

**Tracking Outcomes for a Touched by MIG Population:  
An Opportunistic Approach from Wisconsin**

**Barry S. Delin  
David Sage  
Stout Vocational Rehabilitation Institute  
University of Wisconsin – Stout**

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**The descriptions and interpretations in this paper are those of the authors and do not necessarily reflect those of the Wisconsin Department of Health and Family Services, CMS, or the University of Wisconsin – Stout. All data appearing in this paper are strictly for illustrative purposes.**

## Introduction

The purpose of this paper is to describe a Medicaid Infrastructure Grant (MIG) outcome tracking system being piloted in Wisconsin. This includes a description of the system in its current stage of development and why design choices were made. We also discuss the system's limitations and provide some examples of the types of analyses the system supports. We characterize the development of the system as "opportunistic." By this characterization we seek to connote that (1) the system was constructed external to any existing Wisconsin state agency database and (2) we utilized resources that were fortuitously available due to data agreements that were negotiated for reasons other than setting up a MIG outcome tracking system. We do not contend that other states can or should duplicate the Wisconsin experience. We do not argue that the choices that Wisconsin made in defining populations or in organizing the tracking system will serve other states needs or are the optimum ones for Wisconsin itself. We offer our experience mainly to inform other MIG states' efforts to develop their own approaches.

States applying for MIG (Medicaid Infrastructure Grants) Comprehensive Grants have been expected to either have or develop an "outcome tracking system." These states are expected to be in the process of developing a "comprehensive employment system" that will support gains in employment rates and economic progress for persons with disabilities. The outcome tracking system is expected to measure progress toward these goals. In addition, the outcome tracking system is expected to support tracking of health status.<sup>1</sup> Though CMS has not yet distributed materials for the 2009-11 funding cycle, there is every reason to expect that this requirement will continue and, perhaps, be strengthened. Some form of this requirement appeared in the materials for the 2005-08 funding cycle and, most likely, earlier. The Wisconsin MIG project narrative for 2004 contains language stating that staff will explore how state level estimates of the employment dynamics of the population eligible to use a Medicaid Buy-in might be made.

It has long been clear that the MIG grants, particularly the comprehensive grants, are intended to improve employment outcomes for a population larger than current Medicaid Buy-in participants. Yet, using a phrase coined by the late Steve Knapp, just who constitutes the "Touched by MIG population?"<sup>2</sup> According to the MIG 2008 continuation announcement, "...States participating in this grant program will use funds to remove the barriers to competitive employment of persons with disabilities by creating systematic change throughout the Medicaid program or by bridging Medicaid and other programs to further remove barriers."<sup>3</sup> Elsewhere in the material there are references to specific programs including Medicare and the Social Security disability programs.<sup>4</sup>

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<sup>1</sup> The authors are unsure of what CMS means by "health status." Our understanding is that CMS may be referring to information about public and, possibly, private health care coverage. It is also possible that the reference is to health condition and/or health care service utilization.

<sup>2</sup> Stephen Knapp was a CMS (The Centers for Medicare and Medicaid Services) employee who provided guidance and technical advice to the MIG grantees in areas such as data reporting and evaluation.

<sup>3</sup> 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. Baltimore, MD: Center for Medicaid and State Operations, The Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. p. 5.

Nevertheless, there is no material in the 2008 continuation announcement or, to the authors' knowledge, elsewhere that explicitly defines the boundaries of the "Touched by MIG" population.<sup>5</sup> Hypothetically, it could include anyone who might ever be eligible at some point in their lifetime for Buy-in participation.<sup>6</sup> To the extent that one might wish to define a less expansive population that is still broader than current Buy-in participants one must consider which definition of disability to use. Some possibilities include persons covered under the Americans with Disability Act, self-identified disability by census definitions (e.g., "employment disability" on the American Community Survey), or persons who meet the Social Security disability standard (whether or not the Substantial Gainful Activity (SGA) criterion is applied).

### **Wisconsin MIG Builds Its System**

The Wisconsin MIG initially viewed the task of building a MIG outcome tracking system as requiring one or more state agencies to design a system and to enter into data use agreements with other agencies to provide data for that system. In the authors' judgment, little progress toward this was made over the years. In part, this was due to the lack of interest by state entities outside the small agency responsible for the MIG (the Office of Independence and Employment (OIE) in the Department of Health and Family Services (DHFS)). In part, it was that OIE was more immediately concerned with designing and implementing programmatic efforts under the MIG. However, by 2006, the authors (who are university based research staff housed at OIE) decided it would be possible to pilot a small scale MIG outcomes tracking system without the direct involvement of other state agencies.<sup>7</sup>

It was always understood that a MIG outcome tracking system would, at minimum, require a source of information about Medicaid, including Medicaid Buy-in, participation and also a source of information about competitive employment and earnings. In Wisconsin, the most likely source of such employment information was the Unemployment Insurance (UI) records housed at the Department of Workforce Development (DWD).<sup>8</sup>

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<sup>4</sup> 2008 Edition-Announcement, Medicaid Infrastructure Grant, To Support the Competitive Employment of People with Disabilities, HHS-2008-CMA-MIG-0001. 2007. p. 6.

<sup>5</sup> In addition to checking available CMS documents, we asked staff at the National Consortium for Health Systems Development (NCHSD) and MIG-RATS (Medicaid Infrastructure Grants Research Assistance to States) whether they were aware of any explicit definition of the population for which MIG funded efforts are expected to motivate or support better employment outcomes. They responded that they were not aware of any explicit definition from CMS.

<sup>6</sup> This is especially true for states such as Wisconsin that operate Medicaid Buy-ins authorized under the 1997 Balanced Budget Act. A BBA Buy-in has no age after which either eligibility ends or cannot be established.

<sup>7</sup> We acknowledge the contribution of Anne E. Reither of MIG-RATS to our early thinking about how an outcomes tracking system might be piloted within the Wisconsin MIG itself.

<sup>8</sup> For reasons similar to IRS records, Wisconsin Department of Revenue individually identified tax data are essentially impossible to obtain. No Medicaid or other DHFS records include ongoing employment and earnings data for program clients on anything shorter than an annual basis.

OIE already had a data use agreement with DWD for access to individually identified UI records for evaluation and policy development purposes. This agreement was originally entered into to aid the evaluation of Wisconsin's State Partnership Initiative demonstration, but had been expanded to include evaluation and policy development related to the Medicaid Buy-in. Gaining access to relevant Medicaid data proved the larger challenge.

Although both OIE and the primary custodian of Medicaid data, the Division of Health Care Access and Accountability (DHCAA) are located within DHFS, DHCAA is a HIPAA covered entity, while OIE is not. Thus OIE needed to negotiate a data use agreement with DHFS to obtain data for evaluation and policy development purposes. An agreement was concluded in September 2006. While not negotiated for the purpose of setting up an outcome tracking system, the authors thought and OIE management agreed that the language of the data use agreement would support that effort.

### Defining a "Touched by MIG" Population

The single most important decision that needed to be made to design a Wisconsin MIG outcome tracking system was to choose the population of interest. In doing this we had practical as well as conceptual concerns. While it would be crucial to define a population that allowed one to obtain useful information about the employment status of persons with disabilities, especially persons who use or might use the Medicaid Buy-in, it was also essential that one defined a population for which one could collect meaningful and reasonably consistent information over time.

Our first choice was to limit our population of interest to those Wisconsin residents of "working age." The purpose was to limit our analysis to an age range that in the general population would be expected to have high rates of ongoing labor force participation. We chose to adopt the convention used in the Census Bureau's American Community Survey (ACS): ages 21 through 64. Doing this had the advantage of supporting comparisons with annual ACS data from Wisconsin, the U.S., or other states. This would include data for a self-identified population with disabilities and various disability categories within that population.<sup>9</sup> However, one consequence of this choice was to eliminate some Wisconsin Buy-in participants from our touched by MIG population.

Our next choice was to limit our population of interest to those in the age 21 through 64 age range who had established that they had met the Social Security disability standard (except the SGA exclusion). In addition to including those in the SSDI and SSI programs, in Wisconsin this includes persons who have established eligibility for Medicaid for reason of disability or eligibility to the Medicaid Buy-in without other eligibility to either a Social Security disability program or Medicaid. Though this choice certainly includes a broad range, indeed the likely majority, of those theoretically eligible for the Buy-in, it does exclude some groups of interest. By definition it excludes those persons who would meet the SSA disability standard, but for whatever reasons had not sought or not received a favorable disability determination. It also excludes persons who

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Moreover, such data has been both incomplete and inaccurate in the past, though substantial efforts are under way to correct that, at least in the context of managed long term care expansion.

<sup>9</sup> The ACS category of "employment disability" is of particular interest.

might be expected to soon reach a level of disability that would meet the SSA standard; that is, the target population for the CMS sponsored Demonstration to Maintain Independence and Employment. Additionally, as will be described in the next section, there are data availability problems that result in excluding a significant (but still unknown) number of those meeting the Social Security disability standard from the Wisconsin “Touched by MIG” population.

### Sampling and Data

We decided to use samples from our defined “Touched by MIG” population for practical considerations. As the pilot MIG outcome system would be maintained outside official state data systems as a “test bed,” we decided to use an available, off the shelf software that would support simple, spur of the moment analyses of the data: Microsoft Excel. Our version of Excel sets an effective upper limit of approximately 65,000 cases.<sup>10</sup>

We drew our sample of cases from Medicaid records. Over recent years, the number of individuals ages 21 through 64 who have Medicaid eligibility for reason of disability has approached 100,000. Thus the use of Excel necessitated sampling.

In Wisconsin, roughly 10% of those in the relevant age range with Medicaid eligibility for reason of disability are, at any given time, Medicaid Buy-in participants. SSI recipients are automatically eligible for Medicaid in Wisconsin. SSDI beneficiaries do not have automatic eligibility. Thus, the WI outcome tracking system has the limitation of excluding some number of SSDI beneficiaries.<sup>11</sup>

We decided to have two separate sub-samples. The first sub-sample was that for Medicaid Buy-in participants. As we thought OIE would be especially interested in the employment dynamics of Medicaid Buy-in participants and given the fact that these individuals constituted only about 10% of our operative “Touched by MIG” population, we decided to use a 50% sample for this group. Taking a 5% sample of others in Medicaid for reason of disability resulted in a second sub-sample of roughly similar size. Thus, estimates of employment and earnings outcomes for the overall “Touched by MIG” population would have to be weighted to reflect the relative proportions of the sub-samples in the overall population of interest.

The two sub-samples include roughly 10,000 cases. We thought this number would result in reasonably accurate estimates for the defined population and the Buy-in and non-Buy-in subgroups within it. The 10,000 cases also had the advantages of being easy to manipulate in Excel and of allowing the data to be obtained at an acceptable

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<sup>10</sup> Data, of course, can be exported into statistical software with greater analytical capabilities.

<sup>11</sup> It should be possible to make a rough estimate of the number of these exclusions as those with concurrent SSDI/SSI eligibility have Medicaid eligibility and there is some Medicare information available for SSDI beneficiaries who have established Medicaid eligibility through the Buy-in or other non-SSI eligibility categories.

cost.<sup>12</sup> For reasons that will be explained in the next section, “Data System Structure,” new samples are drawn every January.

Employment outcomes data are drawn from Unemployment Insurance (UI records) on a calendar quarter basis. This data includes information about both employment and quarterly earnings. Because of UI reporting rules, essentially all reported employment is competitive. This fact and standardized data collection make UI data an attractive option for a MIG outcome tracking system.

However there are significant exclusions from the system. The most important of these are self-employment and out of state employment and the earnings derived from either. UI data also has significant limitations in assessing employment duration. One either has or doesn’t have UI employment in any calendar quarter. The quarterly data structure also makes it impossible to assess whether individuals’ earnings meet monthly benchmarks of potential interest such as SGA or the Trial Work Period threshold amount.<sup>13</sup>

Additionally, the pilot MIG outcome tracking system includes some demographic and geographic information available from the state’s Medicaid records. Available demographic data are (unfortunately) limited to age, sex and a race/ethnicity indicator. We also gather county of residency information. This is aggregated into seven regional areas that match the geographic regions for the Wisconsin MIG’s Regional Initiative project. At present, we do not draw health care utilization information, but in principle this could be added. Similarly, we could track individuals’ Medicaid eligibility and their eligibility category across time, including how long it has been since an individual entered either Medicaid or the Medicaid Buy-in. However, for the present, we use eligibility category as a static variable drawn from the specific time period used to draw a sample.

### Data System Structure

We think that a useful MIG outcome tracking system would have two capabilities. The first would be to measure or estimate changes in outcomes for relevant populations across time. The second would be to identify changes in the status of the overall system over time. These capabilities, while to some degree complementary, are not the same.

In particular, the members of the populations of interest change over time. People enter and leave the 21 to 64 age range. People may gain or lose Medicaid or Medicaid Buy-in eligibility. People die or move out of Wisconsin. In short, to track population outcomes means that one cannot continue to track the outcomes of the same individuals indefinitely.

However, the characteristics of relevant populations may change over time as well. Some of these changes may stretch over decades, for example the age distribution within a population. Others may occur very quickly. For example, changes in Medicaid

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<sup>12</sup> OIE pays for UI data. Also, we expect to increase the non Buy-in sample size to 10% in 2008 to support better estimates at the regional level.

<sup>13</sup> Additionally, the UI data allows identification of unique employers, albeit only on a calendar year basis. Unfortunately, our use of samples, especially sub-samples, raises difficult technical challenges to estimating total numbers of employers hiring individuals from the touched by MIG population.

eligibility rules can rapidly change the aggregate characteristics of those in the program or any particular eligibility category such as a Buy-in. One may end up comparing employment outcomes for very different “Touched by MIG” populations. The only way to fully avoid this type of analytical problem is to adjust the sample to reflect changes in population characteristics.

Our aim was to develop a data system structure that would allow us to look at both system changes and the progress (or lack thereof) of the same people, with the understanding that doing so would make it impossible to do either task in an optimum fashion. We found a model in the basic logic of the discontinued Survey of Income and Program Participation (SIPP).<sup>14</sup>

Each January we draw samples of working age Medicaid Buy-in and other Medicaid for reason of disability consumers. We then track the UI data for these individuals for the calendar quarter of the sample draw and eight successive calendar quarters. Thus the last data point for any sample is the first calendar quarter of the second year following the January in which the sample is drawn.

Consequently, there are always five calendar quarters of overlap with the samples drawn either the January immediately prior or following the January any particular sample is drawn. There is a one quarter overlap with the samples drawn from the January two years before or after, providing a single quarter in which to compare outcomes across three successive samples.

The payoff is that one gets to assess system status on a continuing basis by comparing different samples at or over comparable time points in their history, while also getting the full analytical benefit of true longitudinal tracking of individuals over a limited time period of nine calendar quarters. One may legitimately ask, “why only nine quarters?” The answer is that it is our current best guess as to how long it takes for the sample to drift unacceptably from being a good reflection of population characteristics. However, this is an answer that can be informed by further analysis.<sup>15</sup>

Nonetheless, our data system structure has an important limitation. Sometimes it is important to compare individuals relative to their time of entry into a Buy-in. The Wisconsin MIG outcome tracking system does not directly support analyses in “participant time.” To some extent, this problem could be addressed by adding a data element indicating initial entry into the Buy-in or other markers of public program entry or exit.

Finally, use of UI data involves some time lag. In Wisconsin’s case this is typically four or five months following the end of the calendar quarter of interest. There are even longer time lags involved with some health utilization data of potential interest.

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<sup>14</sup> Of course, our pilot outcome tracking system is far less sophisticated than the SIPP.

<sup>15</sup> In principal, it is possible to get information about age related entry and exit, death, movements into or out of Medicaid or Medicaid categories, and movement into and out of Wisconsin. The issue is one of resources. A somewhat similar problem is how to account for attrition from a sample over the nine quarters, as attrition can contribute to observed declines in employment rates or mean earnings. In the context of piloting a MIG outcome tracking systems we have deferred this issue, but may revisit it over the coming year.

These issues can become important in the context of reporting cycles, whether to CMS, state authorities, or other stakeholders.

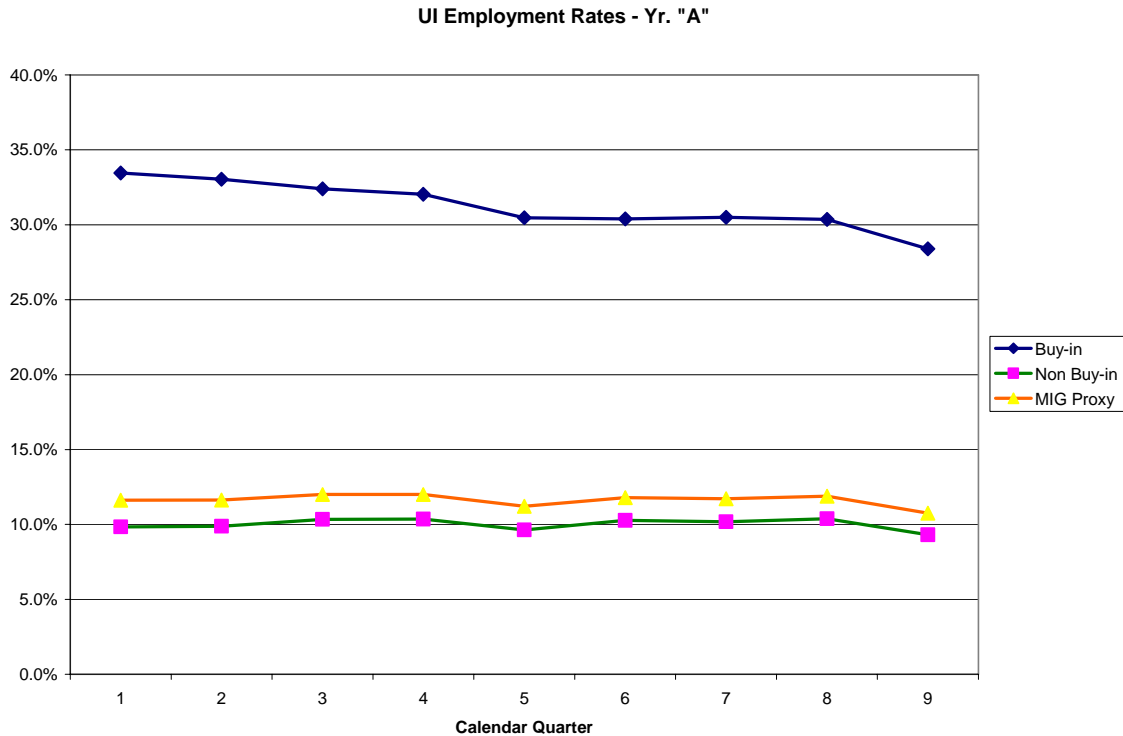
### **Examples of Applications**

In this section of the paper we display some examples of the types of analyses the Wisconsin MIG outcome tracking system currently supports. All of the examples are illustrative. Nothing should be inferred as to the actual employment and earnings trends associated with the Wisconsin MIG.

It is also important to note that no population level outcome tracking system by itself can be used to directly confirm any causal relationship between MIG activities and employment outcomes for a “Touched by MIG” population. Even the Medicaid Buy-in is relatively small in relationship to the relevant population. This is all the more the case in using a population level tracking system to assess the causal impact of specific projects funded or supported through a MIG. Nonetheless, it is relevant to ask whether the system as a whole is making progress toward desired goals. After all, facilitating such progress is the primary reason Congress established the MIG program.

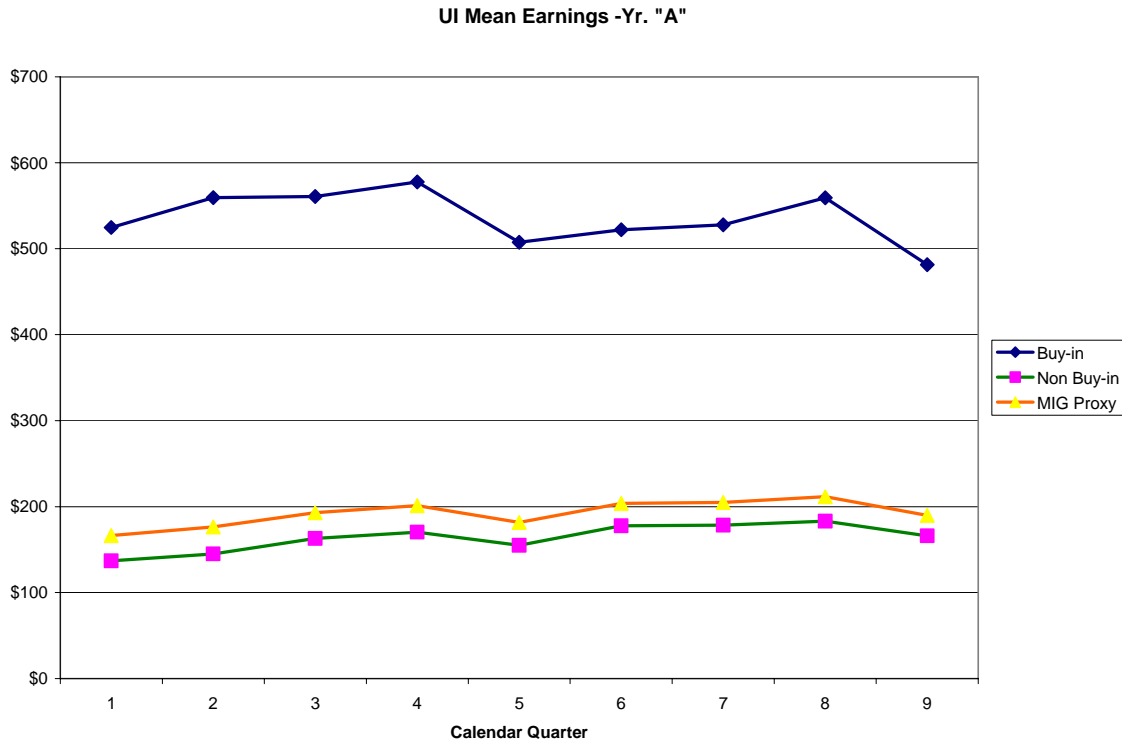
The first two charts display, respectively, estimated UI employment rates and mean earnings for the “Touched by MIG” population that was sampled in January of year “A.” In addition to providing information about the “Touched by MIG” population (called “MIG proxy” in the chart legends), the charts also display the trend lines for the Medicaid Buy-in and non-Buy-in components of the “Touched by MIG” populations. These charts display data for all nine quarters the sample is followed.

Chart 1: UI Employment Rates, for Touched by MIG, Buy-in, and Non Buy-in populations, from Year “A” Sample.



The data in chart 1 confirms that UI employment rate for Buy-in participants is substantially higher than that for either the “Touched by MIG” population or the non Buy-in individuals in that population. The fact the trend lines for the “Touched by MIG” population and the non Buy-in group within it track closely, reflects the much higher proportion of non Buy-in individuals (compared to Buy-in participants) in the Touched by MIG” population. An interesting feature of the data for all three groups (though most easily seen in the Buy-in group’s data) is the reduction in the UI employment rate over time. This phenomenon will also be observed in the chart 2 earnings data. An important analytical question is whether this effect solely represents decreases in employment outcomes or may also represent attrition from the population (e.g. death, migration out of Wisconsin).

Chart 2: UI Mean Earnings in Constant Dollars, for Touched by MIG, Buy-in, and Non Buy-in populations, from Year “A” Sample.

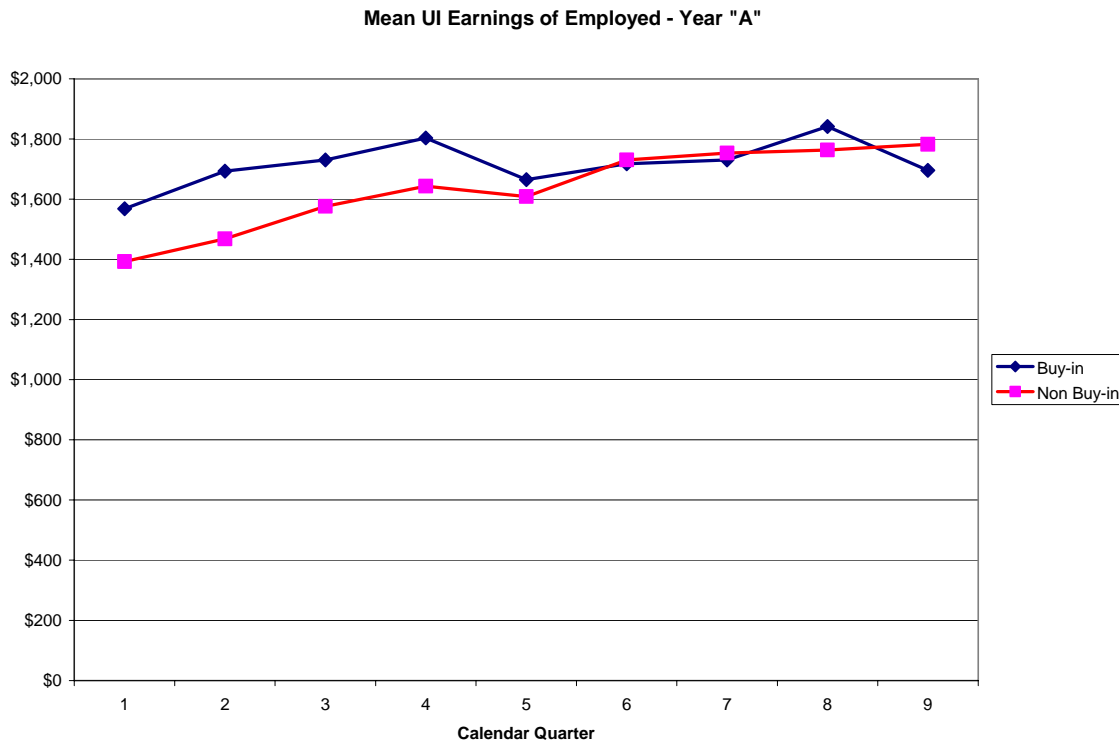


Note: Monetary amounts adjusted for changes in the CPI-U, August 2005 = 100.

The earnings trends observed in chart 2 are similar to those seen in the employment rate data. Earnings, in all charts, have been inflation adjusted using the Consumer Price Index for Urban Consumers (CPI-U). However, we have set our reference point at August 2005 instead of the 1982-84 baseline used in the published data. This was done to keep our adjusted data reasonably close to current dollar values. It is important to recognize that mean earnings data include all individuals in the population, irrespective of whether they have UI earnings. Sometimes, looking at just those individuals with reported employment can present a very different picture.

Chart 3 exhibits data for just those persons who have UI earnings data reported in any particular quarter out of the nine. Notice that the average earnings for both the Buy-in and non Buy-in groups are substantially higher than in chart 2 (the full "Touched by MIG" group isn't shown so as to make the subgroup data easier to see). However in our view, the more interesting observation is that the differences between those in the Medicaid Buy-in and those who are not are much less than observed in chart 2. Both the outcome levels and trends for both groups are markedly similar, especially over the last several quarters.

Chart 3: UI Mean Earnings for those with UI Employment in Constant Dollars, for Buy-in, and Non Buy-in Components of the Touched by MIG population, from Year "A" Sample.



Note: Monetary amounts adjusted for changes in the CPI-U, August 2005 = 100.

Note: N varies by calendar quarter based on UI reported employment.

Our first three charts focus on overall employment and earnings trends in the “Touched by MIG” population and participation (or lack of) in the Medicaid Buy-in. The three charts present examples of sub-group data. Such data might be especially useful in supporting program development and improvement for important demographic or experiential components of a “Touched by MIG” population.

Chart 4 displays UI rates from two different regions in Wisconsin. The Wisconsin MIG includes a major project (The Pathways Regional Initiative) aimed at developing and sustaining system change efforts responsive to issues and context in each of seven regions. The reader will note that on this chart, as well as charts 5 and 6, only seven quarters of data are displayed. This indicates that the data for the last two quarters of the nine were not available when this chart was prepared.

In this particular case, Region 2 exhibits somewhat higher employment rates across the available time period. However, the difference between the two regions’ employment rates also appears to be growing across time. While these data alone give no information about why this is so, it can alert the MIG staff, public decision makers, and other stakeholders, of the utility of further analysis and, possibly, for program development.

Chart 4: UI Employment Rates, for Touched by MIG populations in Regions One and Two, from Year “B” Sample.

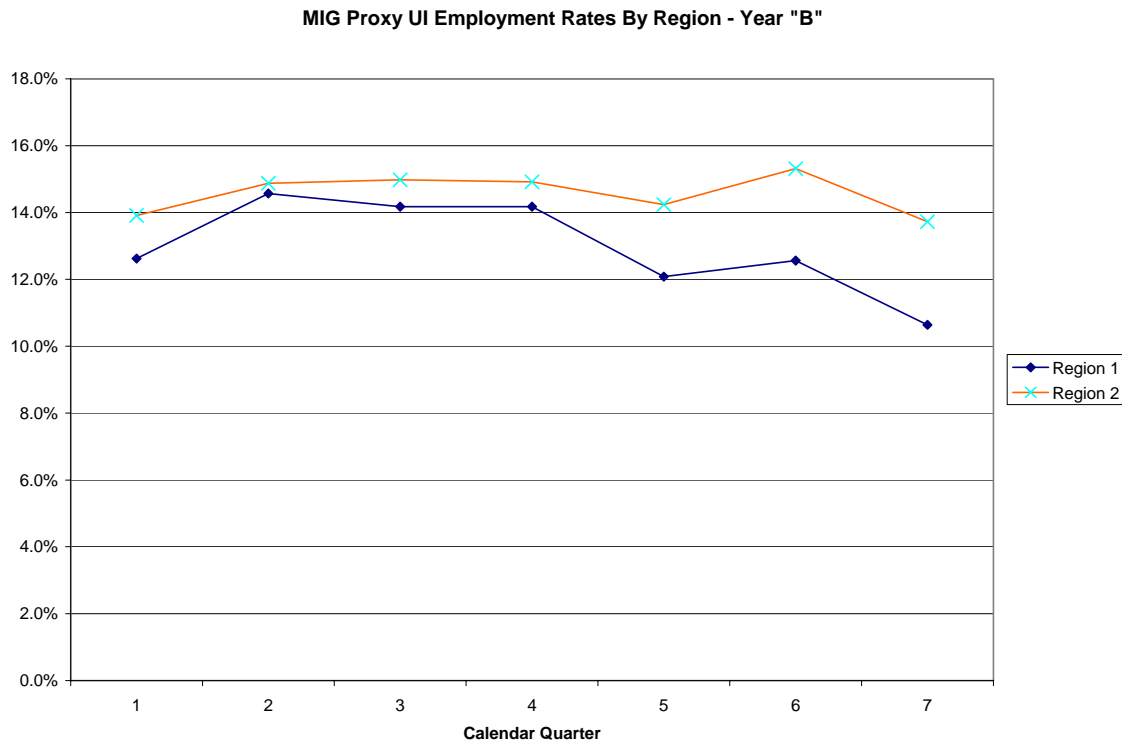
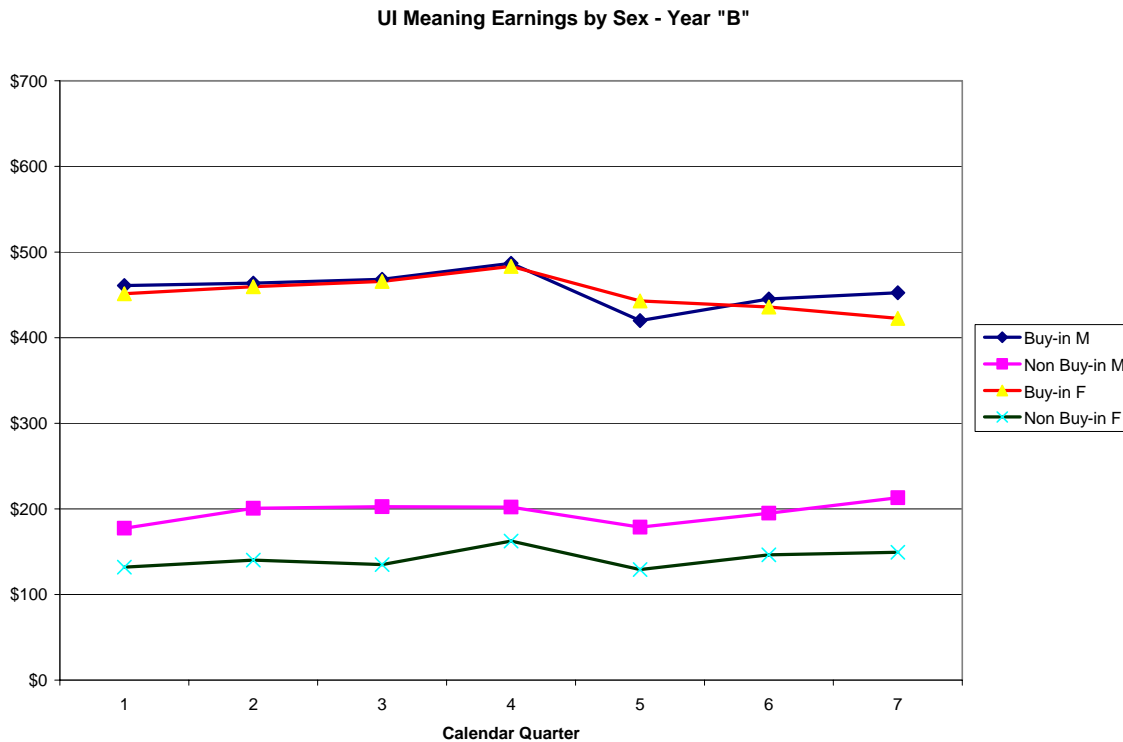


Chart 5 contains data that allows one to compare earnings trends for females and males based on whether individuals in the “Touched by MIG” population were in the Buy-in when the year “B” sample was drawn. It can serve as an example of the many types of subgroup analyses that might be performed with other socio-demographic data believed to be related to employment outcomes (e.g., education, race, age, work experience). In this particular example, we note that those in the Buy-in have higher mean earnings, irrespective of sex. We can also observe, that the differences between female and males are less among Buy-in participants than those who were not in the Buy-in when the Year “B” sample was drawn. Additional analysis would be needed to understand why the mean for females not in the Buy-in is lower than for males. Perhaps the main factor is a difference in employment rates; perhaps it reflects differences in pay rates or hours of work.

Chart 5: UI Mean Earnings in Constant Dollars, by Sex, for Buy-in, and Non Buy-in components of the Touched by MIG population, from Year “B” Sample.



Note: Monetary amounts adjusted for changes in the CPI-U, August 2005 = 100.

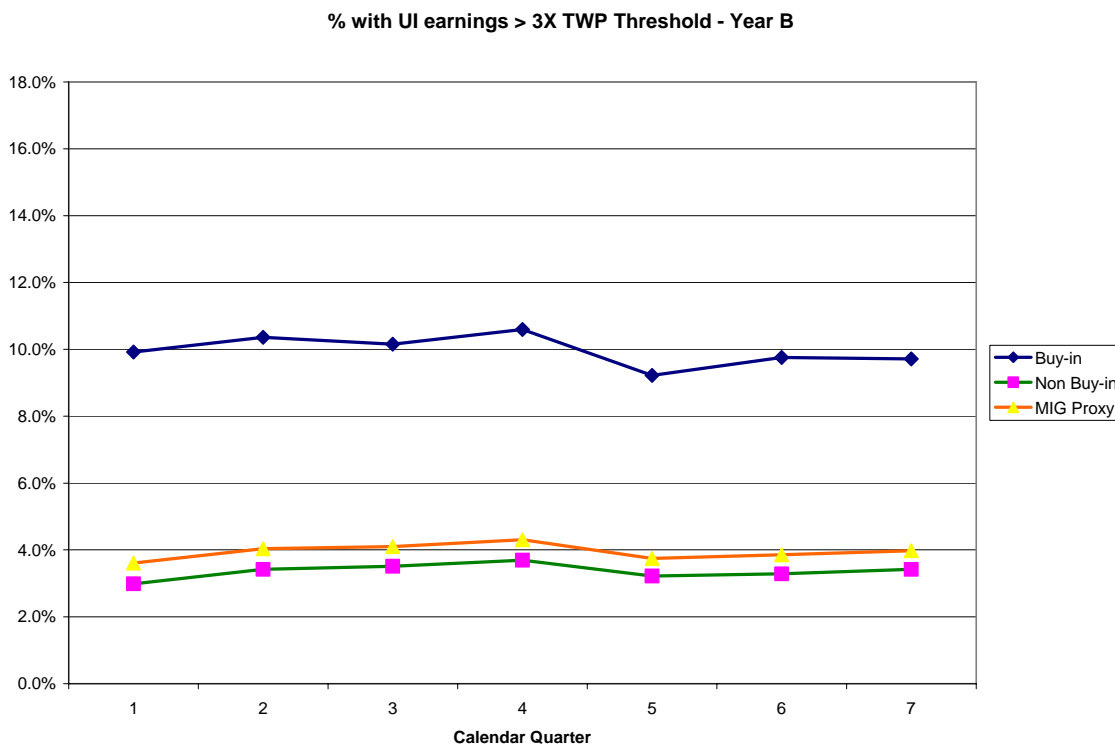
So far, we've concentrated on providing examples displaying measures of central tendency. It can also be useful to examine the distribution of outcomes either within a group or across multiple groups or time periods.

Chart 6 presents a simple example of a distributional outcome across time. In this example, we show how the proportion of those earning three times the Trial Work Period (TWP) threshold varies across time for the "Touched by MIG" population sample in January of Year "B."<sup>16</sup> We could as easily have displayed a different benchmark or multiple benchmarks (e.g., a series of markers related to some fraction or multiple of the poverty threshold).

The data displayed in Chart 6 suggests that Buy-in participants are about three times more likely to have quarterly earnings that meet or exceed the TWP monthly threshold level. Additionally, at least for the sample observed, the proportion of Buy-in participants with such earnings does not seem to change appreciably over the seven quarters of available data.

<sup>16</sup> The TWP Threshold is a monthly figure. For SSDI beneficiaries, who have not completed their TWPs, it identifies the amount of earnings that signal the use of one month of the nine month TWP. As such it denotes a level of earnings that the Social Security Administration recognizes as indicating a serious return to work effort. UI data is quarterly. Consequently, we have no direct measure of monthly earnings. Thus the proportions with 3 times TWP threshold figure serves as a proxy for the actual proportion with earnings at or above the TWP Threshold.

Chart 6: Percentage with UI Earnings Equal or Greater to Three Times the TWP Threshold in Constant Dollars, for Touched by MIG, Buy-in, and Non Buy-in populations, from Year “B” Sample.



Note: Monetary amounts adjusted for changes in the CPI-U, August 2005 = 100.

Note: The August 2005 value of the TWP was \$590. Three times that amount (the quarterly equivalent) equals \$1770.

To this point, all of the charts have focused on data drawn for only one sample. The last two charts display data drawn from two samples drawn in two successive years. Quarter 1 on each chart represents the first quarter of data for each “Touched by MIG” sample, however (in this example) calendar quarter one for the “A” sample occurred one year earlier than quarter one for the “B” sample. Also, note that the full data series is not displayed for the “B” sample.

Charts 7 and 8 essentially replicate charts 1 and 2, though with the addition of the year “B” data. We could have also have redone charts 3 through 6 to display data taken from multiple samples. A quick comparison of employment rates in chart 7 and mean earnings in chart 8 suggest that “conditions on the ground” have not changed appreciably over the single year between when each “equivalent” calendar quarter occurred. Of course, the goal of the MIG is that when one looks at multiple samples one would see (1) either later trend lines being higher than earlier ones and/or (2) later trend lines being steeper than earlier ones.

Chart 7: UI Employment Rates, for Touched by MIG population, from Year "A" and "B" Samples.

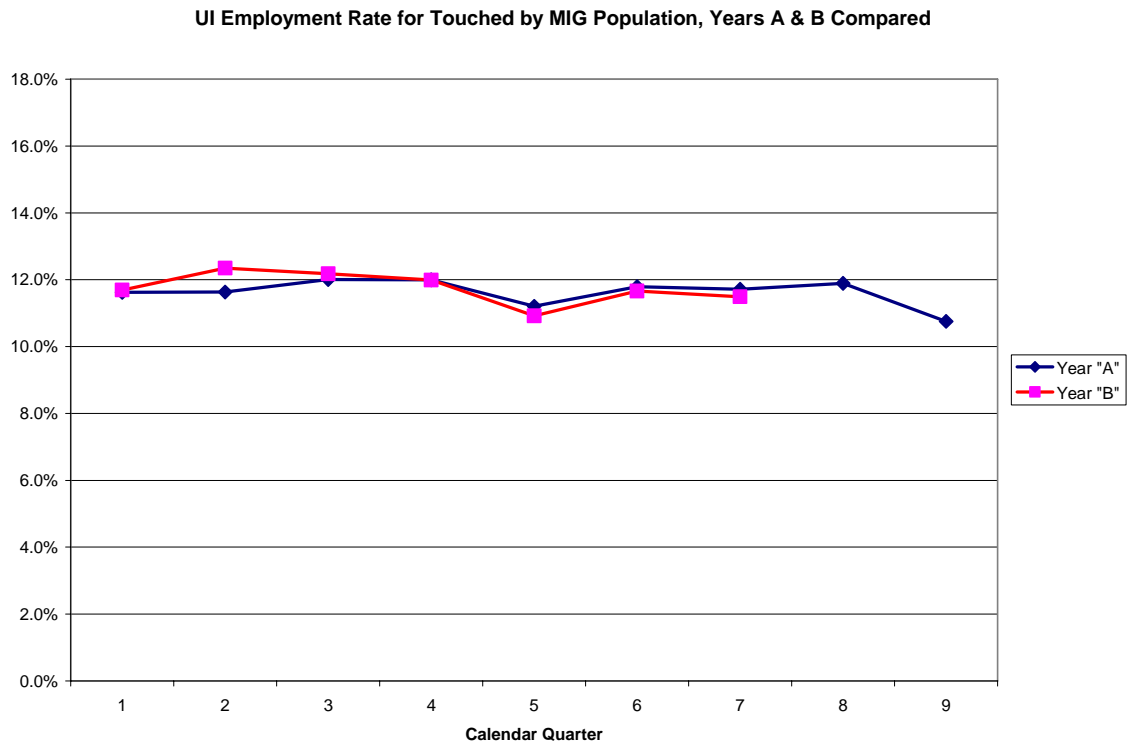
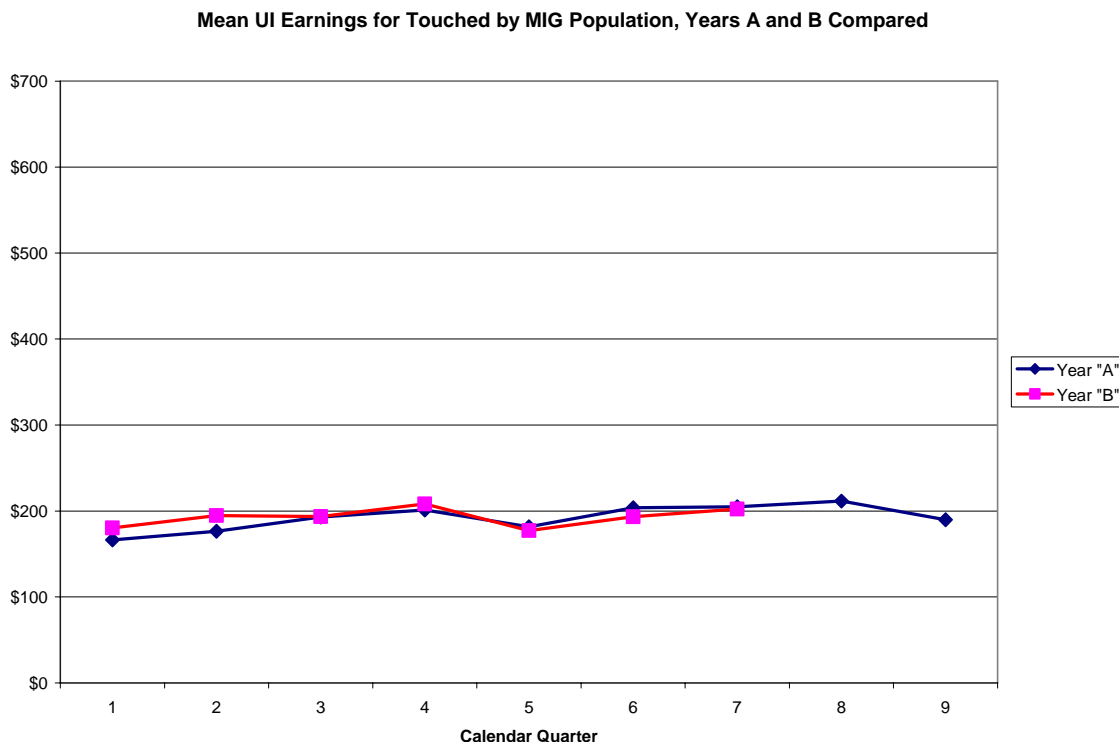


Chart 8: UI Mean Earnings in Constant Dollars, for Touched by MIG population, from Year "A" and "B" Samples.



Note: Monetary amounts adjusted for changes in the CPI-U, August 2005 = 100.

### How the Wisconsin MIG Outcome Tracking System Has Been Used

The main purpose for constructing a MIG Outcome Tracking System is to provide information about how much progress is being made toward achieving the ultimate goals of the Medicaid Infrastructure Grant program and associated federal efforts. As previously discussed, there is some ambiguity to this task as the scale of the MIG is modest compared to the scale of the system MIG is expected to move. To the extent that MIG can be expected to lead to better employment outcomes for persons with serious disabilities, system change must be driven by both explicit MIG efforts and other efforts, public and private, that can be said to occur in the shadow of MIG.

In brief, what can be said about the use of the system in Wisconsin to date? The only explicit use has been to provide reporting information to the funding entity (CMS) and its agents. At least initially, MIG managers did not seem to have a good understanding of which numbers would best serve their reporting needs. The distinction between reporting changes within a particular sample over time and between samples proved somewhat difficult to explain, as was the implications of only being able to follow any particular sample nine quarters. With about a year of experience, it appears that MIG managers have a better understanding. The converse also appears true. Those who developed the system (that is, the authors) have become somewhat better at explaining the capabilities and limits of the system for reporting purposes.

At present there is no evidence that MIG staff have used the system to develop or improve programs. In part, this is a reflection of the frankly developmental nature of the system. Reports of findings, outside of CMS reporting, are still ad hoc and driven largely by what the university staff finds interesting rather than by requests from MIG managers and program staff. It is also likely that the range of data elements currently collected are of limited use for targeted program development or assessment. This is remediable to some degree, as it is possible to add additional data elements available from Medicaid records and other Wisconsin Department of Health and Family Services data sources. Yet there are ultimately limits on what can be done utilizing two or three individuals' "extra time" and the opportunistic use of pre-existing data agreements. At some point, Wisconsin may need to revisit the option of building a sophisticated multi-agency database to link information pertinent to tracking and understanding employment outcomes for those with serious disabilities.