 2002, 2003



Source: Average caseloads reported by CMO staff in May 2001, May 2002, and May 2003.

Exhibit VIII-4
RN Caseloads for all Target Populations,
May 2001 and 2002



Source: Caseloads reported by CMO staff May 2001 and May 2002.

Note: Richland did not have a target for RNs in 2001.

The care management teams are still working on fully integrating consumers, families, and providers into the interdisciplinary team decision-making processes. Advocates indicated that consumers have limited involvement in the care planning processes. They felt that consumers merely signed-off on their care plans instead of actively participating in care planning.[12] Some providers also indicated that many consumers did not have a basic understanding of the program or that they were a part of the CMO. DHFS continues to monitor the CMOs' use of the member-centered plan, a fluid document which records client strengths, resources, skills, desired outcomes and steps to achieve them. DHFS reviews member-centered assessments and plans on a quarterly and annual basis. The review process includes reviewing a sample from each CMO to determine the quality of the collaborative assessment and planning process with the member, and the extent to which the member's preferences and desires appear in the written plan. In 2002, DHFS identified a need to improve consumer involvement in care planning for some of the counties.

In adopting Family Care values, care management teams have faced three challenges: 1) balancing cost and consumer preference; 2) balancing equity across members and a primary focus on the individuals; and 3) integrating the services covered by the CMO with acute and primary care.

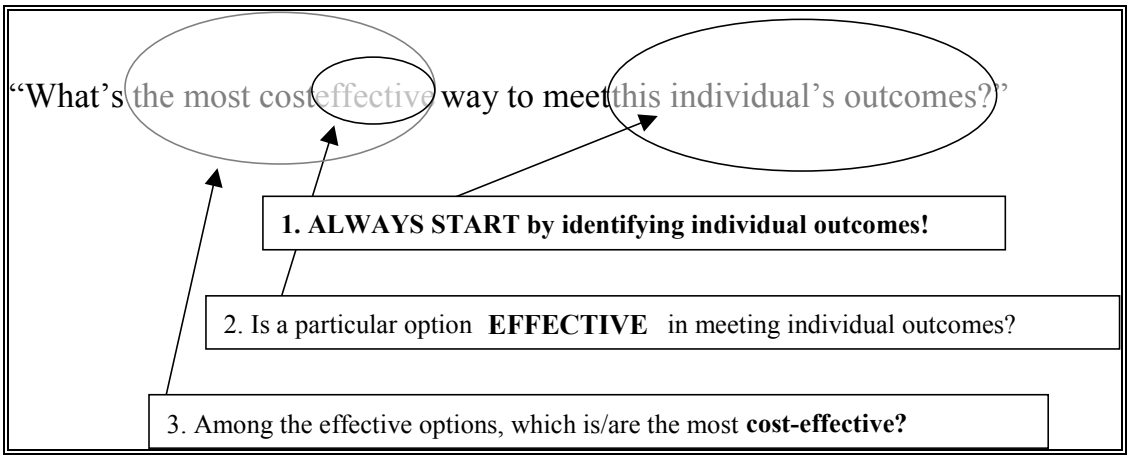
1. The RAD Method: Balancing Cost and Consumer Preference

DHFS developed the Resource Allocation Decision (RAD) Method in anticipation of care management teams, responsible for care provision and its associated cost, needing a tool to

[12] The federal 1915 b/c waiver requires that a member sign the individual service plan (ISP) any time it is changed.

guide them in determining how best to use resources. The process directs interdisciplinary teams to identify desired outcomes for the consumer, examine effective options to meet the outcome, and decide on the most cost-effective option (***Exhibit VIII-5***).

Exhibit VIII-5
The DHFS Resource Allocation Decision (RAD) Method



Source: DHFS.

It provides logic for the care management team to follow when making service decisions. The RAD steps include:

1. Identify the need, goal, or problem;
2. Determine if it relates to the client's assessment, service plan, and desired outcomes;
3. Determine ways in which the need could be met;
4. Verify if there are policy guidelines to guide the choice of option, and if so, follow them;
5. Discover which option the member (and/or family) prefer;
6. Determine which option(s) is/are the most effective and cost-effective in meeting the desired outcome(s); and
7. Explain, engage in dialogues, and negotiate with the client.

Following initial training in 2000 and 2001, care managers generally thought the tool would be useful, but had little experience with it in the field. During 2002, DHFS and the CMOs invested heavily in training staff in the use of the RAD method. Despite this training, we reported in 2002 that the CMOs seemed to be struggling with the concept of balancing consumer preference and cost. Some county representatives mentioned that requiring counties to be motivated by both these concerns was an impossible feat. For example, Portage County wrote a letter to DHFS expressing their confusion. DHFS responded by reinforcing the design of the Family Care model and encouraging the county to continue to understand and implement the use of the RAD method. DHFS has offered numerous trainings on the method to the individual counties

and has also been available for case consultations. DHFS noted that the inclusion of CMO supervisors and management in the training was critical in increasing the support to care managers using the method. They also had CMO fiscal staff attend the trainings to ensure that they understood the philosophy and did not inappropriately influence care decisions. In addition, county staff conducted their own internal trainings on the method. Currently, DHFS has begun introducing the RAD method to non-Family Care counties.

Initially, as the counties transitioned individuals from other waiver programs to Family Care, minimal, if any, changes were made in service plans due to the large volume of cases to be transitioned and the CMOs' lack of comfort or familiarity with the RAD method. Subsequently, CMO staff reported using the method in staff meetings in order to review difficult cases and all CMOs had procedures in place to document the use of the method. In May 2002, consumer advocates interviewed indicated hearing complaints related to reductions in services. This timing is consistent with waiver conversion cases undergoing their annual re-certification and review of care plans and the CMOs more frequent use of the RAD method which resulted in changing care plans and sometimes reductions in services. This was especially true in Milwaukee and Fond du Lac where individuals using the personal care option under the state plan were newly subject to care management review for these services, where previously providers had more latitude in determining the amount of services.

2. Equitable Care Plans vs. Individualized Consumer Focus

Discussions with CMO staff and advocates suggested that CMOs struggled to simultaneously honor consumer preference and provide consistent care to all members. One of the goals of care management under Family Care includes keeping decisions about care as close to the consumer level as possible. This requires the interdisciplinary teams to understand the core issues facing the consumer and that the consumer play a central role in care decisions. In addition to the long-term care benefit package, the CMO is responsible for developing service plans that include other services, such as treatments or supports, when they are more appropriate or likely to result in better outcomes for the individual than the services in the benefit package. For example, although massage therapy does not fall within the Family Care benefit package of services, the La Crosse CMO purchased these services for some CMO members. Additionally, they have contracted with an Asian restaurant to provide meals that better meet the dietary preferences of Hmong members. However, as an agency responsible for an entire enrolled population, the CMO must also ensure fair and equitable service to its members. CMO staff must mediate care decisions and provide information about the most cost-effective ways to meet an individual consumer's needs.

The CMOs adopted a variety of strategies to promote consistency across interdisciplinary teams. As a very large organization with many Care Management Units providing care management to members, Milwaukee faced particular challenges related to consistency. Milwaukee implemented team facilitators who meet with all of the interdisciplinary teams bi-weekly to consult and supervise team decision making-processes. The team facilitator consulted on cases in which the primary team, consisting of a registered nurse (RN), social worker (SW), and member, needed further mediation. More recently, the CMO contracted with Community Care for the Elderly (the PACE and Partnership contractor) to assist the CMO administrative staff in providing oversight, training, and quality assurance. Milwaukee also developed several

protocols for care management teams on such topics as "wound care" and "working with discharge planners." During 2003, La Crosse's quality monitoring and improvement focused on case management timeliness and consistency.

The other counties have been less formal in their approach. The CMO manager in Portage interviewed all staff in the CMO to assess practices and determine consistency. Portage hired an additional supervisor to reduce supervisor caseload, created specific guidelines for the use of the RAD method and SDS option, and added questions about consistency to member and provider surveys. In La Crosse, only the CMO director conducted RAD method training for all new staff in an effort to consistently convey the information.

DHFS monitors consistency among care management teams through a formal review of county procedures. During the annual 2001 quality site visit, DHFS reviewed the CMOs' adherence to contract provisions around care decisions. In the CMO contract, any authorization decisions made outside of the interdisciplinary team must use regularly updated review criteria that are clearly documented and are based on reasonable evidence, or consensus among individuals involved to ensure consistency in decisions. DFHS closely monitored these procedures at the site visits to ensure that, in the process of promoting consistency among teams, individualized planning still remained central. For example, DHFS did not approve Fond du Lac's procedure for interdisciplinary team consistency, in which the management team granted prior authorization for items over $100, absent documented decision criteria. DHFS also urged La Crosse and Portage to institute a written plan to assure such consistency. Additionally, DHFS closely examined the role of the team facilitator in Milwaukee to ensure that consumer preference remained central. The 2003 quality site visits will be conducted in the summer.

3. Integration with Acute and Primary Care

In the original re-design proposal, released by Secretary Leean in May of 1997, acute and primary care were included in the Family Care benefit package. But advocates, fearing an overly medical system, successfully limited the program to long-term care (LTC). Yet, coordination across acute, primary, and LTC service providers remains a necessary and important component of appropriate planning and service delivery under Family Care.

Several barriers exist to designing an integrated system where service providers work together to achieve the best outcomes for consumers. In the case of home health services, nursing supervisory visits are a federal requirement for Medicaid, even if a CMO nurse follows the case. These visits, combined with the attention of the Family Care RN, often duplicate effort. Nursing facilities must also conduct their own comprehensive assessments, duplicating the assessment by the CMO team. Further, CMO staff reported challenges in working with primary care physicians who have limited time and incentive to consult on cases.

Despite these barriers, CMOs recognized the potential health benefits of integrated care for their consumers and developed procedures that facilitate communication between the acute and primary care providers. Efforts of the CMO interdisciplinary teams to integrate care varied across counties:

- Smaller counties, such as Portage and Richland, reported an easier time opening communication lines.

- The La Crosse CMO sent letters to physicians and Fond du Lac invited physicians to tour community-based housing settings.

- Portage, Richland, La Crosse and Milwaukee have worked to educate and establish productive relationships with discharge planners at hospitals. In addition, Portage arranged to obtain discharge planning information from the local hospital via automated information systems.

- Milwaukee developed a Medicare and Medicaid consultant role to assist the teams in understanding the complexities of the two programs and coordinating with an in-home visiting physician program.

County staff reported that the addition of the RN to the interdisciplinary team also helped to engage the attention and cooperation of physicians. They indicated that educating primary care providers might help to reverse the view that institutional care offers the only solution for consumers in need of long-term care.

B. Consumer Direction/Advocacy

Consumers exert influence beyond care planning through varying degrees of directing their own care or through advocacy channels. Family Care promotes consumer direction through providing members the opportunity to select and manage services provided to them along a continuum of increasing control, from directing services to hiring and firing care workers. Opportunities for advocacy in Family Care exist to assure a fair and equitable system that honors consumer rights.

1. Self-directed Supports

The DHFS contract requires CMOs to offer a self-directed support option after two years of operation. Portage, La Crosse, and Milwaukee have offered the option since the CMOs' beginning, Fond du Lac's began October 2001 and, with a state modification of their contract, Richland will offer the option in January 2004 rather than in 2003.

The CMOs expressed some concern about the implementation of the self-directed supports options. Fond du Lac noted having difficulty developing the option concurrently with the Family Care model because of the many requirements in developing the new program. Some counties' CMO staff expressed concern that allowing consumers to manage care, given the managed care model of Family Care, proved difficult to reconcile. They questioned the ability to

fairly establish budget limits when service authorization for Family Care offers a different amount to each consumer, dependent on need, rather than a maximum allowable amount as in the COP and waiver programs. As more members elect self-direction, La Crosse staff expressed concern over the potential amount of time interdisciplinary teams will need to spend training self-directing members. DHFS used its CMS Bridges to Work Grant to focus on the self-directed supports program in each CMO and develop "a personal futures planning" resource manual for use by each CMO.

Exhibit VIII-6 indicates that approximately 20 percent of CMO members have exercised some self-direction, although the overall average belies differences among the CMOs. Fond du Lac, La Crosse, and Portage have similar models for the SDS option and participation ranges from 6 to 13 percent. They all allow members or caregivers to choose between a co-employment agency or a fiscal agent to direct care. The co-employment-agency acts as the employer for the individual care provider selected by the consumer. The fiscal agency model, on the other hand, allows the consumer to act as an employer, but includes an agency to handle fiscal concerns, such as payroll.

Exhibit VIII-6
CMO Members Self-Directing Care as of May 2002 and May 2003

CMO	Members Self Directing Care		% of total CMO Enrollment	
	2002	2003	2002	2003
Fond du Lac	59	52	6%	6%
La Crosse	75	117	7%	9%
Milwaukee	1,200, with independent providers[1]	1,200	36%	30%
Portage	74	87	15%	13%
Total	1,408	1,456	23%	20%

Source: CMO reported information.

[1] Milwaukee employed 1,200 independent providers of members' choice, 10 of whom used a fiscal agent. This policy carried over from prior to the CMO's implementation when the county employed independent providers for 80% of all supportive home care.

Note: According to the CMO contract Richland does not have to offer the SDS option until January 2004. They currently have 13 CMO members using a fiscal agent to employ caregivers. * La Crosse reports majority self-directing care are elderly or physically disabled. Figures by target population were unavailable.

Milwaukee's model differs from the other counties because they designed the program with the philosophy that self-direction for older adults may not depend on assuming the employer role. Milwaukee offers self–directing services along the following continuum: developing personal outcomes or goals; requesting training in self advocacy; assessing available resources; being aware of cost of resources; choosing providers; and assessing safety and risk. Few Milwaukee CMO members use the fiscal agent option, however, pre-Family Care practices allowed 1,200 individuals to select their own provider, usually family members (but not spouses or parents).

2. Advocacy

Over the course of Family Care's evolution, there have been three formal advocacy positions – an independent advocate, which was a separate organization from the RC, CMO and the county; a member advocate, which serves as an internal advocate for CMO members; and disability benefit and elderly benefit specialists, which serve as advocates for individuals on eligibility and benefit issues.

From 2000 to October of 2001, when the Governor signed a biennial budget that eliminated funds for independent advocacy in Family Care, Wisconsin Coalition for Advocacy (WCA) provided independent advocacy in CMO counties. The role of the independent advocate included providing an impartial entity to assist consumers with grievances, appeals, and fair hearings related to entitlements and benefits broader than Family Care (e.g., social security, disability insurance, supplemental security income). It also included providing information and assistance, training, and technical support to individuals about how to obtain services and supports. WCA's role as independent advocate included education and advocacy surrounding Family Care. They created a consumer booklet which was given to all CMO members by the CMOs. Since the independent advocate's elimination, some advocacy organizations still provide limited advocacy to CMO members. However, without state funding, these agencies do not have the resources to serve the entire CMO population.

The member advocate position is a CMO staff member outside the member's interdisciplinary team that reports to management at the CMO. He or she functions as a quality assurance mechanism to ensure care management teams honor consumer's preferences by: 1) following up with members at least two months after enrollment; 2) alerting members to advocacy options and answering questions; 3) assisting members with issues related to care management or service provision, including appeals and grievances; and 4) assisting with overall quality assurance at the CMO.

The Elderly Benefit Specialist (EBS), which existed prior to Family Care and is funded by Older Americans Act and state funds, and the Disability Benefit Specialist (DBS), created by the Family Care legislation, also serve as advocates for individuals primarily interacting with the RCs regarding eligibility for the CMO benefit. Their role includes providing advocacy for benefit programs on the following issues: eligibility, coverage/denials, terminations, overpayments, and explanation of notices. A position paper on the DBS role noted that the DBS should restrict advocacy to initial eligibility for Family Care and not subsume the responsibilities of the independent advocate listed above, to maintain their role as a short-term intervention.[13] The paper also stressed that the position should conduct systemic advocacy by using individual cases to identify programmatic changes needed for Family Care.

[13] Abramson, B. (November, 2001). Disability Benefit Specialist Program: Summary of Issues and Recommendations. Prepared for Wisconsin Department of Health and Family Services (DHFS), Wisconsin Division of Supportive Living (DSL), and Wisconsin Bureau of Aging and Long-Term Care Resources (BALTCR).

C. Quality Assurance and Improvement

The Department has committed substantial resources to the quality design of Family Care and devised a comprehensive strategy that integrates state and county approaches. A major tenet of the Department's philosophy of quality in Family Care directs responsibility and accountability as close to the consumer as possible. Therefore, the state has encouraged pilots to assume a high level of responsibility and has also provided avenues for consumers to assume responsibility through internal advocacy, governing boards, local Long Term Care Councils and grievance procedures. Many resources are being committed to an assessment of program quality through the Member Outcome Tool. The tool, in keeping with leading-edge research in long-term care quality, measures consumer outcomes from the consumer's perspective instead of program procedures traditionally measured in assessments of program quality.

DHFS indicated that they want to be partners with the pilots in quality assurance, rather than an auditor monitoring paperwork, as in the previous system. Quality improvement implies an on-going effort to improve services. DHFS identified four areas in which they will continue to measure quality of the program: 1) LTC system objectives, 2) consumer outcome indicators, 3) Family Care system indicators, and 4) population health indicators. They remained heavily invested in the Multilevel Quality plan (outlined in the ***Program Overview*** section) and provided feedback to the counties on their procedures related to quality. A large part of the plan involves providing feedback to CMOs via a quality site-review process. In past reviews, they evaluated the QA/QI program, health, safety & welfare plans, provider network, self-directed support option, interdisciplinary teams, member transitions into and out of the CMO, and member-centered plans in each county. County staff mentioned that these reviews and subsequent feedback helped shape their quality improvement planning efforts.

1. Provider Accountability

CMOs began to require increased provider accountability. With the creation of the CMO, counties can now hold providers accountable for quality service provision at the local level. Under the old system, very few monitoring activities accompanied a county's contract with local providers. The state Bureau of Quality Assurance (BQA) constituted the only systematic way of tracking provider quality through state licensing procedures. Milwaukee, La Crosse, and Portage have all now established good working relationships with BQA, wherein they share provider deficiencies they identify with the agency.

CMOs noted that involvement of care managers in all aspects of service provision serves as an effective means of quality control. Two specific examples illustrate such quality control. In 2001 and 2002, the CMO in Fond du Lac took corrective action with a particular residential provider. The provider had instances of caregiver abuse, medication errors, and staff training deficiencies. The CMO included a contract requirement with this provider to employ an assistant quality assurance staff person to act as a liaison among the agency, consumers, and guardians. Also, counties, such as Milwaukee and Fond du Lac, using the personal care option under the state plan, more closely monitored service provision. In these counties, prior to Family Care, no care managers were involved in the care of consumers receiving personal care under the state plan. Therefore, personal care providers had great latitude to set the number of hours an individual could receive. Incentive existed for providers to set the number of hours higher to arrange more convenient work schedules for employees and to maximize Medicaid payment from each

individual. CMOs report that under Family Care, the interdisciplinary team offers a more objective assessment of consumer need. County staff noted they spend funds more efficiently, which promotes more cost-effective services.

A state-wide workgroup was formed to develop quality language to be used in the CMO provider contracts. DHFS has also offered the counties sample language on quality assurance. Each county incorporated its own methods into its provider processes:

- Milwaukee developed and implemented a quality indicator system for monitoring both individual providers and providers of a certain service type. The indicators are mapped to the expectations outlined in the contracts and important criteria discussed in a focus group with members. Milwaukee also has a provider/consumer liaison who communicates areas in need of improvement back to the CMO staff.

- Portage has included specific quality expectations in the contracts with providers. Care managers, as the link between providers and consumers, monitored the expectations. They have taken corrective action against providers due to deficiencies identified through this process. Additionally, Portage required providers to complete an application packet with quality checks, and conducted an annual quality site visit to assess provider personnel files.

In 2002, the other three CMOs had just begun to incorporate quality monitoring into their provider contract provisions.

In 2002, the small sample of providers we interviewed did not report any additional requirements or quality assurance standards under Family Care that affected the way they operated or delivered services. Further, some providers raised concerns regarding an increase in unlicensed independent providers with Family Care who might not be conducting criminal background checks. The CMO is required by HFS 12, Wis. Adm. Code, to perform criminal background checks on anyone who is paid to provide services to a CMO member. MetaStar, DHFS' External Quality Review Organization (EQRO), will review these practices annually during upcoming quality site visits.

2. Member Outcomes

DHFS uses the Member Outcome Tool, developed in partnership with the Council for Quality and Leadership (the Council), to evaluate quality in Family Care. The tool measures consumers' perceptions of outcomes and whether or not supports exist to achieve those outcomes in several areas: privacy, the ability to choose services, housing, safety, the degree to which members are respected and experience continuity, and satisfaction with services.[14] The results of these interviews are highlighted in the ***Outcomes*** section. 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.

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

3. Grievances and Appeals

In response to stakeholder confusion regarding the complexity of the mechanisms for complaints, grievances and appeals, in the 2003 CMO contract the Department clarified members rights, including explicitly defining the requirements for filing grievances and the appeals process. The 2003 contracts dropped all references to complaints and defined grievances and appeals as shown in ***Exhibit VIII-7***. Appeals apply to a specific set of actions by CMOs related to provision of services and the acceptability of a member's Individual Service Plans. A grievance is a formal expression of dissatisfaction with matters other than those covered by the appeals process (e.g., quality of care or services provided, aspects of interpersonal relationships, or failure to respect enrollee's rights).

Exhibit VIII-7
Definitions of Grievances and Appeals for Family Care CMOs

Appeal
Request for review of an action, where actions include: 1. Denial or limited authorization of a requested service, including type or level of service; 2. Reduction, suspension or termination of a previously authorized service; 3. Denial, in whole or in part, of payment for a service; 4. Failure to provide services and support items included in the member's Member Centered Plan (MCP) and Individual Service Plan (ISP) in a timely manner; 5. Failure of a CMO to act within specified timeframes; and 6. Unacceptability of the Individual Service Plan (ISP) to the member because of any of the following: a) contrary to member's wishes as to where to live; b) does not provide sufficient care. treatment or support items to meet the member's need and identified outcomes; and/or c) requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee.
Grievance
Means of expression of dissatisfaction about any matter other than an "action."

Source: 2003 CMO contract.

CMOs must have a grievance process, an appeal process and a system in place for member to access the State's fair hearing system. The 2003 CMO contract spells out requirements for these processes and systems, in terms of filing, notifications, timing, assistance to members, documentation, continuation of benefits during the process, and resolution. Members can also appeal and/or grieve the same range of issues directly to the Department, either in conjunction with the CMO process or in lieu of it (although the CMOs have been instructed to encourage the internal process as the first step).

Finally, the State Fair Hearing process is limited to a subset of the actions under the appeals process (reduction of and timeliness of services, as well as unacceptability of the ISP) plus involuntary disenrollment. A fair hearing can be requested before, during or after using the CMO processes and is held by an Administrative Law Judge who works for the Wisconsin Division of Hearings and Appeals. This Division is independent of both the county that operates the CMO and the Department of Health and Family Services. The CMO must obey a hearing decision, unless it appeals the decision in the legal system.

The Resource Centers also must have a system for complaints and grievances and specified timelines. They also serve as one of the avenues for assistance to CMO members filing grievances or appeals. Individuals can also access the State Fair Hearing Process regarding the following Resource Center/Economic Support related issues:

- Determination of ineligibility for the Family Care CMO benefit;
- Determination of cost-sharing for the Family Care CMO benefit;
- Determination that the person is eligible for, but not entitled to the Family Care benefit (primarily would apply to those meeting the intermediate level of care);
- Determination in regard to divestment, treatment of trust amounts, and protection of income and resources of a couple for maintenance of the community spouse; and
- Failure of the Resource Center to provide timely services and support.

PART THREE:
PRELIMINARY OUTCOMES AND COST-EFFECTIVENESS

IX. OVERVIEW OF OUTCOMES AND COST ANALYSES

As we noted in our 2002 Implementation Update, defining cost-effectiveness and measuring outcomes can be difficult. Issues related to "how to measure costs", "cost to whom?", "how to quantify outcomes or benefits", and "compared to what?" emerge. Cost-effectiveness analysis (CEA) is one of the techniques of economic evaluation designed to compare the costs and benefits of a healthcare intervention.[15] The choice of technique depends on the nature of the benefits specified. In CEA, the benefits are expressed in non-monetary terms related to health effects, such as life-years gained or symptom-free days, whereas in cost–utility analysis they are expressed as quality-adjusted life-years (QALYs) and in cost–benefit analysis in monetary terms. As with all economic evaluation techniques, the aim of CEA is to maximize the level of benefits – health effects – relative to the resources available.

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

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

Unless otherwise noted, costs examined in this report are total federal, state, and county spending captured through the administrative data systems for Medical Assistance, the Medicaid Management Information System (MMIS), and the long-term care portion of the Human Services Reporting System (HSRS). These systems do not capture all costs related to the CMO benefit and the comparison group spending. While the CMO capitated payment includes an allocation for CMO administrative expenses of 12 percent, the CMO long-term care benefit spending includes only the payments for services. Neither the capitated payment nor the CMO long-term care benefit spending include administrative costs associated with state oversight, or

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

in-kind support provided by the counties, such as discounted office space and payroll processing. The comparison group spending does not include county or state administrative spending, the routine seven percent added to COP and Medicaid HCBS waiver programs for administrative charges, nor any county spending for benefits that were not reported through the HSRS system.

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

To what should costs and benefits be compared? We have pursued a methodology that focuses on both specific counties selected for their similarity regarding measurable characteristics of their long-term care systems and the remainder of the state for the period prior to and after Family Care. As outlined in the methodology section, for most of the cost measures, we choose to use an approach that accounts for changes over time unrelated to the Family Care program by adjusting for the change experienced by a similar group not subject to Family Care (comparison areas) called a difference-in-difference (DID) analysis. The underlying assumption is that the time trend in the control group is an adequate proxy for the time trend that would have occurred in the Family Care CMO counties in the absence of Family Care. The legislation authorizing Family Care also required a comparison to nursing home costs.

The outcome and cost-effectiveness analyses focused on the key components of the Family Care program: access to information and services; choice and self-determination; community integration; health and safety; and spending. ***Exhibit IX-1*** summarizes the key outcomes and cost analyses conducted. Details regarding each of the measures can be found in ***Appendix F***.

Exhibit IX-1
Key Outcomes and Cost Analyses Conducted

Indicator	Analysis
Access	
Information	
RC Outreach Activities	Range of efforts by county over time
Resource Center Contacts	Relative to contract standard by county
Benefits	
Wait Lists	CMO counties trend relative to rest of state
CMO Enrollment	Trend by county and by target population
Choice of Providers	Number of contracted providers over time
Service Use by Type	Pre/post CMO counties relative to comparison
Quality of Life/Care	
Choice and Self-Determination	
Treated fairly	Member Outcome Tool for CMO & waiver
Privacy	Member Outcome Tool for CMO & waiver
Personal dignity & respect	Member Outcome Tool for CMO & waiver
Choose services	Member Outcome Tool for CMO & waiver
Choose daily routine	Member Outcome Tool for CMO & waiver
Achieve their employment objectives	Member Outcome Tool for CMO & waiver
Satisfied with services	Member Outcome Tool for CMO & waiver
Community Integration	
Choose where and with whom they live	Member Outcome Tool for CMO & waiver
Participate in the life of the community	Member Outcome Tool for CMO & waiver
Informal support networks connection	Member Outcome Tool for CMO & waiver
Residential care use	Post CMO counties relative to comparison
Nursing home use	Post CMO counties relative to comparison
Health and Safety	
Free from abuse and neglect	Member Outcome Tool for CMO & waiver
Best possible health	Member Outcome Tool for CMO & waiver
Safety	Member Outcome Tool for CMO & waiver
Continuity and security	Member Outcome Tool for CMO & waiver
Decubitis ulcer	Post CMO counties relative to comparison
Hospital use	Post CMO counties relative to comparison
Emergency room use	Post CMO counties relative to comparison
Death	Post CMO counties relative to comparison
Spending	
Total Medicaid & state benefit spending	Pre/post CMO counties relative to comparison
LTC Medicaid & state spending	Pre/post CMO counties relative to comparison
Spending on new enrollees	Post CMO relative to existing enrollees
Nursing Facility versus Community	CMO counties

X. ACCESS

The evidence, much of it presented in the previous part of the report, suggests greater access to information in the nine Resource Center counties and to long-term care benefits in the five CMO counties.

A. Access to Information

The measures used to assess the degree of access to information were: 1) the range of outreach activities the Resource Centers pursued; and 2) the number of contacts per capita for each of the target populations relative to DHFS established standards.

The Resource Centers appear to have increased the degree of access to information to the target populations. Prior to Family Care, most of the nine counties lacked a centralized source of information regarding long term care services available and options for meeting need. Today, the Resource Centers coordinate information for the three target groups (except in Milwaukee where the focus is only older adults) and actively conduct outreach through a variety of mechanisms (see ***Exhibit VII-3*** in the previous part of the report). The outreach activities have moved beyond the traditional approaches that generally created informational brochures and distributed them during community presentations and health fairs to encompass additional distribution avenues, such as websites and gatekeepers (e.g., groceries, pharmacies and paramedics), media, including radio and television, and targeted outreach to specific communities (e.g., Hmong, children entering the adult system, providers, and rural areas). In addition, all but two of the nine Resource Centers have met or exceeded a DHFS established standard of eight contacts per month per 1,000 for each of the target groups (see ***Exhibit VII-4*** in the previous part of the report). In the two counties that did not meet the standard, Marathon and Kenosha, this occurred only among the individuals with developmental disabilities; they met or exceeded the standard for the elderly and for individuals with physical disabilities.

B. Access to Benefits

The measures used for access to benefits include: 1) wait lists in the CMO counties relative to the remainder of the state; 2) the trend in CMO enrollment; and 3) the mix of services received by CMO members relative to comparison areas. All three measures indicate increased access to benefits in the CMO counties.

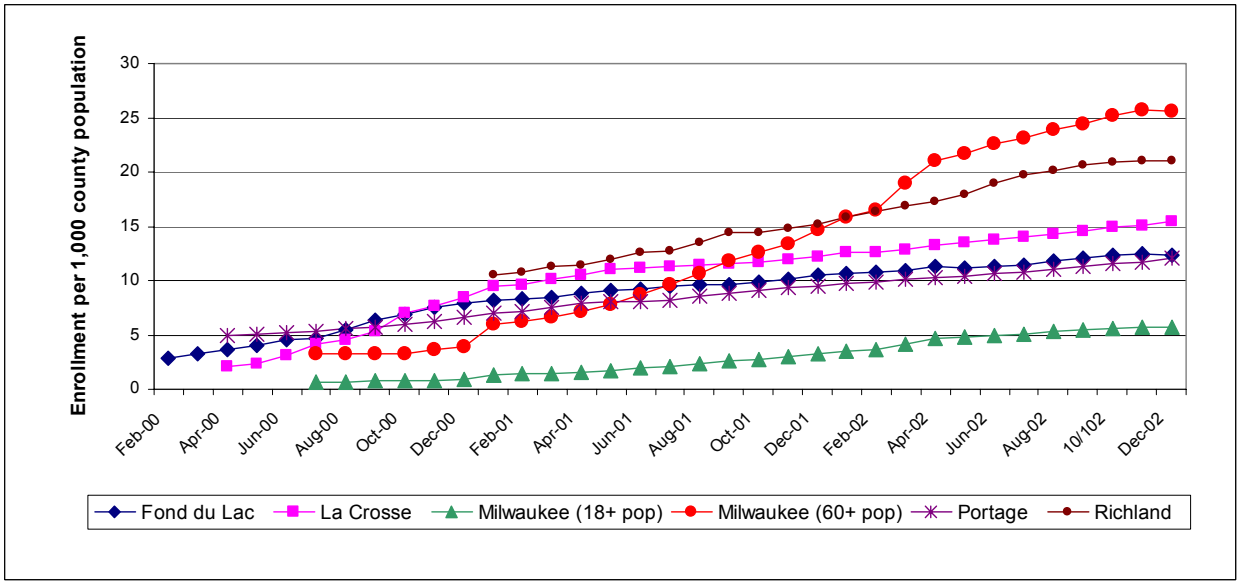
1. Wait Lists

Previously, the number of people who could be served was limited by state and federal approval processes. Today, in the five CMO counties, individuals seeking long-term care services that qualify for Medical Assistance due to a lack of financial resources can enroll in a CMO and begin to receive services without having to wait for an opening in the program. Fond du Lac, La Crosse, and Portage moved all eligible individuals on their wait lists into services by the spring of 2001, while Milwaukee and Richland accomplished this by the end of summer 2002.

2. CMO Enrollment Trend

CMO enrollment grew steadily since the start of the program and only recently appears to be leveling off. ***Exhibit X-1*** shows CMO enrollment per 1,000 adult county population. This measure standardizes the level of enrollment across the counties and provides an indication of the relative access in each of the counties. However, the measure does not account for differences in the financial circumstances nor population in need of services, making it difficult to draw definitive conclusions based on the relative differences across the counties. ***Exhibit X-2*** provides disability rates and economic data for the CMO counties from the 2000 Decennial Census to inform the discussion below.

Exhibit X-1
CMO Enrollment per 1,000 Adult County Population



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

Note: Enrollment data since January 2001 reflect totals presented in the most recent Family Care Activity Report. Revised data for 2000 were not available, possibly affecting the curve of data presented. The number of county residents remains the same for all of the calculations over the period.

Enrollment in Fond du Lac and Portage followed similar paths and, as of the end of 2002, approximately 1.2 percent of the counties' adult population were enrolled in the CMO. La Crosse had somewhat higher enrollment relative to population with approximately 1.5 percent enrolled in the CMO. These three counties have adult populations ranging in size from 51,000 in Portage to 73,000 in La Crosse. Based on 2000 Census data, they also had similar disability rates, however Fond du Lac had lower general poverty rates, but similar age 65+ poverty rates compared to the other two counties. Richland, the smallest and most rural county with approximately 18,000 residents, started with higher enrollment to population levels and continued to have higher levels through the end of 2002 with 2.1 percent of the adult population enrolled. In December 2002, Richland's enrollment rate among the adult population was

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

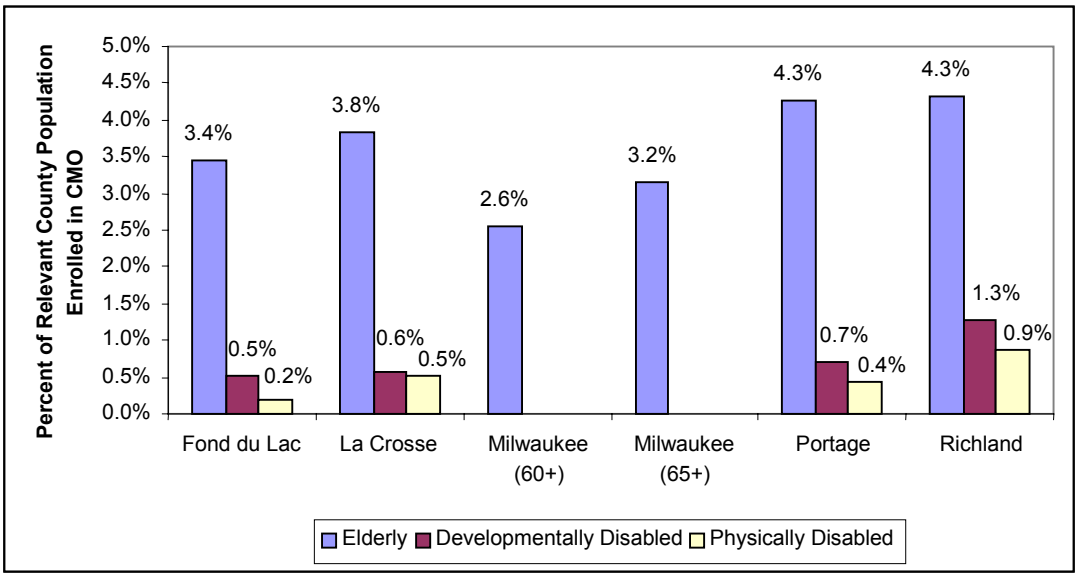
	Fond du Lac	La Crosse	Milwaukee	Portage	Richland
Disability Rates in 2000					
Age 5-20	7.5%	7.5%	9.8%	6.5%	8.1%
Age 21-65	11.9%	13.4%	19.6%	11.5%	14.6%
Age 65+	36.6%	35.4%	39.7%	36.1%	39.6%
Economic Status in 1999					
% Below Poverty (All)	5.8%	10.7%	15.3%	9.5%	10.1%
% Below Poverty (age 65+)	8.2%	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

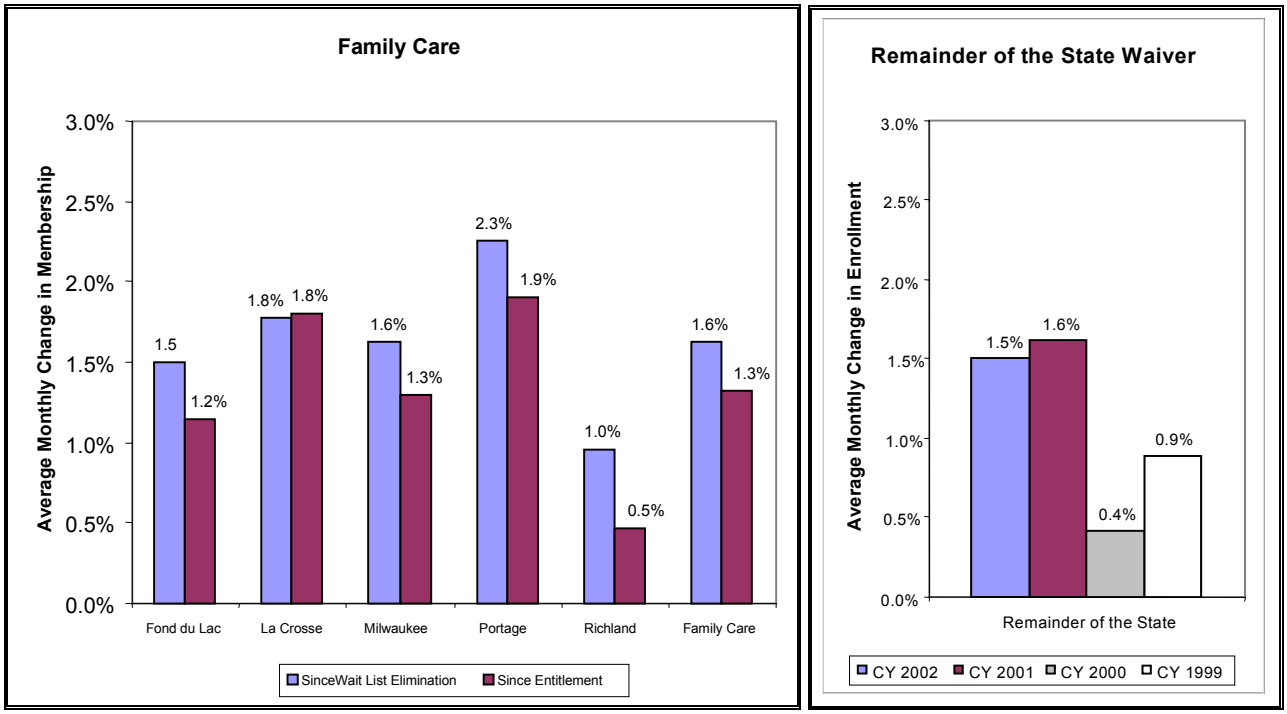


Source: The Lewin Group analysis of data from DHFS Monthly Monitoring Reports for December 2002 available March 2003.

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.

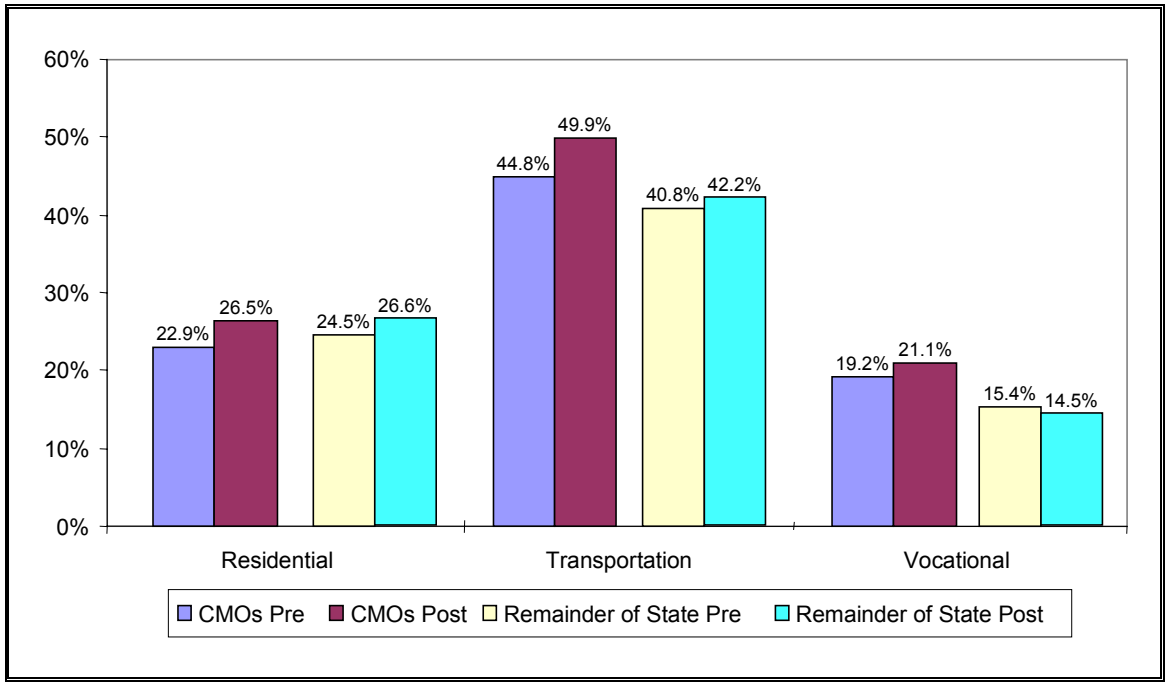
As indicated previously in this report, for the three CMOs for which the number of contracted providers were available over time (Fond du Lac, La Crosse and Portage), the number and range of contracted providers increased between May 2001 and May 2003 (see ***Exhibit VII-8*** and ***Appendix E***).[16]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

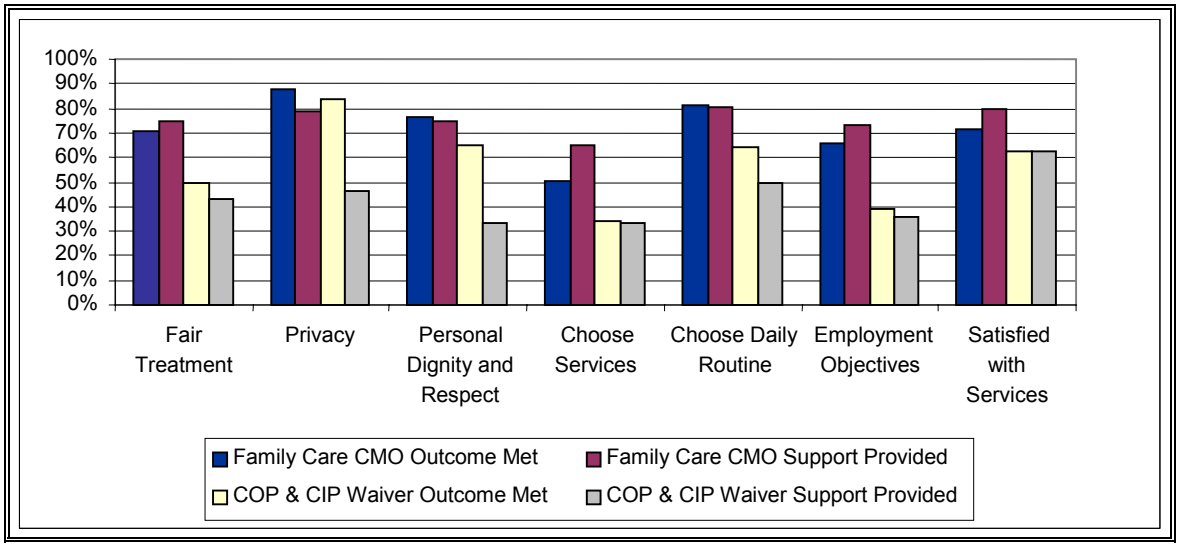
The Member Outcome Tool measures for choice and self-determination included the following specific outcomes:

- 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.

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.

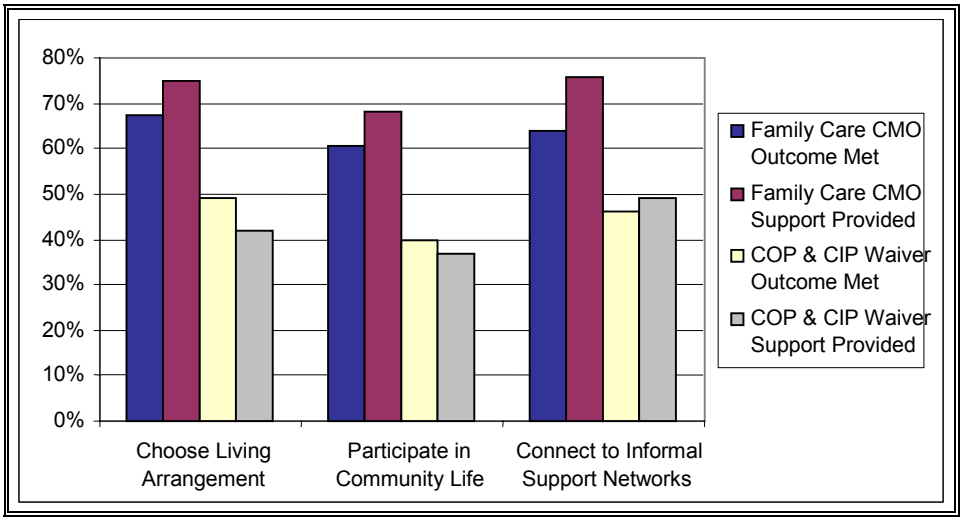
Two of the counties took active efforts related to community integration as a result of the first round of member outcome interviews:

- **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.

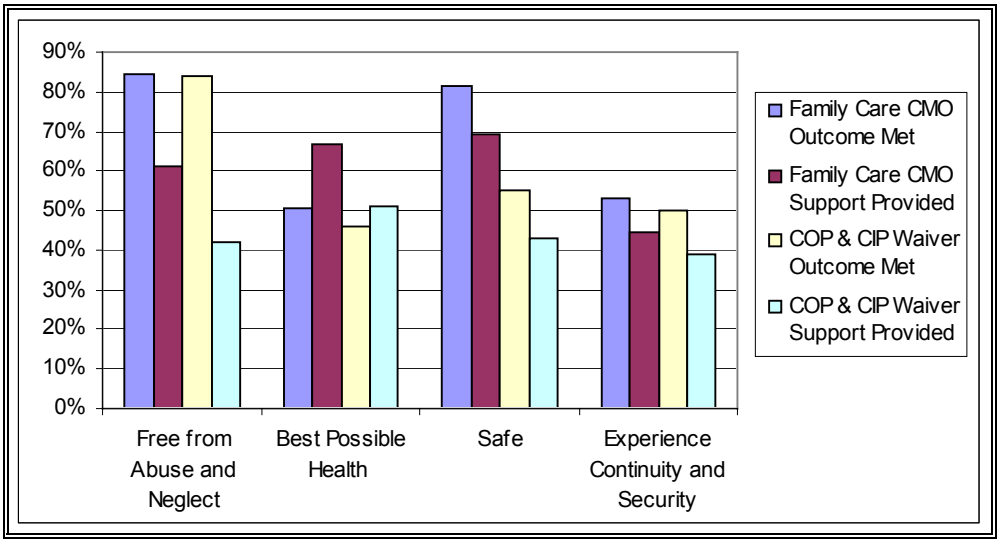
C. Health and Safety

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%

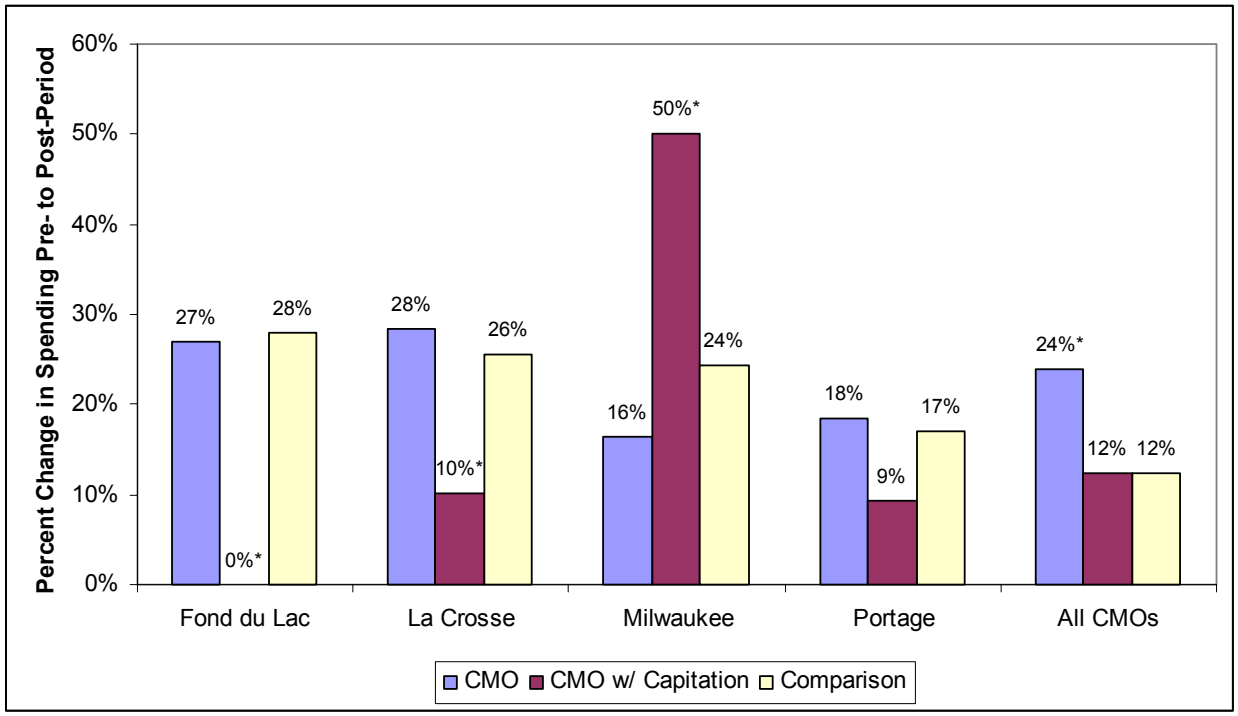
Source: The Lewin Group analyses.

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.

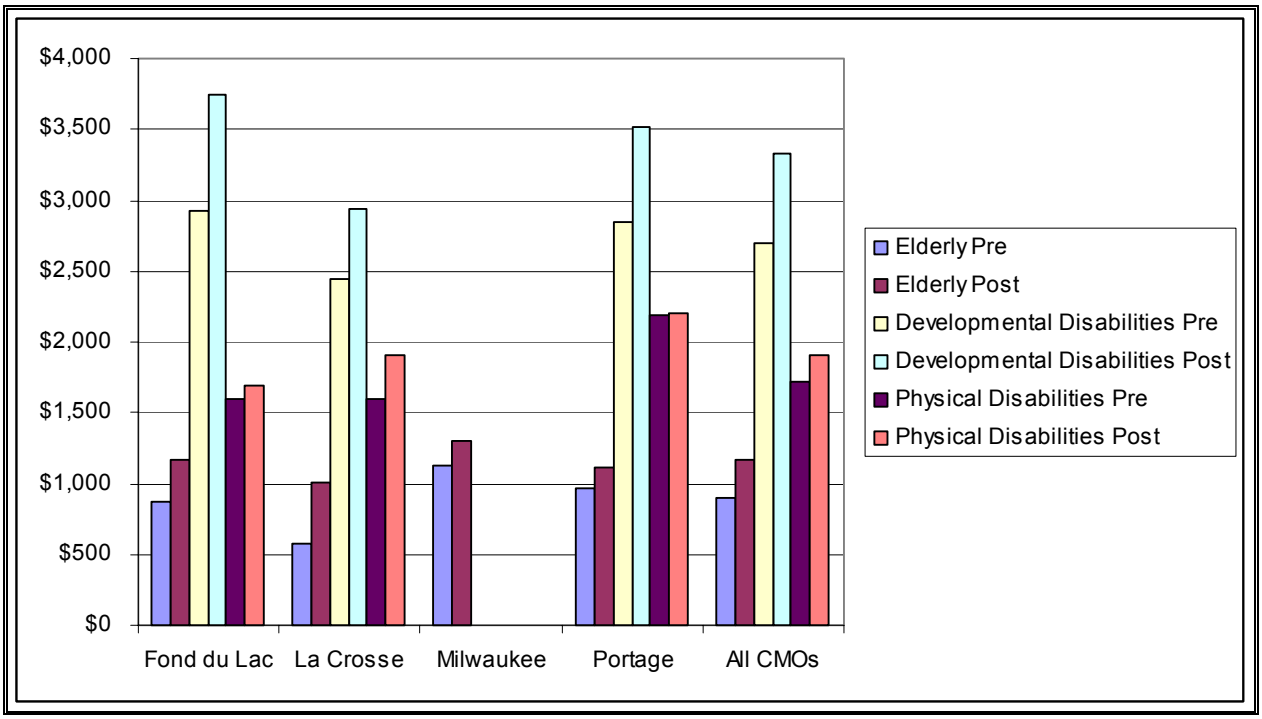
Exhibit XII-4
CMO Monthly Capitation Amounts, 2000-2003

	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 at the intermediate and skilled nursing levels of care (***Exhibit XII-8***).[25] The difference in the spending declines as the level of care increases, with the community spending approximately 54 percent of the nursing facility spending for the intermediate level of care and 75 percent at the skilled level of care. At the intensive skilled nursing level of care, however, average monthly Medicaid long-term care spending in the community is higher than spending in a nursing facility; community spending is approximately 108 percent of the nursing facility spending at this 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	$1,128	53.6%
Skilled Nursing	$2,538	$1,913	75.4%
Intensive Skilled Nursing	$2,976	$3,218	108.1%

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.

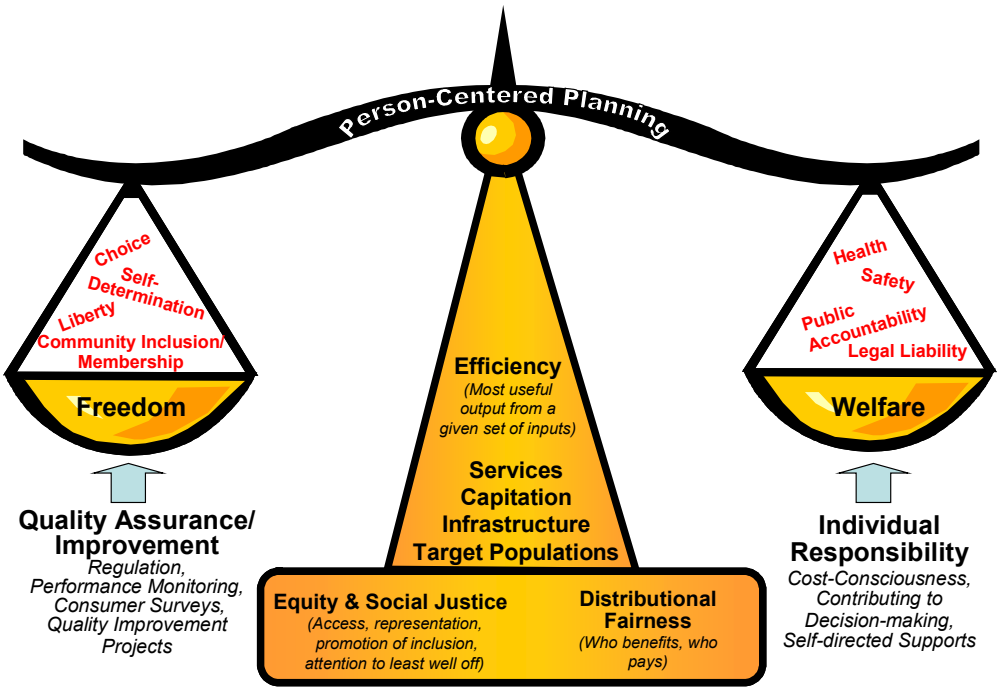
In the following sections, we discuss Wisconsin's implementation model and the the four major tenets of the Family Care program: 1) choice; 2) access; 3) quality; and 4) cost-effectiveness. We conclude with a summary of the outcome and spending measures from this report and a discussion of some of the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

Exhibit B-4: CMO New Enrollees
1999 Sample Characteristics, continued

Portage	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	NA	105	105
Percent	NA	100.0%	100.0%
Age			
18-44	NA	34.3%	36.9%
45-59	NA	12.4%	14.4%
60-74	NA	12.4%	12.0%
75+	NA	41.0%	36.8%
Average Age	NA	58.3%	56.6%
Sex			
Male	NA	36.2%	36.9%
Female	NA	63.8%	63.1%
Dual Eligible			
Medicare & Medicaid	NA	76.2%	78.7%
Medicaid Only	NA	23.8%	25.0%
Target Group			
Elderly	NA	46.7%	41.6%
Physically Disabled	NA	12.4%	16.3%
Developmentally Disabled	NA	41.0%	42.0%
Impairment in Activities of Daily Living			
0-1	NA	33.3%	34.7%
2	NA	21.0%	21.3%
3+	NA	45.7%	44.0%
Severe Medical	NA	NA	NA
Impairments in Instrumental Activities of Daily Living			
0-1	NA	13.3%	14.0%
2	NA	21.9%	22.2%
3+	NA	64.8%	63.8%
Severe Medical	NA	NA	NA
Residential Setting			
Other/Unknown	NA	8.6%	8.3%
Own Home	NA	83.8%	84.8%
Nursing Home	NA	3.8%	3.4%
CBRF	NA	3.8%	3.5%
Residential Care Apartment Complex		0.0%	0.0%
Length of Time on Program			
0-5 months	NA	72.4%	71.5%
6-11 months	NA	27.6%	28.5%
Average Monthly Spending 2000			
	NA	$1,298	$1,297
Average Monthly LTC Spending 2000			
	NA	$1,011	$1,010

Exhibit B-4: CMO New Enrollees
1999 Sample Characteristics, continued

La Crosse			
	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	NA	262	262
Percent	NA	100.0%	100.0%
Age			
18-44	NA	37.0%	36.2%
45-59	NA	19.1%	16.0%
60-74	NA	15.3%	15.1%
75+	NA	28.6%	32.7%
Average Age	NA	55.9%	57.3%
Sex			
Male	NA	37.0%	36.2%
Female	NA	63.0%	63.8%
Dual Eligible			
Medicare & Medicaid	NA	76.0%	77.6%
Medicaid Only	NA	24.1%	22.4%
Target Group			
Elderly	NA	38.9%	45.0%
Physically Disabled	NA	26.7%	17.3%
Developmentally Disabled	NA	34.4%	37.7%
Impairment in Activities of Daily Living			
0-1	NA	37.0%	37.1%
2	NA	21.0%	20.9%
3+	NA	42.0%	42.0%
Severe Medical	NA	NA	NA
Impairments in Instrumental Activities of Daily Living			
0-1	NA	12.6%	10.8%
2	NA	19.5%	18.5%
3+	NA	67.9%	70.7%
Severe Medical	NA	NA	NA
Residential Setting			
Other/Unknown	NA	18.3%	20.3%
Own Home	NA	76.3%	74.4%
Nursing Home	NA	1.5%	1.2%
CBRF	NA	2.7%	2.8%
Residential Care Apartment Complex		1.2%	1.3%
Length of Time on Program			
0-5 months	NA	80.2%	79.7%
6-11 months	NA	19.9%	20.3%
Average Monthly Spending 2000			
	NA	$1,553	$1,549
Average Monthly LTC Spending 2000			
	NA	$1,138	$1,135

Exhibit B-4: CMO New Enrollees
1999 Sample Characteristics, continued

Milwaukee			
	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	NA	223	NA
Percent	NA	100.0%	NA
Age			
18-44	NA	0.0%	NA
45-59	NA	0.0%	NA
60-74	NA	43.5%	NA
75+	NA	56.5%	NA
Average Age	NA	76.8%	NA
Sex			
Male	NA	21.1%	NA
Female	NA	78.9%	NA
Dual Eligible			
Medicare & Medicaid	NA	94.2%	NA
Medicaid Only	NA	5.8%	NA
Target Group			
Elderly	NA	100.0%	NA
Physically Disabled	NA	0.0%	NA
Developmentally Disabled	NA	0.0%	NA
Impairment in Activities of Daily Living			
0-1	NA	14.8%	NA
2	NA	16.6%	NA
3+	NA	68.6%	NA
Severe Medical	NA	NA	NA
Impairments in Instrumental Activities of Daily Living			
0-1	NA	14.8%	NA
2	NA	16.6%	NA
3+	NA	68.6%	NA
Severe Medical	NA	NA	NA
Residential Setting			
Other/Unknown	NA	21.1%	NA
Own Home	NA	66.4%	NA
Nursing Home	NA	0.0%	NA
CBRF	NA	10.3%	NA
Residential Care Apartment Complex		2.2%	
Length of Time on Program			
0-5 months	NA	78.9%	NA
6-11 months	NA	21.1%	NA
Average Monthly Spending 2000			
	NA	$1,811	NA
Average Monthly LTC Spending 2000			
	NA	$1,364	NA

Exhibit B-4: CMO New Enrollees
1999 Sample Characteristics, continued

Family Care			
	Sample Frame	Analysis Sample	Weighted Analysis Sample
Number	NA	864	864
Percent	NA	100.0%	100.0%
Age			
18-44	NA	28.4%	29.5%
45-59	NA	11.3%	12.4%
60-74	NA	21.4%	21.0%
75+	NA	38.9%	37.1%
Average Age	NA	61.7%	60.8%
Sex			
Male	NA	33.9%	34.5%
Female	NA	66.1%	65.5%
Dual Eligible			
Medicare & Medicaid	NA	82.1%	81.1%
Medicaid Only	NA	17.9%	18.9%
Target Group			
Elderly	NA	31.6%	53.5%
Physically Disabled	NA	12.2%	14.5%
Developmentally Disabled	NA	31.6%	32.0%
Impairment in Activities of Daily Living			
0-1	NA	34.0%	34.6%
2	NA	23.6%	23.5%
3+	NA	42.4%	41.9%
Severe Medical	NA	NA	NA
Impairments in Instrumental Activities of Daily Living			
0-1	NA	10.9%	11.2%
2	NA	16.4%	16.7%
3+	NA	72.7%	72.2%
Severe Medical	NA	NA	NA
Residential Setting			
Other/Unknown	NA	14.7%	14.3%
Own Home	NA	74.8%	75.4%
Nursing Home	NA	0.9%	1.0%
CBRF	NA	7.9%	7.8%
Residential Care Apartment Complex		1.7%	1.7%
Length of Time on Program			
0-5 months	NA	77.9%	77.8%
6-11 months	NA	22.1%	22.2%
Average Monthly Spending 2000			
	NA	$1,561	$1,558
Average Monthly LTC Spending 2000			
	NA	$1,211	$1,209

Appendix C

Fidelity Measure

The chart below displays a prototype fidelity measure for Family Care for the five counties with CMOs. The fidelity measure matrix presents the baseline assessment of Family Care implementation by county for each of the core domains and program components. The measure includes components under the Family Care core domains, as well as sample **ranges** for some components. All observations are as of May 2001, May 2002, and May 2003.

The **core domains** identified reflect the fundamental features of the Family Care model and will most likely remain constant. Lewin solicited feedback from the Department, all pilot counties, and state-level stakeholders on the adequacy of the core domains used to report on Family Care in the first Implementation Process Report and received affirmation.

The **sample ranges,** however, reflect a dynamic definition that has been and will continue to be refined with input from the Department and the Family Care pilot counties. Only some components have sample ranges. For example, "CMO, RC, and ES Relationship" does not contain a range, and "Staffing" ranges from, "Have staff in all required roles", to "staffing level sufficient to carry out functions." The definitions or ranges associated with the other components were derived empirically from information collected from each of the pilot programs.

Some areas added since the 2001 update contain an "N/A", indicating that Lewin did not assess that component in 2001. Also, "N/A" may appear in areas where Lewin did not have sufficient information to make an assessment for that area. For example, Lewin could not assess the degree to which providers were participating in the care planning process across counties from the limited provider interviews. Some components are required elements of the Family Care contract, while others have emerged as critical components in the course of program implementation. Required components are defined as specified in the Family Care contract.

Exhibit C-1
Fidelity Measure for Family Care: Status of Family Care County Implementation in May 2001, May 2002, and May 2003

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]			Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
System Structure																			
CMO, RC and ES Relationship	Eligibility and enrollment plan between CMO and RC, ESU and EC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Resource Center contact made within timeline (October 2000-March 2001)[2]	Y	Y		63%			94%			43%			95%			57%		
	Set meeting time for ES, CMO and RC or availability to meet when problems arise				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Degree of involvement of ES from the beginning of implementation – ES workers devoted solely to FC eligibility determination – information sharing between ES and RC staff				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Re-certification policies in place and approved by DHFS				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Web-based functional screen				N	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y
Staffing Level	**Range: Have staff in all required roles → Staffing level sufficient to carry out functions**																		
	All positions filled				Y	Y	Y	Y	Y		Y	N		Y	Y		Y	Y	
	Freedom to hire new staff independent of the county board or agreement worked out for Family Care				N/A	N		N/A	N		N/A	N[3]		N/A	N	N	N/A	N	
	RC contacts per FTEs (Feb 2001 and March 2002 contacts used; March 2001 and 2002 FTEs used)				24	26		30	29		69	60		151	96		21	24	
	CMO functions – caseload goals met for all target populations				N	Y		N	N	N	N	N	N	N	N	N	Y	Y	Y

1 Based on the 2001, 2002, and 2003 RC and CMO contracts.

2 DHFS no longer recording this information in Quarterly Activity or Monthly Monitoring Reports.

3 Milwaukee does not need County Board approval to add contracted care management units.

Exhibit C-1, Continued
Fidelity Measure for Family Care: Status of Family Care County Implementation in May 2001, May 2002, and May 2003

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]			Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
System Structure (continued)																			
IT System	**Range: IT development plans → Fully developed IT system supporting functions of RC and CMO**																		
	I and R outcomes				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Functional Screen				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Assessment				Y	Y	Y	N	N	N	Y	Y	Y	N	N	Y	N	N	N
	Case Notes				Y	Y	Y	N	N	N	Y	Y	Y	N	N	Y	N	N	N
	ISP and outcomes				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
	Prior authorization				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Billing Internal				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Provider Claims Processing				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Governance																			
RC and CMO Separation	Establishment of separate governing board with no overlap in membership	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Role of Governing Bodies	Established with correct make-up → integral in CMO and RC operations	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outreach																			
Targeting	**Range: Slightly under contact goals → Exceeding contact goals, innovative strategies to reach target populations**																		
	Exceeding contact goals	Y	Y		Y	Y		Y	Y		Y	Y		Y	Y		Y	Y	
PAC Referrals	Receiving referrals from facilities according to PAC plan → referrals are appropriate[2]	Y	Y		Y	Y		Y	Y		Y	Y		Y	Y		Y	Y	
	Outreach to institutional residents		Y		N	Y		N	Y		N	Y		N	Y		N	N	Y
	Actively engaged in prevention activities	Y	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y	N	Y	Y
Service Access																			
Functional Screen	Consumers screened within 14 days of contact[4]	Y	Y		96%			95%			100%			100%			100%	N/A	
Type of Information Provided by RC	Broad range of services				Y	Y		Y	Y		Y	Y		Y	Y		Y	Y	

[4] DHFS no longer reporting this information in Quarterly Activity or Monthly Monitoring Reports.

Exhibit C-1, Continued
Fidelity Measure for Family Care: Status of Family Care County Implementation in May 2001, May 2002, and May 2003

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]			Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
System Structure (continued)																			
Format of Provider Information at RC	**Range: Paper brochures → Searchable database → Consumer searchable**																		
	Consumer searchable listing on the website				Y	Y	N	N	Y	Y	N	N	N	N	N	N	N	N	N
	Waiting list eliminated				Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	Y
	Entitlement reached				N	Y	Y	N	Y	Y	N	N	Y	N	Y	Y	N	N	Y
	Delayed enrollment instituted				Y	N	N	Y	N	N	N	Y	N	N	N	N	Y	Y	N
Enrollment Rate	% increase from March 2001 to March 2002				30			28			180			34			50		
	Enrollment reached a stable state				N			N			N			N			N		
Consumer Unmet Needs	Pilot identified consumer unmet needs → addressed unmet needs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prior Authorization	Procedures established, procedures followed and understood by providers (verbal, written)				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community Alternatives Developed and Supported	County has options available for all target populations[5]	Y	Y																
	Institutional relocations occurring				Y	Y		Y	Y		Y	Y		Y	Y		not tracking		
	Number of institutional relocations since beginning of CMO				5	6	11	34	42	72	20	0		3	13	7	not tracking		
CMO Provider Network	**Range: CMO meets quality requirements in provider contracts → Provider network meets consumer needs**																		
	Number of providers under contract with the CMO				195	241	262	258	287	300	N/A	N/A	N/A	132	179	228	301	200	118
	Quality language beginning in provider contracts				Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	N	Y	Y
	Full-time provider network staff				Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Provider training in place				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Care Management																			
Composition of CM Team	**Range: County developed goal. → Followed through with goal. → Evaluation of effectiveness of composition.**																		
	Teams in place				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
RN to Consumer Ratio	At least one RN per 80 consumers				N	N	Y	N	N	N	N	N	N	N	N	N	Y	Y	Y

[5] Discussed in the outcome evaluation.

Exhibit C-1, Continued
Fidelity Measure for Family Care: Status of Family Care County Implementation in May 2001, May 2002, and May 2003

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]			Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
Care Management (continued)																			
RN Responsibility	**Range: Assessment/ consultation → Prevention → Coordination of nursing with other Interdisciplinary Team (IDT) members**																		
	Role moving beyond assessment				Y	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	Y	Y	N	Y	Y
RAD Method	RAD training given to all CMs → documented use by all CMs																		
	Training and documentation of use				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consumer Participation in Care Planning	Ability to participate in the care plan communicated to the consumer by the CMO → Use of the member centered plan to identify preferences and outcomes	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Provider Participation in Care Planning	Providers receiving prior authorization, receiving ISP → helping to create ISP				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Relationship to Acute and Primary Care	Collaboration w/acute primary care →meeting w/local hospital staff → information sharing occurs				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prevention	Prevention activities occurring	Y	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	N	Y[6]
Quality																			
Quality Plan	Plan created and approved by DHFS – moving forward on agenda	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Internal Advocacy	Member handbook developed	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Full-time member relations coordinator	N	N	N	N	N	N	N	Y	N	N	Y	N	N	Y	N	Y	Y	Y

[6] Just beginning in May 2003.

Exhibit C-1, Continued
Fidelity Measure for Family Care: Status of Family Care County Implementation in May 2001, May 2002, and May 2003

Core Domain and Components	Indicator and Example Definition or Range	Contract Requirement[1]			Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
		2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
Degree of Consumer Involvement	**Range: Limited involvement of consumers → Extensive input from consumers into day-to-day operation (e.g., Self-Directed Support Option committees)**																		
	Number of committees with consumer involvement other than the LLTCC and governing bodies				N/A	2	2	N/A	1	1	N/A	4	4	N/A	3	2	N/A	2	2
Consumer Choice Supported	Degree to which consumers have choices about their care scores higher than 60%t for all choice related outcome on Member Outcome Tool across all target populations				N	N	N/A	N	N	N/A	N	N	N/A	N	N/A	N/A	N/A	N/A	N/A
Self-Directed Support Option	Self-directed support option available → documented use of the SDS Option developed according to standards	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
	SDS committee with consumer representation				N/A	Y	Y	N/A	N	N	N/A	N	N	N/A	N	Y	N/A	N	Y
Local LTC Council	LTC Council formed and meeting regularly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Independent Advocacy	Local agency provides advocacy independent of the county				N/A	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	Y	Y	N/A	Y	Y
	State funded Independent Advocate in place[7]				Y	N	N	Y	N	N	Y	N	N	Y	N	N	Y	N	N
Capitation																			
Pilot Viability	**Range: Pilot county ability to manage the rates → Factors such as adequacy of rate set by DHFS, management of services → Track adjustments in the rate**																		
	CMO assumes full risk				Y	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y
	CMO does not rely on county funds				Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

[7] Funding for independent advocate was not included in 2001-2003 state budget.

Appendix D

Acronyms and Glossary of Terms

ACRONYMS

ADL	**Activities of Daily Living:** Refers to the ability to carry out basic self-care activities. Activities include such tasks as bathing, dressing, walking, transferring (getting in and out of bed or chair), toileting (including getting to the toilet), and eating.
ALF	**Assisted Living Facilities:** Three types of residential assisted living facilities are subject to regulation**.** Community-based residential facilities serve five or more adults; adult family homes may serve up to three or four adults; residential care apartment complexes serve five or more adults in independent units.
AAA	**Area Agency on Aging:** A public or private non-profit organization designated by the state to develop and administer the area plan on aging within sub-state geographic planning and service area. AAAs advocate on behalf of older people within the area and develop community-based plans for services to meet their needs and administer federal, state, local and private funds through contracts with local service providers.
BOALTC	**Board on Aging and Long-Term Care:** An independent state agency that advocates on behalf of elderly and disabled persons who are receiving long-term residential care, mainly by monitoring development and implementation of policies and programs and investigating complaints about care. As part of the Family Care initiative, BOALTC's responsibilities were expanded to provide advocacy services to potential or actual recipients of the Family Care benefit and authorized to contract for the external advocacy service.
BALTCR	**Bureau of Aging and Long-Term Care Resources:** A unit within the Wisconsin Department of Health and Family Services designated for planning, coordinating, funding and evaluating state and federal programs for older adults.
CARES System	**Client Assistance for Re-Employment and Economic Support:** The CARES system uses data supplied by an applicant for public assistance benefits to determine an applicant's eligibility for MA, Wisconsin works, food stamps and child care programs, to issue public assistance benefits and to track program participation.
CBRF	**Community-Based Residential Facility:** A place in which five or more unrelated adults live and where they receive care, treatment, or services, but not nursing care on any permanent basis, in addition to room and board. CBRFs are licensed by DHFS under ch. HFS 83 rules.[1]

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

CHF	**Congestive Heart Failure:** a condition in which the heart is unable to maintain an adequate circulation of blood in the bodily tissues or to pump out the venous blood returned to it by the veins causing the buildup of fluid accumulating in the lungs and around the heart.
CIP	**Community Integration Program:** • CIP-IA is for developmentally disabled persons relocated or diverted from DD centers; • CIP-IB is for developmentally disabled persons relocated or diverted from nursing homes; • CIP-II is for elderly and physically disabled persons diverted or relocated from nursing homes to appropriate community settings with the assistance of home and community-based care and with continuity of care. Care in the community is financed by MA (Medical Assistance).
CMO	**Care Management Organization:** Entity that provides or arranges for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. The CMO must coordinate care across different delivery systems (including primary health care, Long-Term Care [LTC], and social services) and funding sources (including Medicaid fee-for-service and other commercial health insurance, Medicare, and funding sources for vocational and social services).
CMS	**Centers for Medicare & Medicaid Services** (formerly HCFA): The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).
CMUs	**Care Management Units:** Milwaukee CMO contracts with CMUs, private agencies, to serve as care managers with CMO members.
COP-W	**Community Options Program Waiver:** In January of 1987, Wisconsin received approval of the COP-Waiver request from the federal government. The waiver permits the use of federal Medicaid funds to finance services provided to eligible persons in the community, as an institutional alternative.
COP	**Community Options Program:** A DHFS financed, county-administered program to support individuals who desire to remain in the community setting. The program involves assessing the need of Medical Assistance eligible persons faced with nursing home placement and assisting them via a range of available supportive services in the community, care planning and management, and paying for gap-filling supportive services to make continued or new community residence possible.

CSDRB	**Community Services Deficit Reduction Benefit**: A program under which counties, tribes, and local health departments are able to claim the federal matching dollars to cover approximately 60% of their deficits for certain Medicaid-covered services. These public agencies are responsible for providing the non-federal matching dollars (approximately 40% of total costs) with local funds.[2]
DD	**Developmentally Disabled:** See MR/DD definition.
DHCF	**Division of Health Care Financing**: Responsible for administering the Medical Assistance (Medicaid), Chronic Disease Aids, WisconCare, Health Insurance Risk Sharing Program (HIRSP) and General Relief programs.[3]
DHFS	**Department of Health and Family Services:** Wisconsin State Department of Health and Family Services, began July 1, 1996 and oversees Medicaid and other health programs and social service programs.[4]
DHHS	**Department of Health and Human Services**: The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
DME	**Durable Medical Equipment:** Covered by the Family Care benefit and includes items such as wheelchairs, canes, etc.
DMS	**Disposable Medical Supplies**: A benefit included in the Family Care program that supplies members with disposable medical supplies intended for one-time or temporary use, such as cotton balls, dressing materials, etc.
DSL	**Division of Supportive Living:** Within the State Department of Health and Family Services, the division manages and regulates programs involving mental health, substance abuse, developmental disability, as well as aging and long-term support programs.
DWD	**Department of Workforce Development:** Directs the Eligibility process for the following programs:

Child Care	Child Support Enforcement
Food Stamps	Medical Assistance
Temporary Assistance for Needy Families (TANF)	Welfare to Work
W-2 Welfare Initiative	

2 Definition from the DHFS cost model November 1999.

3 Definition from http://www.dhfs.state.wi.us/aboutdhfs/DHCF/dhcf.htm

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

ESU	**Economic Support Unit:** County unit responsible for fiscal resources in the county.
FC	**Family Care:** A voluntary long-term care managed care program. The State contracts with Care Management Organizations (CMOs) that provide or arrange for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. Family Care will foster recipients' independence and quality of life, while recognizing the need for support to remain independent.
FDD	**Facility for the Developmentally Disabled:** A type of nursing home primarily for developmentally disabled persons. State centers for developmentally disabled persons are FDDs. Licensed under ch. HFS 134 rules.[5]
FFES	**Functional and Financial Eligibility Screen:** A tool developed by DHFS and used by trained Resource Center staff to determine functional and financial eligibility for Family Care.
HCBS	**Home and Community-Based Services:** Alternatives to nursing home care that provide services to people living in the community. With further developments in community supports and technological advances, there is an increased opportunity for individuals at many levels of disability to be effectively served in the community.
HIPAA	**Health Insurance Portability and Accountability Act of 1996:** The act offers improved portability and continuity of health insurance coverage and regulations to guarantee patients rights and protections against the misuse or disclosure of their health records, including regulations for electronic health information.
I & A	**Information and Assistance:** Service provided by the Resource Centers using a telephone number that is toll-free to all callers in its service area. Information provided is related to aging, physical and developmental disabilities, chronic illness and long-term care, including referrals to and assistance in accessing services.
IADL	**Instrumental Activities of Daily Living:** Refers to tasks required to maintain an independent household. Activities include such tasks as meal preparation, light housework, using the telephone, arranging and using transportation and the ability to be functional at a job site.

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

ICF	**Intermediate Care Facility:** A federal Title XIX term for Medical Assistance reimbursement purposes to a lower level of nursing care than that provided in a skilled nursing facility (SNF).
ICF-MR	**Intermediate Care Facilities for Individuals with Mental Retardation:** An ICF serving only or mainly mentally retarded residents providing active treatment for residents, and certified under 42 Code of Federal Regulations (CFR) 435 and 442. In Wisconsin, these are called facilities for the developmentally disabled (FDDs).
ISP	**Individual Service Plan:** A plan of care developed by the CMO and the Family Care member. It is based on a comprehensive assessment of the individual and reflects the individual's values and preferences for care.
IT	**Information Technology:** IT refers to information and businesses regarding computers, software, telecommunications products and services, as well as, Internet and online services.
LAB	**Legislative Audit Bureau:** A non-partisan legislative service agency created to assist the Legislature in maintaining effective oversight of state operations. The Bureau conducts objective audits and evaluations of state agency operations to ensure financial transactions have been made in a legal and proper manner and to determine whether programs are administered effectively, efficiently, and in accordance with the policies of the Legislature and the Governor. The LAB is the agency administering the contract to The Lewin Group for the independent evaluation of Family Care.[6]
LOC	**Level of Care:** The level at which an individual screens functionally eligible for Family Care, either comprehensive or intermediate.
LTC	**Long-Term Care:** A range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self-care. Services may be continuous or intermittent but are delivered for sustained periods to individuals who have a demonstrated need, usually measured by some index of functional incapacity.
MA Card	**Medical Assistance Card:** Card provided by Wisconsin Medicaid and covers a broad range of health care services, including home health and nursing facility care as well as the Personal Care option.
MA	**Medical Assistance:** Wisconsin's term for the Medicaid (Title XIX) program which pays for necessary health care services for persons whose financial resources are not adequate to provide for their health care needs.
MOU	**Memorandum of Understanding:** Document clearly defining respective responsibilities of multiple entities.

[6] Definition from http://www.legis.state.wi.us/lab/AgencyInfo.htm

MCO	**Managed Care Organization:** Any system that manages healthcare delivery to control costs.
MCP	**Member-Centered Plan:** The plan developed by the CMO staff and the Family Care member which outlines the member's preferences and personal outcomes. The plan should inform the Individualized Service Plan (ISP) which records services and supports needed in order to meet the Family Care member's outcomes.
MR/DD	**Mentally Retarded/Developmentally Disabled** **Mentally Retarded:** Individual with subnormal intellectual functioning which originates during the developmental period and is associated with impairment of one or more of the following: (1) maturation, (2) learning, (3) social adjustment. **Developmentally Disabled:** Disorder in which there is a delay in development based on that expected for a given age level or stage of development. These impairments or disabilities originate before age 18, may be expected to continue indefinitely, and constitute a substantial impairment.[7]
PAC	**Pre-Admission Consultation:** Consultations designed to inform individuals of available long-term care options and counsel them regarding their options before making permanent decisions on their LTC. It is also an opportunity to determine if they are eligible for family care.
PACE	**Program for the All-Inclusive Care of the Elderly:** Provides on-site, comprehensive, integrated medical and psychosocial services by a multi-disciplinary team and a strong adult day component to approximately 400 Medicaid and Medicare eligible individuals 55 and older at the nursing home level of care in Milwaukee.
PD	**Physical Disability:** A physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person.
RAD	**Resource Allocation Decision method:** Developed as a tool for the care management team to determine how best to use resources and serves to identify individual outcomes and derive cost-effective options to meet these outcomes.
RAP	**Resource Allocation Program:** Under ch. 150, Wis. Stats.,*, and ch. HSS 122, Wis. Adm. Code, the program of adjusting caps on nursing home and FDD

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

	beds, distributing newly available beds, and prior review of capital expenditures of nursing homes and facilities for the developmentally disabled (FDDs). [8]
RC	**Resource Center:** Entity offering a variety of services, including one-stop shopping for older adults, people with disabilities, and their family members for a wide range of information and providers that are available in the local communities. The RCs also provide counseling about long-term care options and eligibility determination for the Family Care benefit and serve as a clearing-house of information designed to assist service personnel working with populations in need of long-term care services.
RCAC	**Residential Care Apartment Complex:** One type of assisted living facility (1997 Wisconsin Act 13 amended statutes to change official name to Residential Care Apartment Complex); an RCAC may serve five or more adults in independent apartment units.
RFP	**Request for Proposal:** Document that solicits proposals from outside parties in a competitive bidding process.
RN	**Registered Nurse:** A graduate trained nurse who has been licensed by a state authority after qualifying for registration.
SNF	**Skilled Nursing Facility:** A federal Titles XVIII and XIX certification term and state licensing term for long-term care facilities that provide care to residents who no longer need the type of care and treatment provided in a hospital but do require some medical attention and continuous skilled nursing observation.
WCA	**Wisconsin Coalition for Advocacy:** An independent non-profit agency with experience in consumer advocacy, especially around advocacy issues, to protect and promote the interests of developmentally disabled persons and mentally ill persons.
WHCA	**Wisconsin Health Care Association:** A non-profit organization representing 250 primarily for-profit nursing homes.
WAHSA	**Wisconsin Association of Homes and Services for the Aging:** A non-profit organization with 190 not-for-profit members principally serving the elderly and disabled, including nursing home facilities for the developmentally disabled, community-based residential facilities, independent living facilities and community service agencies.

[8] Definition from http://www.legis.state.wi.us/rsb/stats.html

GLOSSARY

Direct Services	Services provided directly to people by agency staff rather than purchased by the agency from an outside provider.
Indirect Services	Services to people provided by DHFS through various public and private agencies under contract.
Nursing Home	A facility that provides 24 hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care. Nursing homes are licensed by DHFS under ch. HFS 132 rules (Health and Family Services).
Options Counseling	RCs offer consultation and advice about the options available to meet an individual's long-term care needs. This consultation will include discussion of the factors to consider when making long-term care decisions. Resource centers will offer pre-admission consultation to all individuals with long-term care needs entering nursing facilities, community-based residential facilities, adult family homes and residential care apartment complexes to provide objective information about the cost-effective options available to them. This service is also available to other people with long-term care needs who request it.[9]
Partnership	Partnership integrates all medical and long-term care services in a community-based setting for approximately 1,300 older adults and adults with physical disabilities at four sites in three Wisconsin counties, but relies less on adult day centers than does PACE.
Personal Care	Refers to assistance with activities of daily living such as eating, dressing, bathing and walking.
Selective Contracting	The process by which CMOs will begin to include quality requirements as part of the contracts process with providers.
Supportive Home Care	Care provided to elderly and disabled persons residing in their own homes; consists of assistance with daily living needs, including household care and personal care.

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

Community Aids	Community Aids provides core funding to counties for basic community services to people with developmental and other disabilities and other needs. When the Community Aids system was established in 1974, the state used a combination of state and federal dollars to provide approximately 90% of the funding for county-run human services. Counties had to provide a "match" of approximately 10% in order to capture funding. Over time, the amounts contributed by some counties has grown larger than 10%.

Appendix E

CMO Contracted Providers

Exhibit E-1
Number of Providers Contracting with the CMOs
May 2001, May 2002, and May 2003

Type of Service	Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003
Adaptive Aids	1	5	9	3	3	4		[c]	5	6	6	8	27	22	12
Adult Day Care	1	3	6	8	8	6		19	17	2	1	2	9	4	1
Adult Family Home	17	28	24	128	156	160		26	43	29	38	42	30	30	15
Assisted Living Facility	3	3	4	4	4	4		6	11			0	5	3	1
Care Management	1	1	1	1		1		20	26	2	1	2	8	1	1
CBRF	23	22	29	19	16	14		124	143	17	19	20	17	14	9
Chore Services	4							[c]							
Congregate Meals	1	1	2	2 (many sites)	1	NA		2 (20 sites)	Dept. of Aging (Admin.	1	2	1	1 (6 sites)		1
Daily Living Skills	8	12	8	5	5	5		10	11	5	4	7	1	2	2
Day Services/ Treatment	5	9	3	4	5	5		[c]	6	2	2	1	2	2	4
Employment-Related [a]	9	6	4	3	2	4		[c]	1	6	5	5	9	4	1
Guardianship/Money Management		2	4	4	4	5		4	3	1	1	1	2	3	10
Home Care (Medical & Supportive)	31	38	30	8	14	16		33 [c]	29	7	11	16	29	12	18
Home Modification		3	6	various	various	Various per bids		6	5	1	1	3	12	9	10
ICF/MRs		1	2		1	1		c	N/A		3	5		4	1
Interpreter Services		[b]	2	2	4	3		2	2	2	2	3	1		1
Meal Delivery	5	5	5	3	7	6		2	1	2	6	2	4	3	2

Exhibit E-1, continued
Number of Providers Contracting with the CMOs
May 2001, May 2002, and May 2003

Type of Service	Fond du Lac			La Crosse			Milwaukee			Portage			Richland		
	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003	May-2001	May-2002	May-2003
Medical Equipment/Supplies	28	43	28	17	18	15		8 [c]	5	6	6	17	13	24	16[f]
Mental Health	4	5	9	5	6	7		4 [c]	2	6	5	7	4	4	4
Nursing Facility	11	9	11	11	11	10		22 [c]	15	6	8	15	12	10	5
Recreation/Alternative Activities	6							[c]							
Rehabilitation/Therapy	6	10	9	9	11	11		[c]	3	6	7	13	39	8	10
Respite Care	10	12	48	4	3	3		[c]	3	14	38	47	34	25	29
Speech & Language Path.	5	6	4	7	7	7		[c]	[c]	4	5	4	6	6	5
Substance Abuse	1	5	3	3	4	4		2 [c]	2	2	2	1	11	2	1
Transportation	10	12	11	8	9	9		12 [c]	90[e]	6	6	6	22	8	10
Other															14[g]
Total	**195**	**241**	**262**	**258**	**299**	**300**		[d]	**423**	**132**	**179**	**228**	**301**	**200**	**153**
Percentage of Change		**24%**	**9%**		**16%**	**0%**					**36%**	**27%**		**-34%**	**-24%**

[a] Includes supported employment and sheltered workshop.
[b] Fond du Lac obtains these services from the county.
[c] Milwaukee will accept any certified Medicaid and Medicare providers for this service.
[d] Unable to calculate total for Milwaukee due to the numerous categories in which any certified Medicare or Medicaid provider was accepted.
[e] The CMO uses Certified Medicare & Medicaid Providers for this service.
[f] Includes 2 providers of PERS Units.
[g] Includes services such as 7 snow removal, 4 massage, 3 therapeutic

Note: The total number may not represent the total number of contracts that the CMO has because some providers may be counted twice if they provide more than one service type.

Source: Data provided by counties in May 2001, May 2002, and May 2003. Milwaukee 2001 information not available. Lewin did not ask counties to provide numbers of ICF/MRs in 2001.

Appendix F:
Detailed Explanation of Outcome Measures and Additional Tables

This appendix provides the detailed tables associated with the outcome analyses, as well as detailed explanations of the claims-based measures used. In all tables, the groups included are individuals who were a member of a CMO (participant in a relevant waiver for the comparison areas) in December 2000 and also a participant in a relevant waiver in December 1999. The pre-period period covers October 1999 through March 2000 and the post-period covers January 2001 through June 2001. Costs examined are total federal, state, and county spending captured through the administrative data systems for Medical Assistance, the Medicaid Management Information System (MMIS), and the Long-Term Care portion of the Human Services Reporting System (HSRS). These systems do not capture all costs related to the CMO benefit and the comparison group spending. While the CMO capitated payment includes an allocation for CMO administrative expenses of 12 percent, the CMO long-term care benefit spending includes only the payments for services. Neither the capitated payment nor the CMO long-term care benefit spending include administrative costs associated with state oversight, or in-kind support provided by the counties, such as discounted office space and payroll processing. The comparison group spending does not include county or state administrative spending, the routine seven percent added to COP and Medicaid HCBS waiver programs for administrative charges, nor any county spending for benefits that were not reported through the HSRS system. Our focus on the difference over time and the consistent treatment of the CMO counties and comparison areas mitigate any issues associated with the costs included.

Exhibit F-1 presents the percent of existing enrollees using different categories of services in the pre- and post-periods for CMO members that were existing enrollees and the remainder of the state. It provides an indication of service pattern use before and after CMO implementation.

Exhibit F-2 presents the average monthly spending for existing enrollees associated with the categories of service for the same two groups.

Exhibit F-3 presents average monthly spending for existing enrollees for the following categories of service: 1) total spending; 2) actual spending for CMO services; 3) the CMO capitation payment; and 4) non-CMO actual spending. The total in this table differ from ***Exhibit F-2*** because this table subtracts client cost-share amounts. Tests of significance were based on a Z test where the standard errors were estimated using a Taylor approximation.

It should be noted that caution should be exercised in examining the analyses by county and target population, specifically individuals with physical disabilities, because some of the counties have small sample sizes. In Waupaca and Pierce, the number of individuals with physical disabilities was less than 20 (18 and 13, respectively). For all the other counties, the number exceeded 30.

Additional analyses on Medicare status were conducted, but the findings did not differ from those included in the report and therefore are not presented.

The claims-based outcomes were defined as follows:

Hospital and Emergency Room Use -- An individual's hospital and emergency room uses were defined by having at least one hospital or emergency room MMIS claim with the date of service occurring during the post period of January 2001 through June 2001. Hospital claims were characterized by having the performing provider type equal to 61, 62, or 64, and the original claim type equal to 40 or 50. Emergency room claims were distinguished by having the performing

provider type equal to 61 or 62, the original claim type equal to 23 or 31, and the revenue code between 450 and 459.

Nursing Facility Use -- A person's nursing facility use was defined by having at least one MMIS nursing home or HSRS institutional claim with a date of service in the post period. MMIS nursing home claims were differentiated by having a performing provider type of 64 and a performing provider specialty equal to '053' or '085'. Additionally, MMIS claims with a performing provider type of 79 or 80 were also categorized as nursing home claims. HSRS institutional claims were identified by an SPC code equal to 505.

Alternative Residential Facility Use – An individual's alternative residential facility use was defined by having at least one HSRS residential claims with a date of service in the post-period. HSRS residential claims were defined by having and SPC code equal to 202, 203, 204, 205, 506 or 711.

Decubitis Ulcer -- Decubitis ulcer was defined by having an MMIS claim whose date of service was during the post period and whose ICD9 diagnosis code was "707.0" for decubitis ulcer. Both first and second diagnosis codes were considered in this categorization.

Death -- If an individual had MMIS or HSRS data indicating death during the post period, that person was included in the "Death" category.

In order to determine whether the CMO counties differed from the comparison areas for these outcome measures we used a T test.

Exhibit F-1
Percent of Existing Enrollees Using Services in the Pre- and Post-Period

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

Note: DME= Durable Medical Equipment and MH = Mental Health. 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.

Source: The Lewin Group analyses.

Exhibit F-2
Changes in Average Monthly Spending Per Participant for Existing Enrollees by Type of Service

	Care Management Organizations					Remainder of the State				
	Pre-Period	Post-Period	Diff.	% of Diff.	% Diff.	Pre-Period	Post-Period	Diff.	% of Diff.	% Diff.
Acute Care										
Inpatient	$16	$74	$58	11.5%	362.6%	$28	$45	$17	7.2%	61.1%
Outpatient	$23	$23	$0	0.0%	-1.5%	$29	$23	-$6	-2.6%	-17.7%
Emergency Room	$4	$4	$0	0.0%	-13.9%	$3	$4	$1	0.4%	16.3%
Physician	$9	$12	$3	0.6%	39.5%	$14	$10	-$4	-1.7%	-31.9%
Dental	$5	$7	$2	0.4%	36.0%	$5	$4	-$1	-0.4%	-7.1%
Lab/Radiology	$4	$6	$2	0.4%	44.3%	$5	$4	-$1	-0.4%	-20.0%
Drugs	$206	$227	$21	4.2%	10.6%	$196	$229	$33	14.0%	16.9%
Other	$47	$39	-$8	-1.6%	-18.4%	$83	$88	$5	2.1%	5.3%
Non-CMO Capitation	$0	$1	$1	0.2%		$0	$0	$0	0.0%	
Acute Subtotal	$314	$393	$79	15.7%	25.2%	$363	$407	$44	18.7%	12.1%
Long-term Care										
Adaptive Equip/DME	$82	$71	-$11	-2.2%	-13.3%	$61	$53	-$8	-3.4%	-13.2%
Adult Day	$142	$175	$33	6.5%	23.2%	$107	$118	$11	4.7%	10.5%
Case Management	$83	$128	$45	8.9%	53.1%	$125	$135	$10	4.3%	8.5%
Habilitation/Therapies/MH	$8	$15	$7	1.4%	84.7%	$16	$15	-$1	-0.4%	-5.7%
Housing	$26	$8	-$18	-3.6%	-70.4%	$19	$3	-$16	-6.8%	-86.5%

Nursing Home	$26	$128	$102	20.2%	393.2%	$16	$75	$59	25.1%	374.5%
Nursing Home Prescriptions	$2	$11	$9	1.8%	403.4%	$4	$9	$5	2.1%	109.6%
Personal Care	$738	$802	$64	12.7%	8.7%	$882	$923	$41	17.4%	4.6%
Residential	$360	$509	$149	29.6%	41.4%	$413	$494	$81	34.5%	19.8%
Respite	$37	$42	$5	1.0%	11.5%	$18	$17	-$1	-0.4%	-4.8%
Transportation	$57	$67	$10	2.0%	11.5%	$48	$50	$2	0.9%	5.1%
Vocational	$126	$156	$30	6.0%	23.9%	$88	$96	$8	3.4%	8.5%
LTC Subtotal	$1,687	$2,112	$425	84.3%	25.2%	$1,797	$1,988	$191	81.3%	10.6%
Total	**$2,001**	**$2,505**	**$504**	**100.0%**	**25.2%**	**$2,160**	**$2,395**	**$235**	**100.0%**	**10.9%**

Note: Diff = Post-Period minus Pre-period; % of Diff = Service/Number/Total Diff.; % Diff. = Diff/Pre-Period; DME= Durable Medical Equipment; MH = Mental Health. The categories of service are not directly mapped to those included in the CMO capitated payment because some LTC services are not included in the CMO benefit (e.g., inpatient therapies), but the services in the long-term care category are generally covered by Family Care. 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.

Source: The Lewin Group analyses.

Exhibit F-3
Difference in the Change in Average Spending for Existing Enrollees Using Alternative Measures and Comparisons

	Total Spending			CMO Services			CMO Capitation		Non-CMO Services		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Fond du Lac	$2,219	$2,738	23%	$1,827	$2,321	27%	$1,826	0%	$392	$417	6%
Waupaca	$1,927	$2,410	25%	$1,677	$2,147	28%			$250	$263	5%
Difference-in-Difference			-1.7%			-1.0%		-28.1%*			1.2%
La Crosse	$1,834	$2,385	30%	$1,549	$1,989	28%	$1,706	10%	$285	$396	39%
Manitowoc	$1,808	$2,236	24%	$1,501	$1,885	26%			$307	$351	14%
Difference-in-Difference			6.4%			2.8%		-15.4%*			24.6%
Milwaukee	$1,460	$1,776	22%	$1,123	$1,307	16%	$1,686	50%	$337	$469	39%
Rock	$1,827	$2,198	20%	$1,460	$1,815	24%			$367	$383	4%
Difference-in-Difference			1.3%			-7.9%		25.8%*			34.8%*
Portage	$2,409	$2,866	19%	$2,143	$2,539	18%	$2,344	9%	$266	$327	23%
Pierce	$2,555	$2,981	17%	$2,328	$2,725	17%			$227	$256	13%
Difference-in-Difference			2.3%			1.4%		-7.7%			10.2%
CMO Members	$1,993	$2,477	24%	$1,673	$2,072	24%	$1,881	12%	$320	$405	27%
Rem. of State	$2,148	$2,383	11%	$1,790	$2,012	12%			$358	$371	4%
Difference-in-Difference			13.3%*			11.4%*		0.0%			22.9%

* Significant at the 0.05 level

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.

Source: The Lewin Group analyses**.**

Exhibit F-4
Difference in the Change in Average Spending for Existing Enrollees Using Alternative Measures and Comparisons by Target Group

	Total			CMO Services			CMO Capitation		Non-CMO Services		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Fond du Lac											
Elderly	$1,223	$1,521	24%	$869	$1,162	34%	$1,831	111%	$354	$359	1%
DD	$3,177	$4,076	28%	$2,931	$3,747	28%	$1,823	-38%	$246	$329	34%
PD	$2,367	$2,397	1%	$1,591	$1,685	6%	$1,796	13%	$776	$712	-8%
Waupaca											
Elderly	$1,191	$1,753	47%	$979	$1,441	47%			$212	$312	47%
DD	$2,307	$2,792	21%	$2,143	$2,592	21%			$164	$200	22%
PD	$2,506	$2,631	5%	$1,817	$2,261	24%			$689	$370	-46%
Difference-in-Difference											
Elderly			-22.8%*			-13.5%		64%*			-45.8%*
DD			7.3%			6.9%		-59%*			11.8%
PD			-3.7%			-18.5%		-12%			38.1%
La Crosse											
Elderly	$807	$1,296	61%	$583	$1,010	73%	$1,708	193%	$224	$286	28%
DD	$2,646	$3,191	21%	$2,441	$2,945	21%	$1,710	-30%	$205	$246	20%
PD	$2,202	$2,896	32%	$1,602	$1,912	19%	$1,692	6%	$600	$984	64%
Manitowoc											
Elderly	$1,168	$1,493	28%	$863	$1,147	33%			$305	$346	13%

DD	$2,832	$3,524	24%	$2,612	$3,197	22%			$220	$327	49%
PD	$1,509	$1,669	11%	$1,033	$1,259	22%			$476	$410	-14%
Difference-in-Difference											
Elderly			32.8%*			40.3%*		160%*			14.2%
DD			-3.8%			-1.7%		-52%*			-28.6%
PD			20.9%			-2.5%		-16%			77.9%*

* Significant at the 0.05 level

Exhibit F-4 (cont.)
Difference in the Change in Average Spending for Existing Enrollees Using Alternative Measures and Comparisons by Target Group

	Total			CMO Services			CMO Capitation		Non-CMO Services		
	Pre	Post	% Diff.	Pre	Post	% Diff.	Post	% Diff.	Pre	Post	% Diff.
Milwaukee	$1,460	$1,776	22%	$1,123	$1,307	16%	$1,686	50%	$337	$469	39%
Rock	$1,827	$2,198	20%	$1,460	$1,815	24%			$367	$383	4%
Difference-in-Difference			1.3%			-7.9%		25.8%*			34.8%*
Portage											
Elderly	$1,233	$1,398	13%	$969	$1,120	16%	$2,163	123%	$264	$278	5%
DD	$3,066	$3,827	25%	$2,846	$3,518	24%	$2,457	-14%	$220	$309	40%
PD	$2,615	$2,690	3%	$2,188	$2,206	1%	$2,343	7%	$427	$484	13%
Pierce											
Elderly	$1,002	$1,261	26%	$826	$1,051	27%			$176	$210	19%
DD	$3,081	$3,609	17%	$2,891	$3,382	17%			$190	$227	19%
PD	$2,908	$3,071	6%	$2,376	$2,576	8%			$532	$495	-7%
Difference-in-Difference											
Elderly			-12.5%			-11.7%		96%*			-14.0%
DD			7.7%			6.6%		-31%*			21.0%
PD			-2.7%			-7.6%		-1%			20.3%
CMO Members											
Elderly	$1,195	$1,538	29%	$897	$1,168	30%	$1,782	99%	$298	$370	24%

DD	$2,915	$3,619	24%	$2,694	$3,332	24%	$1,960	-27%	$221	$287	30%
PD	$2,344	$2,691	15%	$1,724	$1,904	10%	$1,869	8%	$620	$787	27%
Remainder of State											
Elderly	$1,405	$1,707	21%	$1,139	$1,373	21%			$266	$334	26%
DD	$2,966	$3,383	14%	$2,732	$3,064	12%			$234	$319	36%
PD	$2,769	$2,407	-13%	$1,909	$1,829	-4%			$860	$578	-33%
Difference-in-Difference											
Elderly			7.2%			9.7%*		78%*			-1.4%
DD			10.1%*			11.5%*		-39%*			-6.5%
PD			27.9%*			14.6%		13%			59.7%*

* Significant at the 0.05 level

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.

Source: The Lewin Group analyses**.**

Appendix G

Case Mix Measure for Community versus Nursing Facility Spending Comparison

In order to develop comparable measures for community and nursing facility users, we used the late loss ADLs that Myers and Stauffer, in addition to other researchers, agree are more predictive of resource use and appear to be the least site-sensitive. These were eating (0-1), toilet use (0-1), and transferring (0-1). For cognitive functioning, we used the MDS Cognitive Performance Scale (CPS) developed under a CMS contract by John Morris, et al, to assess a wide range of cognitive functioning using variables collected by the MDS. The CPS was designed to replace two separate tests of cognitive functioning used in nursing homes, the Mini Mental Status Exam (MMSE), and Test for Severe Impairment (TSE). The CPS is based on an interaction of four variables found on the MDS:

Decision Making—Range from Independent to Severely Impaired (0-3)

Short Term Memory (0-1)

Making Self Understood—Range from Understood to Never Understood (0-3)

Is patient comatose (0-1 and only available from the MDS)

Unfortunately, the summary functional screen data available to us required a large group for mild to very severe cognitive impairment. Finally, for the behavioral measures we used wandering (0-1) and physical abusiveness (0-1). The scoring shown in ***Exhibit G-1*** is consistent with the MDS and functional screen crosswalk the Department developed.

Exhibit G-1
Case Mix Measure for Nursing Facility-Community Comparison

Activities of Daily Living		
Score		**ADL**
0-1		Eating
0-1		Toilet use
0-1		Transferring
0-3		Summary measure (sum of items)
Cognitive Functioning		
Score	**MDS Cognitive Performance Scale Categories**	**Definition**
0	Intact	Independent in decision making, short term memory, and making self understood
1	Borderline Intact	Independent in 2 of the following measures: decision making, short term memory, and making self understood
2	Mild Impairment	Understood/usually understood by others, and independent/modified in decision making
2	Moderate Impairment	Usually understood by others, or modified independence in daily decision making
2	Moderately Severely	Moderate impairment in decision making and sometimes/never understood
2	Severe Impairment	Severely impaired decision making and not totally dependent for eating
2	Very Severe Impairment	Severely impaired decision making and totally dependent for eating or comatose
Behavior		
Score		**Indicator**
0-1		Wandering
0-1		Physically abusive
0-2		Summary measure (sum of items)

Appendix H

Assumptions for Calculating Spending Associated with Net New CMO Users

The key assumptions in estimating spending associated with net new CMO enrollees included the following.

- Remainder of the state trend in monthly net enrollment from 2001 to 2002 applied to CMO enrollment in the month following wait list elimination – 1.6 percent.

- Percent of CMO enrollment attributable to net new enrollees at wait list elimination – 4.2 percent based on DHFS estimates for 2001 and 2001.

	Monthly Change in Net Medicaid Nursing Home Users 12/99 to 3/03	**Monthly Change in Net Medicaid Nursing Home Users 1/98 to 12/99**
Fond du Lac	-0.07%	-0.28%
La Crosse	-0.25%	-0.31%
Milwaukee	-0.58%	-0.51%
Portage	-0.33%	-0.34%
Richland	-0.20%	0.00%
Remainder of the State	-0.16%	-0.26%