

FAMILY CARE

WALA recently co-signed a letter to the Legislative Audit Bureau with WHCA and WASHA. This letter details our concerns with the draft workplan for the evaluation of the Family Care program. The Legislative Audit Bureau hired the Lewin Group to evaluate the resource center and case management pilots. We have concerns about:

- the analysis of the performance pilot projects,
- validation of assumptions upon which the Family Care Program was founded and
- compliance with explicit statutory expectations.

In short, we want to be sure that the evaluation measures apples to apples at ALL LEVELS of care to allow a valid analysis - including assisted living, home care and nursing homes. We contend that the current Lewin Group workplan does not do that, contrary to the authorizing legislation. Call WALA if you wish a copy of the 5 page memo, or download off the WALA website at this link. Thanks to John Keefe for leading the charge for WALA in this analysis.

TO: Kate Wade
Program Evaluation Director
Legislative Audit Bureau

FROM: Tom. Moore, Executive Director, Wisconsin Health Care Assn.
Jim Murphy, Executive Director, Wisconsin Assisted Living Assn.
John Sauer, Executive Director, Wisconsin Assn. of Homes & Services
for the Aging

RE: Draft Work Plan - Evaluation of the Wisconsin Family Care Program

DATE: May 8, 2000

Thank you for affording us the opportunity to review and comment on The Lewin Group's proposed work plan for evaluation of the Family Care resource center and case management pilots.

As detailed below, we do not view the proposed draft acceptable for (1) analysis of the performance pilot projects, (2) validation of assumptions upon which the Family Care program was founded, or (3) compliance with explicit statutory expectations.

First and foremost, we are shocked that The Lewin Group proposal consciously ignores a key task which the state legislature, federal government, and we deem indispensable for evaluation of the pilots' performance and making informed decisions on the future of Family Care.

On page two of its work plan, The Lewin Group states the following:

“The draft work plan does not contain a plan to compare the costs of serving comparable individuals in the community to those in a nursing facility. While this requirement appeared

in the authorizing legislation for the evaluation and the proposal, it was not included in the budget Lewin submitted in response to the RFP. We plan on working with representatives of the nursing home industry to develop a work plan for addressing this issue. The availability of accurate data is a key concern. “

It is impossible to reconcile this position with the legislative mandate that specifically directed that the evaluation of Family Care Pilot Projects “*shall compare the costs of care in a nursing home, as defined in section 50.01(3) of the statutes, to the costs of care in the community and shall provide a breakdown of individual costs involved.*” 1999 Wisconsin Act 9, Section 9134 (3m). Moreover, it appears this critically important comparative analysis, expressly required under the statute and specified in the LAB’s RFP, was neither budgeted nor contemplated in The Lewin Group response to the RFP. This is difficult to comprehend.

The importance of the comparative analysis the statute required cannot be understated. Indeed, we are frankly perplexed that we are being placed in the position of having to seemingly advocate for inclusion of what is most certainly a most critical and obviously necessary component of an objective evaluation of the pilots.

The Family Care redesign initiative was devised, packaged, and promoted to the public and the legislature on the premise that persons presently receiving care in institutional settings could be cared for more cost-effectively in the community. Indeed, the program’s fiscal viability was almost entirely dependent on the assumption that enormous savings derived from reduced utilization of nursing facilities would subsidize the cost of the case management and expanded services and choices envisioned under the Family Care plan.

As immensely popular as this concept is, there unfortunately has been no data or studies offered to support the sentiment. Indeed, the studies that do exist, including those by DHFS, imply quite the opposite and demonstrate that the characteristics and care costs of the respective populations being served in the community and facilities are distinctly different. However, the state’s lack of appropriate data has precluded any definitive resolution of the issue and perpetuated continuous debate over the question.

“The absence of standardized assessment data has implications for program management as well as care planning. Although the State routinely receives copies of individual service plans and other client information, it has never made an investment in systematically processing or evaluating these data. The absence of uniform State level information on the psychosocial, health, functional and cognitive status of clients makes it difficult to make comparisons between COP population and nursing home residents. Yet these comparisons are essential if the state is to reach meaningful conclusions about the ability of the program to successfully divert persons from nursing home admission at an equivalent or lower cost....

If COP clients are more medically stable, have fewer nursing requirements and, perhaps, are less disabled, then we would expect lower average costs due to these factors alone. Stated another way, if we were to adjust for differences in health and functional status between the

two populations we might find that the adjusted costs for COP clients were as high or higher than in the nursing home. Although we hesitate to draw this conclusion without more information we would caution against the opposite conclusion. That is, we can find no clear evidence to conclude that COP is serving a population equivalent to that of the nursing home.”

“A Review of Community Based Long Term Care with Emphasis on Wisconsin’s Community Options Program”, By Mark Sager, MD, Department of Medicine and Preventive Medicine, Geriatrics Section, UW-Madison and Greg Arling, Phd, Center for Health Systems Research and Analysis, UW-Madison. April 1995 (Pages 24 and 31)

The Lewin Group Work Plan noted that “the availability of accurate data for individuals is a key concern” for performance of the comparison the legislature requested. As evidenced by the “Sager” report written over 6 years ago, this is not a revelation. Indeed, if the data existed, we perhaps would have not required the services of an independent evaluator. But the fact is, the conspicuous absence of accurate and adequate data has for the past four years stymied all efforts to substantiate the financial and operational assumptions that were driving forces in the development and design of the Family Care program. However, it was clearly the legislature’s intent that the Family Care pilots would be mandated, operated and evaluated in a manner that would provide uniform and reliable information necessary to verify those assumptions. The draft work plan we reviewed is clearly not consistent with that intent.

We also want to underscore the fact the comparative analysis of client characteristics, costs and outcomes in community and facility settings will be a necessary prerequisite for obtaining HCFA approval of the Family Care plan. To secure that approval the Department must demonstrate to HCFA that benefits provided under the proposed new system cost no more than under the current system. We find it difficult to believe that such a showing could successfully be made absent an apples-to-apples analysis demonstrating that Family Care has been able to more cost-effectively provide care of comparable quality in the community to a population that possesses essentially the same client characteristics of those individuals presently being served in nursing facilities.

Accordingly, we submit that the Lewin Group, DHFS, and the pilot counties must be directed to uniformly seek and secure client specific data on the socioeconomic, health, functional, and cognitive status of the populations being served through the pilots in the community. That information should be linked with client specific data on service delivery and cost of care. This linkage is essential, not only for compliance with the legislative mandate, but more importantly for the objective evaluation of the pilots’ performance and the fiscal and clinical feasibility of the proposed Family Care long term care delivery system.

We also contend the evaluation of individual service costs of pilot program participants, must necessarily track and tabulate differences in participant Medical Assistance Card costs. Prior evaluation of community care clients under the COP-W program revealed that this population experienced 86% higher card costs than nursing home residents. The point being that savings that may be achieved by community placement of individuals under Family Care, could be reduced or

eclipsed by the increased cost of the additional primary or acute care services they require which are paid for by Medicaid but not included in the Family Care benefit. Clearly, the manner in which the Family Care program is operated could have significant cost implications for other aspects of the Medical Assistance program. This issue speaks not only to cost but to quality and the clinical outcomes experienced by persons placed in the community.

As you are aware, the comparability of client population, cost, quality and outcomes between community and facility placement are long standing issues which have been emotionally debated but never rationally resolved. The legislature intended that the documented experience of the Family Care pilots and the objective evaluation of that experience by an independent contractor would put an end to that debate.

We do recognize that the work plan we received is only a draft. We also recognize that The Lewin Group has indicated a willingness to work with DHFS and industry representatives to develop a work plan for the comparability study. However, two things are troublesome. First, Lewin has indicated it has not budgeted for conducting this task. Accordingly, how will Lewin or the State propose to cover the cost of performing the undertaking? We consider the undertaking to be a major component of the evaluation that should given immediate priority in allocation of the contract effort and funding.

Second, since three of the CMO's are already operational time is of the essence in developing a work plan which would identify the data elements necessary to complete the tasks. A game plan for data collection will be most effective if in place before the game commences. While Lewin indicates it plans on working with agency and industry representatives to develop a work plan, it is critical that pilots are presently collecting the data necessary to make that plan work. We can ill-afford to be in a position in a year or two down the road where the plan cannot be executed due to a lack of appropriate data. We have too often run into that situation in the past, where the state maintains the counties don't provide the data, and the counties counter that the state never asked. The type and scope of data that will be necessary must be identified up front and the respective responsibility for its collection and accountability for its accuracy be made clear to all parties.

We underscore that the necessary ingredients for an acceptable work plan, meeting the expectations of current legislation, were long ago formally presented to DHFS during discussions on this very issue. We are attaching a copy of an analysis of DHFS' "Family Care Cost Model Database" which was conducted by Keefe and Associates in September of 1998. In addition to identifying flaws in the department's database, the Keefe analysis lays out the rational parameters of an objective evaluation to compare costs of persons in nursing facilities, assisted living facilities, and other long term care settings. We now, as then, contend the evaluation must:

- 1. Classify enrollees by acuity levels;**
- 2. Identify and include all (Family Care) costs for all acuity level classifications, including administrative and overhead cost allocations;**

3. **Identify and include all (Family Care) services (including informal support systems) provided for all acuity level classifications;**
4. **Identify and include all payor sources involved (including Medicaid card costs and county over-match dollars).**

Clearly, there can be no meaningful comparisons without assessment of acuity levels--with all services, costs, and payor sources being identified and quantified. Without consideration of differences in acuity of the respective populations being served, the comparison of community and nursing facility costs would be incomplete, insufficient, and some might suggest farcical.

It is particularly relevant to recognize that many county officials readily admit that, at least for the first few years of the CMO pilots, it will be their intent to focus enrollment on individuals who are 1) at a relatively low acuity level and 2) are projected to consume relatively few long-term care dollars. In other words, “creaming” of clients for the Family Care program will occur. Absent comprehensive acuity, quality, and cost data spanning the long-term care continuum of services and care levels, a sound empirical evaluation is not possible.

The Lewin Group’s draft plan presented three alternatives for data collection. Alternative 1 - relying solely on HSRS/MEDS data - is simply unacceptable. The inaccuracies and inadequacies in this database are many and well documented. While we recognize the state has made adjustments to the HSRS/MEDS database since its prior rate-setting calculations, its appropriateness and reliability for an undertaking of this magnitude and importance remains unproven.

We recommend two other requirements for the database development:

1. Link the cost database to the **functional screen indicators** used by the Resource Centers: this is a realistic and readily available tool to develop the comparable acuity levels needed.
2. Avoid sampling techniques as proposed in alternative 3. The number of enrollees will be limited, and sampling will only erode the ability to generate statistically reliable data, especially in the smaller counties and for acuity levels with few numbers. Furthermore, it is essential to recognize the distinctions among the pilot project counties (especially urban and rural), and sampling is likely to obscure such distinctions.

We are compelled to note it is extremely disconcerting to witness the frequent references to MEDS data that appear throughout the work plan draft . They infer a predisposition to employ it as the only data source for this analysis. Indeed, the references and the context in which they are used, make it appear the decision has already been made to rely solely on MEDS data, to the exclusion of other key data sources that must be developed as part of the evaluation.

Similarly disturbing is the work plan's disproportionate emphasis of the objectives on non-cost issues. The lack of objectives relating to appropriateness of care, regardless of setting, also cause us concern.

The Lewin Group, in conjunction with the Legislative Audit Bureau, has an unparalleled opportunity to develop an evaluation that objectively addresses the true costs of care under the program, by acuity levels, as well as the equally important access and quality issues. Such an evaluation would be a lasting contribution to long-term care in Wisconsin, as well as a possible model for similar initiatives in other states. We encourage your efforts to assure an objective evaluation of true value.