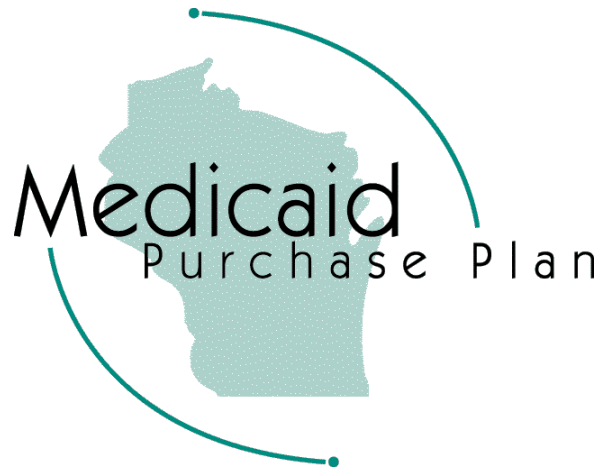


Medicaid Purchase Plan Evaluation Annual Report



for

Office of Independence and Employment,
Department of Health and Family Services

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Submitted by:
APS Healthcare

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I. Executive Summary

Under a contract with the Department of Health and Family Services (DHFS), Division of Long-Term Care, Office of Independence and Employment (OIE), APS Healthcare (APS) is conducting an ongoing evaluation of the Medicaid Purchase Plan (MAPP). This annual report summarizes findings from year seven of the evaluation, from January 2007 through December 2007.

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new Medicaid subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level (\$25,525 in 2007 for an individual). In Wisconsin, this subprogram is called MAPP. MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000. The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

The evaluation of MAPP conducted by APS began shortly after program implementation in 2000. This year's Annual Report is focused on analyses developed throughout 2007 to address specific questions regarding MAPP, or results of long-term analyses completed in 2007.

Since the program's inception, MAPP enrollment has grown steadily. As of December 2007, a total of 20,583 individuals had ever been enrolled in the program – nearly double the number enrolled as of December 2004. Active enrollment through December 2007 reached 12,051, an increase of 1,339 program participants over the same month in the prior year. By comparison, from December 2005 to December 2006 the program only experienced a net increase of 537 participants.

The majority of participants (61%) are between the ages of 45 and 64, as in 2006 and up slightly from 2004 and 2005. Overall, the MAPP population is split evenly between males and females, although the proportion of males and females varies across age categories. In December 2007, MAPP participants had earned income ranging from \$0 to \$5,280 per month with an average of \$185 and a median of \$36.¹ The 2007 figures represent a continued decline in average earnings, reflecting an increase in the number enrollees, most of whom enter MAPP with very low cash earnings from work.

¹ These figures include 11,976 participants with income information available through the CARES system. Earned income figures represent monthly earned income reported by participants through CARES as of December 2007.

MAPP participants whose gross individual income exceeds 150% of the federal poverty level for their family size (FPL) are subject to a premium². The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium has dropped from 13% in 2002 to about 6% in 2007. The sum of all premiums collected in December 2007 was \$144,625. From January 2002 through December 2007, MAPP premiums have generated almost \$7.4 million. During the 2007 calendar year, premiums totaled \$1.7 million.

In addition to regular reporting conducted in 2007, APS conducted an expenditure and utilization evaluation comparing MAPP program participants and a matched group of Medicaid enrollees. For both MAPP participants and a similar group of Medicaid enrollees, total spending rose by about \$300 per person per month between 2000 and 2005 and dropped by about \$300 per person per month from 2005 to 2006, when Medicare Part D prescription drug coverage began. Managed care capitation payments began rising faster after 2005 when Wisconsin implemented managed care for adults with disabilities. An analysis of expenditures by MAPP subgroups was also conducted. This included comparisons based on MAPP eligibility, gender, age, RUCA code (rural vs. urban), enrollment cohort, and SSI status.

To complement the expenditure and utilization subgroup analysis that compared enrollment cohorts, this report contains a follow-up to the cohort comparison conducted in 2005. A fourth cohort comprising MAPP enrollees whose first enrollment followed the implementation of Medicare Part D (late 2006/early 2007 enrollment) was compared to the first three cohorts – original enrollees, post-automation enrollees, and late 2004 enrollees. The number of enrollees over the age of 50 has gradually increased from 38.4% in the first group, to 46% in the second, to nearly 50% in the third, and to 52% in the last cohort. This increase can be attributed to an increased percentage of new enrollees aged 50-59. In the cohort of original enrollees, just under one half of enrollees (47.5%) were female. This slight imbalance has shifted over time, with females representing just over half of 2006/2007 enrollees (52.1%). The percentage of premium payers has decreased from 17.1% in the initial enrollee group to 7.8% in the late 2004 enrollee group. Although the decrease in percentage of premium paying enrollees has been documented in monthly reports, this analysis clearly shows that it is the more recent enrollees who are entering the program under non-premium paying Medstat codes.

The MAPP Participant Survey was also completed in 2007. The survey points a very low income working disabled population that needs some support to continue working or increase their work. The survey provides more information on barriers that prevent MAPP enrollees from working or earning more. Information was collected on the nature of enrollees' disabilities, the success of employment support and outreach, and the impact of Medicare Part D, a prescription drug program in which dually eligible MAPP enrollees were forced to enroll beginning in January, 2006. This report contains a condensed version of the full survey report.

Based on the findings from year seven of the MAPP evaluation, OIE, in conjunction with APS, has developed a detailed list of 2008 activities and analyses to be conducted as part of the year eight MAPP evaluation. These activities are designed to strengthen the findings presented in this

² \$15,315 for an individual in 2007

report, but more importantly, to fill gaps where specific program and policy questions remain unanswered. The evaluators will examine the following topics.

- Develop additional analyses based on participant survey data, including but not limited to:
 - Further examine self-employment and in-kind income among MAPP consumers.
 - Examine employment outcomes and barriers among specific subsets of MAPP consumers, such as those earning at substantial levels and those with very low or no earnings.
- Conduct a cost comparison of enrollees using HIPP (Health Insurance Premium Payment).
- Collect more information on utilization of IAs (Independence Accounts), IRWEs (Impairment Related Work Expenses) and MREs (Medical & Remedial Expenses) – perhaps among a subset of MAPP consumers.
- Consider methods for collecting data on participants who earn at substantial levels but disenroll from MAPP
- Assess the need for development and implementation of a second survey of county economic support workers.

II. Background

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new Medicaid subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level (\$25,525 in 2004 for an individual). In Wisconsin, this subprogram is called the Medicaid Purchase Plan (MAPP). MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000.

Evaluation Contract

Under a contract with the Department of Health and Family Services (DHFS), Division of Long-Term Care, Office of Independence and Employment (OIE), APS Healthcare (APS) is conducting an ongoing evaluation of the Medicaid Purchase Plan (MAPP). This annual report summarizes findings from year seven of the evaluation, from January 2007 through December 2007.

APS offers diversified health care consulting services, specializing in data analysis and reporting, program evaluation, survey administration and other technical health care services.

Evaluation Components

The initial MAPP evaluation had three components: impact, fiscal and process. The impact evaluation examined the effects of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitored the effects of MAPP on state and federal Medicaid funding and examined the effects of MAPP on locally funded long-term care services. Finally, the process evaluation determined if the program was implemented equitably across the state and whether the program was efficient and effective.

The MAPP Annual Reports in years 1-3 (2001-2003) emphasized the impact, fiscal, and process evaluation components, and elements of these components have been continued. However, more recent reports are organized differently, focusing on analyses developed after the initial evaluation period to address specific questions regarding MAPP, or results of long-term analyses that reached completion. Many of these analyses contribute significantly to MAPP policy discussions, while others provide a deeper understanding of the “on-the-ground” operation of the program.

III. Program Overview

Program Goals

The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Eligibility Criteria

In order to be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years old. They must be determined to be disabled by the DHFS Disability Determination Bureau (DDB). Participants must also be working or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under \$15,000. Countable assets include items such as cash savings, life insurance policies, and stocks and bonds, but do not include an individual’s home or vehicle.

Program Features

In addition to providing health care coverage, the MAPP program includes a number of features designed to foster independence.

Enrollment in the Health and Employment Counseling (HEC) program provides individuals an opportunity to enroll in MAPP to secure health care coverage, while seeking employment. Enrollment in the HEC program temporarily fulfills the MAPP work requirement by requiring development of an employment plan consisting of benefit counseling, employment barriers assessment, and a plan to address all identified barriers to employment. Upon approval of the employment plan, the MAPP work requirement is waived and the applicant becomes eligible for the MAPP program for at least nine months, with the opportunity for a three-month extension if necessary. If the enrollee remains unemployed after the three-month extension, he/she loses MAPP program eligibility. The HEC program is administered by Employment Resources, Inc. (ERI) under contract with the OIE.

Once enrolled in MAPP, participants can establish Independence Accounts (IAs), which are intended to foster savings for items that increase personal and financial independence. By

establishing an IA, MAPP participants can save earnings above the \$15,000 countable asset limit for the program. Total annual deposits to IAs can not exceed 50% of gross earned income each year.

MAPP policies include a work exemption provision for individuals who are sick and need to take off of work for a period of time. Participants who have participated in MAPP for at least six months are eligible for the exemption. The exemption itself can last up to six months and is limited to two exemptions every three years.

Health Care Coverage

The MAPP program offers health care coverage to eligible individuals. Family coverage is not available. However, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

MAPP participants are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL)³. Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Premiums Requirements

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals would be counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income.

Unearned income includes Social Security benefits, disability benefits and pensions. Adjusted unearned income equals total unearned income less the following deductions:

- Standard living allowance (\$740.00 per month for calendar year 2007)
- MAPP specific impairment-related work expenses (IRWEs), such as transportation to employment
- Medical and remedial expenses (MREs), such as attendant care

Earned income is income from paid or self-employment. Adjusted earned income equals gross earned income before taxes and any remaining income deductions from one's unearned income. In other words, if one's unearned income is less than the sum of the allowable deductions', the difference can be applied as a deduction to one's earned income.

Premium income is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives an \$850 monthly Social Security Disability Insurance (SSDI) payment and earns \$1,200 per month. He spends \$50 a month on cab fare to work and has \$10 in medical payments per month.

³ 150% of FPL in 2007 was \$15,315 annually (\$1,276 monthly).

Calculation of Monthly Premium

Monthly Unearned Income =	\$ 850
Less Standard Living Allowance	\$ 740
Less IRWEs	\$ 50
Less MREs	\$ 10
Adjusted Unearned Income	\$ 50
Monthly Earned Income=	\$1,200
Less Remaining Deductions	\$ 0
Adjusted Earned Income	\$1,200
	x .03
	\$ 36
	+ 50
Premium Income	\$ 86
Premium Amount ⁴	\$ 75

IV. Program Demographics/Participant Characteristics

Explanation of Data Sources

Data used in this section come from four sources: the Eligibility Trends Worksheet, a log of enrollment statistics based on quarterly reports; the Recipient Database from the MEDS Data Warehouse; the BadgerCare Database from the MEDS Data Warehouse; and CARES data.

APS Healthcare drew on several sources of data for the following analyses. For example, analyses including earned income will refer to CARES data, the only readily available repository for such data. However, data from CARES is not identical in format or content to data from other sources. Therefore, some calculations will be slightly different. For example, while CARES shows that current MAPP enrollment as of December 2007 was 11,976, the Eligibility Trends Worksheet shows this number as 12,051 and the Recipient Database from the MEDS Data Warehouse shows 12,202 MAPP participants.

Each analysis included in this section will include a reference to the data source used.

Enrollment Trends⁵

As of December 31, 2007, a total of 20,583 individuals had ever been enrolled in the program. Current enrollment as of the same date was 12,051 individuals. Although MAPP enrollment continues to grow slowly, it appears that the growth has reached a plateau. This might signal that the program has reached the majority of those individuals for whom it was designed. Historically, MAPP enrollment has grown steadily since the program's inception. Following the automation of the MAPP application process in CARES in January 2002, the program began to

⁴ Premium income between \$75 and \$100 results in a premium of \$75. A premium Schedule is included as Attachment A in Section IX. Appendix.

⁵ Source: Calculations for enrollment analyses derived from the Eligibility Trends Worksheet.

experience significant growth. In the two quarters preceding automation, new enrollment averaged about 200 individuals per quarter. In the two quarters following automation, this average almost tripled to about 600 new enrollees per quarter.

The growth in 2002 appeared to be a direct result of automation of the MAPP eligibility process in CARES. As noted in previous annual reports, the complexity of the manual enrollment process was seen by many county workers as a deterrent to enrollment. Consequently, it was expected—and correctly so—that by making it easier for economic support (ES) workers to enroll people in MAPP through automation, MAPP enrollment would increase.

Steady enrollment growth continued following the automation of the application process. Quarterly net growth (i.e., new enrollees minus disenrollees per quarter) in 2002 averaged 569 new enrollees per quarter. This average dropped to 496 in 2003, and rebounded to 553 in 2004. That steady growth continued well beyond the six months following automation suggests that other factors contributed to the consistent growth. For example, MAPP growth has coincided with an overall increase in Medicaid enrollment. Factors that might be contributing to the overall growth of Wisconsin Medicaid, and concurrently the MAPP program, may include a weaker economy, lack of livable wage jobs or other socioeconomic factors. The number of new enrollees in 2005 grew, averaging 874 new enrollees per quarter. Disenrollment averaged 423 individuals per quarter, resulting in an average quarterly net growth of 451 enrollees.

In 2006, the number of new enrollees averaged 770 per quarter. Average disenrollment over these quarters was 486 per quarter. The resulting average net growth was 285 enrollees per quarter. In 2007, the quarterly reports suggested that enrollment growth was reaching a plateau, as new enrollment continued to climb steadily but was countered by increasing disenrollment.

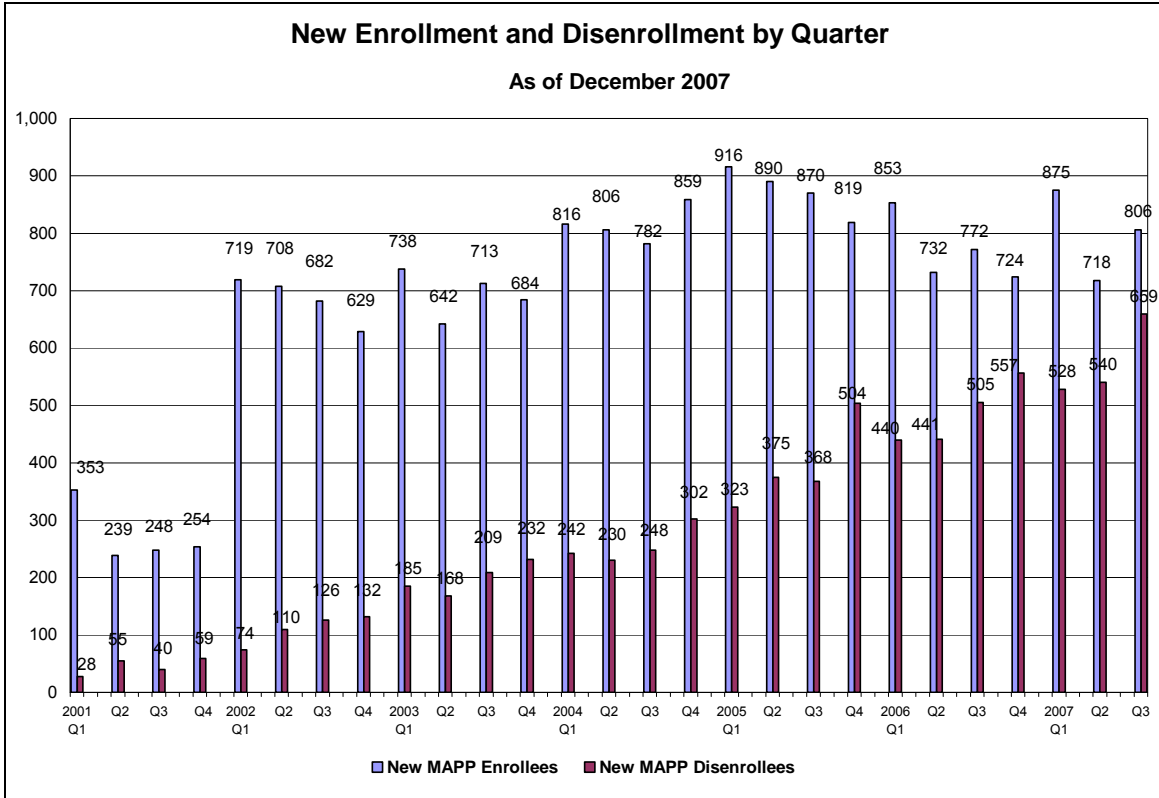
In the first three quarters of 2007⁶, the number of new enrollees averaged 800 per quarter, a small increase over the quarterly average from the year prior. On average, 576 individuals left the program each quarter. Although the number of new enrollees entering the program increased slightly in 2007, the number of participants leaving the program increased even more which resulted in an average quarterly net growth of 224 enrollees, down from 285 in 2006.

Figure 1 shows new enrollment and disenrollment by quarter⁷. The blue (taller) bars represent the number of newly enrolled individuals that quarter while the red (shorter) bars represent the number of newly disenrolled individuals that quarter. While enrollment continued to grow each quarter, the number of disenrollees increasingly approached the number of new enrollees.

Figure 1

⁶ The fourth quarter was excluded from this calculation. At the time of reporting (2/15/2008), data lag prevented accurate measure of fourth quarter enrollment data.

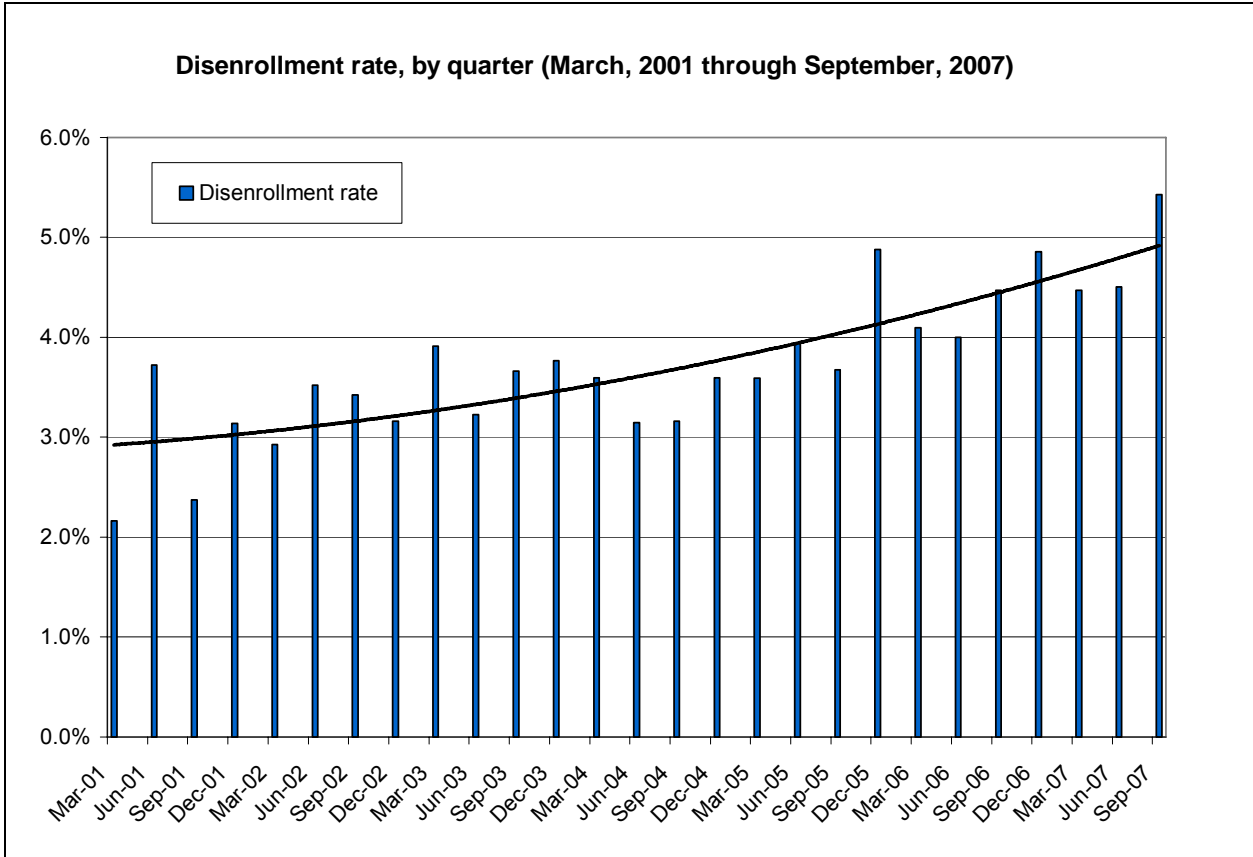
⁷ See above.



Since net growth is the result of both new enrollments *and* disenrollments, it is important to consider each of these factors in attempting to explain the decline of net growth. In 2005, new enrollment was at or above the same level as years prior; however, disenrollments in 2005 began to rise sharply. In 2003, there was an average of 199 disenrollments per quarter. This increased to an average of 263 disenrollments per quarter in 2004, and increased further in 2005 to an average of 423 disenrollments per quarter. In 2006, the number of disenrollments increased further, reaching an average of 486 per quarter. This number continued to climb in 2007, reaching 576 disenrollments per quarter.

Although it is tempting to attribute the overall decline in growth to the increase in disenrollment, it is important to realize that the number of individuals disenrolling would be expected to increase along with overall enrollment. More important is the *percentage* of individuals disenrolling. Figure 2 below shows that throughout 2002, 2003 and 2004 about 3.5% of MAPP enrollees disenrolled per quarter. So, while the absolute number of disenrollees increased, the percentage remained fairly constant. In 2005, however, the percentage of enrollees disenrolling rose to an average of 4% per quarter, and then up to 4.4% per quarter in 2006. In 2007, this trend continued and the percentage of individuals disenrolling averaged 4.8% per quarter.

Figure 2



There are several reasons that may be contributing to an increase in disenrollment. Medicare’s drug coverage plan, Medicare Part D, may have impacted enrollment. For example, dual eligibles (i.e., those eligible for both Medicaid and Medicare), whose primary coverage need is for prescription medication, might have disenrolled from MAPP since their need for prescription drug coverage was met by Medicare Part D.

Although there were no changes to MAPP’s rules or requirements in 2007, it is possible that there were changes in the interpretation of them which may have impacted the level of disenrollment. For example, MAPP’s work requirement has been open to a degree of interpretation. If this work requirement was more stringently adhered to, some enrollees might be forced to disenroll. Future evaluation activities – including a possible survey of economic support workers – will examine this more closely. Please see Section IX Appendix, Attachments B and C for summaries of enrollment and disenrollment as of December, 2007.

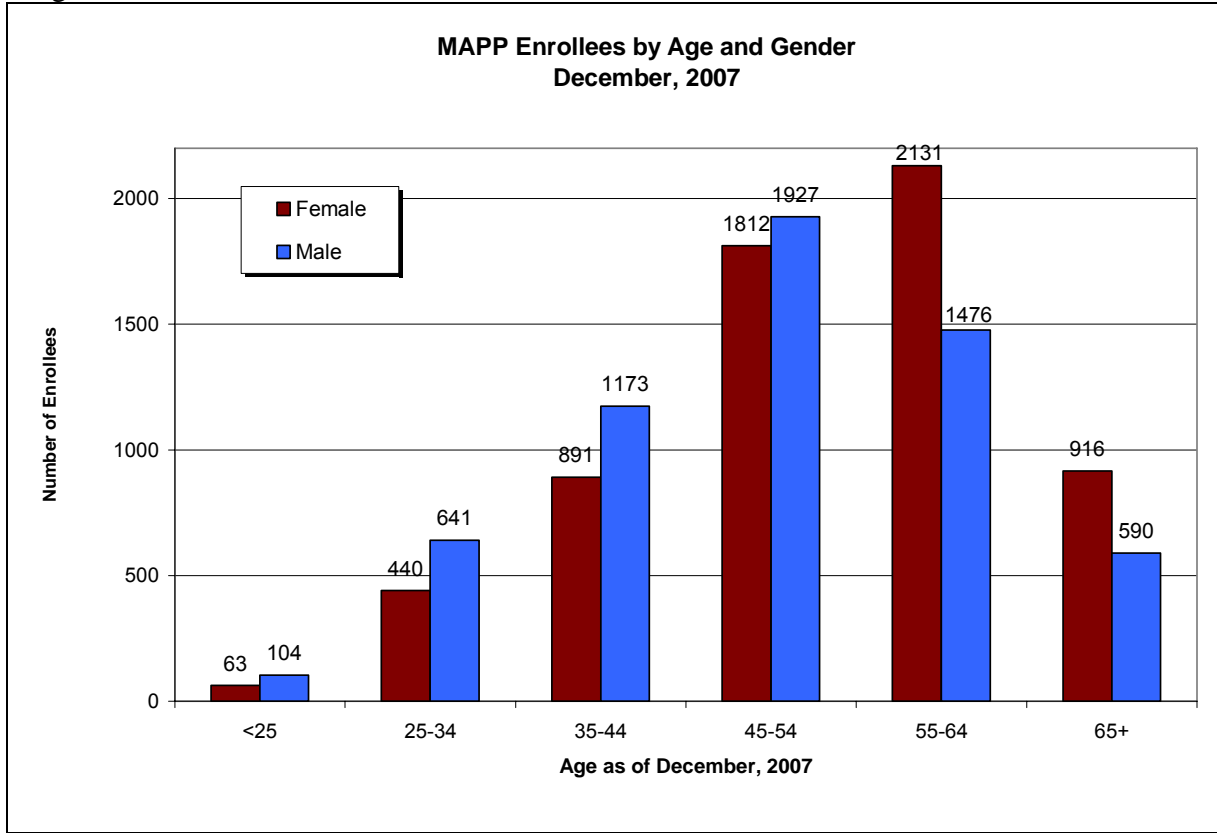
Demographic Data⁸

The following chart provides a breakout of the population by age and gender, as it was in December, 2007. As the chart illustrates, the majority of participants (61%) are between the ages of 45 and 64, as it was in 2006 and up slightly from 2004 and 2005. Overall, the MAPP population is split evenly between males and females, although the proportion of males and

⁸ Source: Data used in demographic analyses derived from Recipient Database, MEDS Data Warehouse.

females varies across age categories. Up to ages 45-54, men comprise more than 50% of the age category. In the two oldest age categories, there are considerably more females than males.

Figure 3



The percentage of African American recipients has increased from 1.6% in 2001 to 5.2% in 2007. During the same period of time the percentage of Caucasian enrollees has remained steady, hovering around 90%.

Earned Income⁹

In December 2007, MAPP participants had earned income ranging from \$0 to \$5,280 per month, with an average of \$185/month and a median of \$36/month, as compared to \$194 and \$40 in 2006, respectively. This is unsurprising, as MAPP enrollees’ earned income has been decreasing each year.

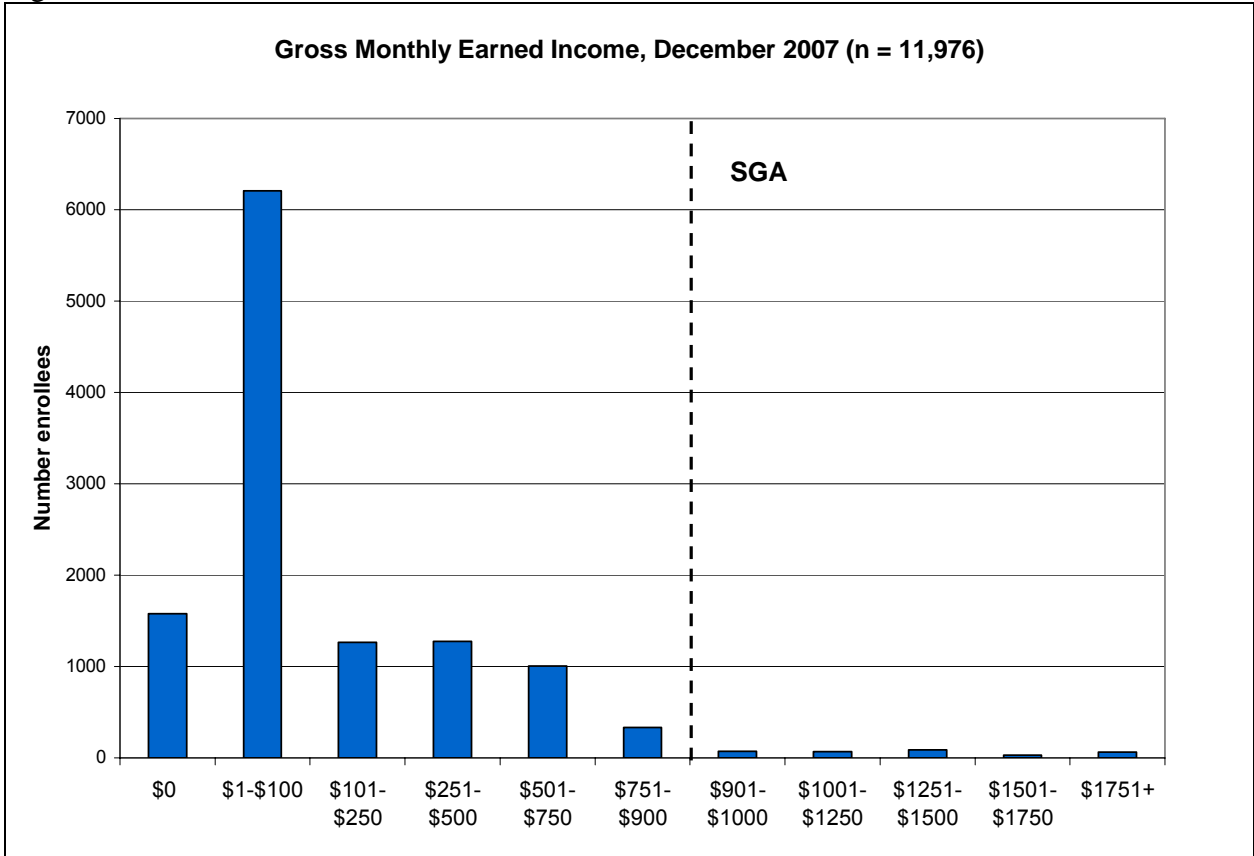
Figure 4 shows the distribution of participants by the amount of their monthly earned income. Of the 11,976 individuals for whom earned income data were available in December 2007, 2.6% earned at or above SGA¹⁰, with the remainder falling below – most far below. This has decreased slightly from 2006, where just over 3% earned at or above SGA. About 65% of MAPP

⁹ These figures include 11,976 participants with income information available through the CARES system. Earned income figures represent monthly earned income reported by participants through CARES as of December, 2007.

¹⁰ \$900/month in 2007. SGA is used as the threshold to separate people as several benefit rules are tied to it.

participants had an earned income of \$100 or less, up slightly from 63% in 2007. This helps explain why the median earned income is significantly less than the average.

Figure 4



Source: CARES data, December 2007

The percentage of MAPP participants reporting \$0 in earnings in 2007 was 13%, as it was in both 2005 and 2006. Although it is possible that some of these participants are not working, there are several other possible explanations as well. MAPP allows its participants to engage in in-kind employment, an activity for which wages are not reported. Participants who work solely for in-kind compensation will likely have \$0 in reported income. Another possible explanation is that some participants may be enrolled in the Health and Employment Counseling (HEC) program, which temporarily fulfills the MAPP work requirement and will result in \$0 reported income. Zero earned income may also reflect a health-related leave from employment, a benefit permitted while enrolled in MAPP. This question has persisted since MAPP’s inception, and was part of the impetus behind the participant survey conducted in 2007, the results of which will be discussed in Section VII of this report.

Average and median earned income in year seven continued to be well below the substantial gainful activity (SGA) level of \$900 per month used by the federal government to maintain social security disability eligibility. Disabled individuals earning above \$900 per month risk

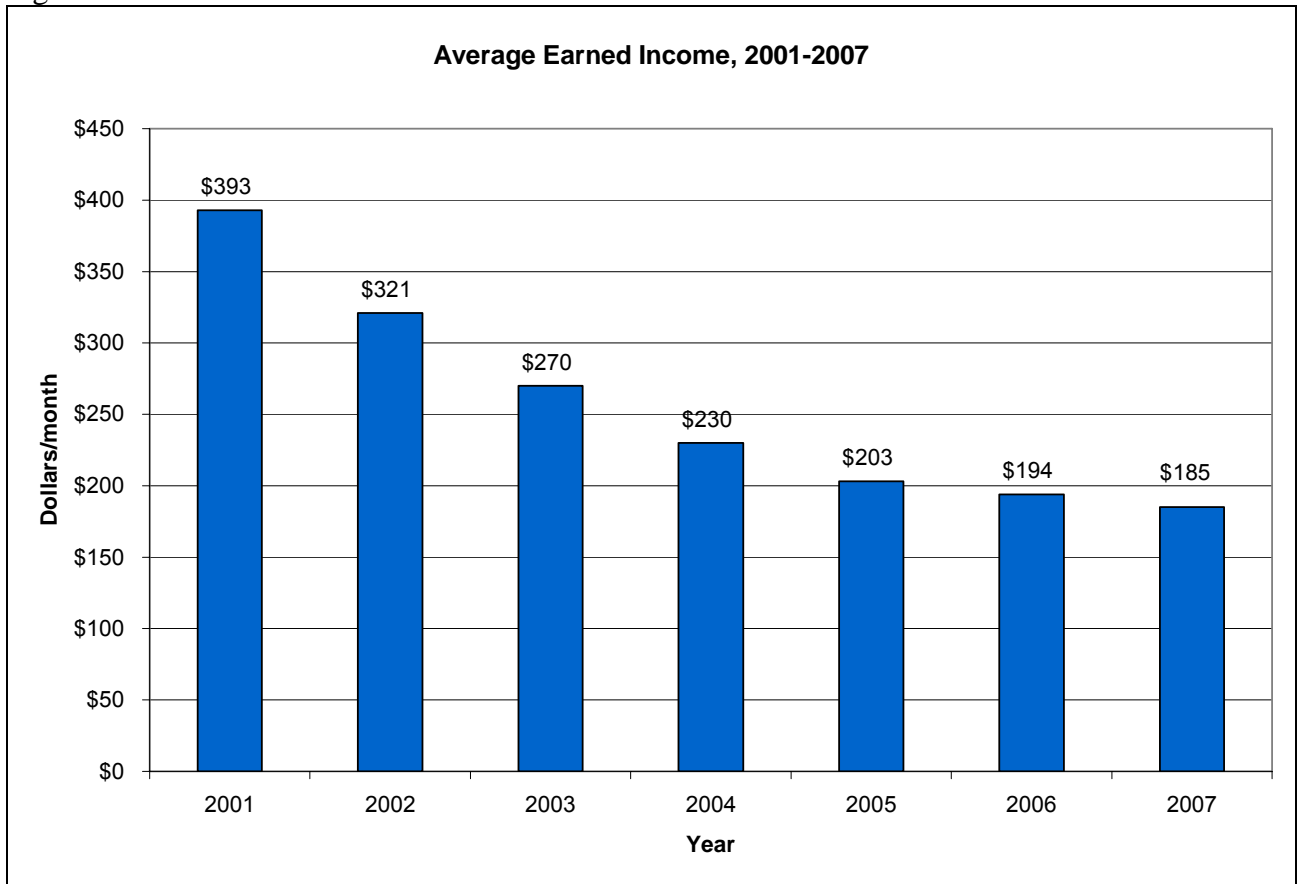
losing their federal Social Security Disability Insurance (SSDI) benefits, which may account for the large drop-off in wage earners above the SGA level (see Figure 4 above).¹¹

The 2007 earned income figures represent a continued decline in average earnings from the first year following implementation. Figure 5 illustrates the decline in average monthly earnings. MAPP participants averaged \$393 per month in year one, \$321 in year two, \$270 in year three, and \$230 in year four, \$203 in year five, \$194 in year six, and \$185 in year seven¹². The drop in average monthly income likely reflects characteristics of new participants, most of whom enter MAPP with very low cash earnings from work.

¹¹ According to data obtained from Mathematica Policy Research, Inc., more than 83% of consumers who had ever been enrolled in MAPP as of December 2005 were SSDI recipients within 12 months before MAPP enrollment, making the SGA level a relevant earnings consideration for the majority of MAPP participants.

¹² Year one earned income data came directly from the MAPP paper applications submitted by each county to CDS (now OIE) and aggregated by APS.

Figure 5



Source: CARES data December 2007

Premium Status¹³

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL) for their family size are subject to a premium¹⁴. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium continued to decline in 2007. Between December 2002 and December 2007, the percentage of premium paying MAPP enrollees has decreased from 13% to 6.3%. Further, in one year, the percentage of premium paying enrollees has decreased from 7.3% in December 2006 to 6.3% in December 2007.

While the total amount of actual premium collections is gradually increasing due to growth in overall enrollment numbers, the number of premium payers has been declining gradually since MAPP's inception. Attachment D in Section IX, Appendix provides a summary of monthly MAPP enrollment by premium status, as of December 2007.

For the December 2007 benefit month, MAPP premiums ranged from \$25 (the minimum possible premium amount) to \$1,149. Of the 773 individuals assessed premiums for December 2007 coverage, 731 paid. Of those who paid, just over 35% (261) were paying either a \$25 or

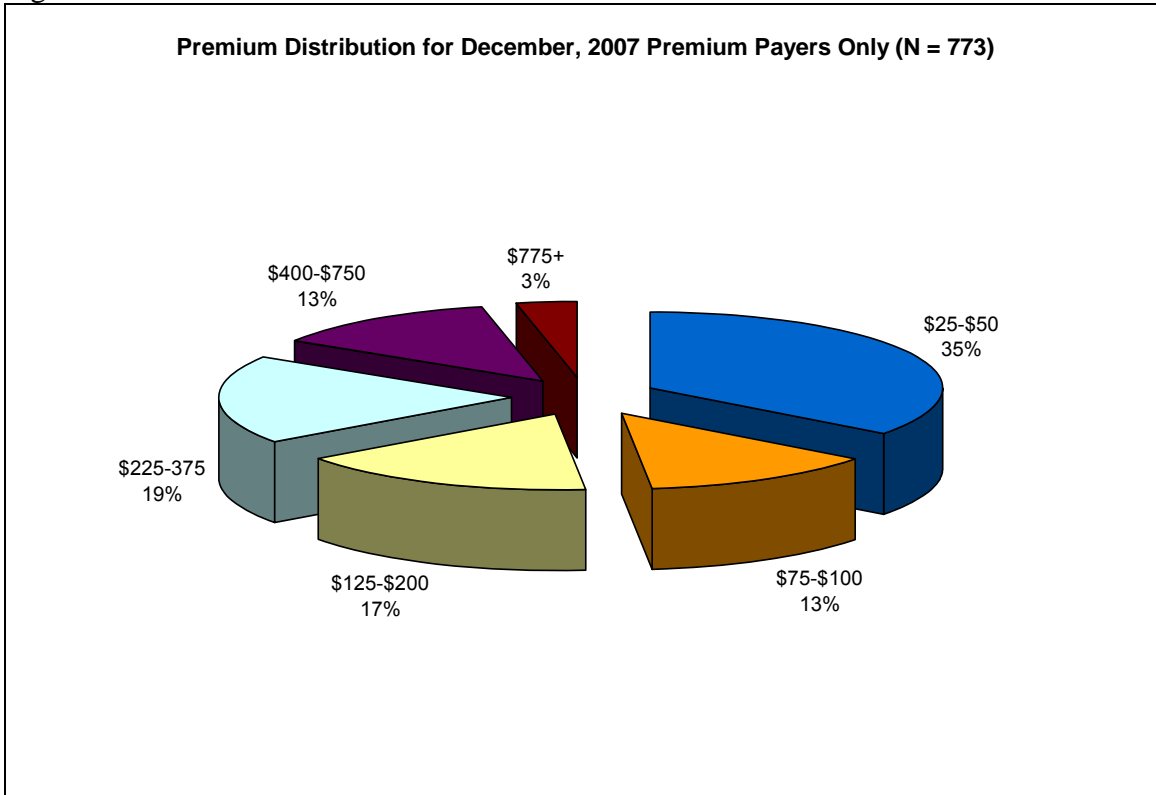
¹³ Source: BadgerCare Database, MEDS Data Warehouse.

¹⁴ 150% of FPL in 2007 was \$15,315 annually (\$1,276 monthly).

\$50 premium.¹⁵ The average premium amount collected was \$198, up from \$186 in 2006. In December 2007, the median premium value was \$125.

Based on the existing premium formula, which weighs unearned income more heavily than earned income, the continuing decrease in earned income, in conjunction with the increase in the average premium payment, suggests the possibility of increased SSDI benefits (including cost of living adjustments) among MAPP participants. Figure 6 summarizes premium amounts owed for December 2007.

Figure 6



Source: BadgerCare Database, MEDS Data Warehouse

The following table details premium payments received for each benefit month from January to December 2007. In addition to the total amount of payments received, the average, median and maximum premium payments for each month are also reported. Data for the table is obtained from the Medicaid Evaluation and Decision Support (MEDS) BadgerCare database, which is loaded with premium data directly from CARES.

Total premium payments dipped slightly in January (\$126,569) and February (\$129,481) of 2007 and then rose steadily throughout the rest of 2007, culminating in December with a total of \$144,625. This pattern has been demonstrated in both 2005 and 2006.

¹⁵ Up to \$1000, premium amounts are rounded down to the nearest \$25 increment. If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than \$1,000 per month, the premium is equal to the exact dollar amount of this sum.

The average premium paid was highest in September (\$199). The median remained at \$125 throughout 2007; however, this is unsurprising as \$125 premium payers comprise a significantly sized group of premium payers right at the 50% mark (see Figure 6). The median premium value in 2006 held at \$100 for most of the year, so it appears that there has been an upward shift over time.

The largest group of premium payers continues to be the \$25 group, which comprised 25% of all premiums paid in 2007. The maximum premium was \$1,149, collected in the latter months of 2007. Please refer to Attachment D in Section IX Appendix for a complete table of 2007 premium information.

Table 1

MAPP Premium Payment History, January –December 2007				
Benefit Month	Payments			
	Received	Average	Median	Maximum
January 2007	\$126,569	\$182	\$125	\$1,069
February 2007	\$129,481	\$184	\$125	\$1,087
March 2007	\$142,238	\$197	\$125	\$1,126
April 2007	\$138,661	\$194	\$125	\$1,223
May 2007	\$137,588	\$193	\$125	\$1,126
June 2007	\$143,450	\$195	\$125	\$1,126
July 2007	\$142,825	\$192	\$125	\$1,126
August 2007	\$145,400	\$193	\$125	\$1,126
September 2007	\$145,350	\$199	\$125	\$1,126
October 2007	\$143,897	\$196	\$125	\$1,149
November 2007	\$140,912	\$192	\$125	\$1,149
December 2007	\$144,625	\$198	\$125	\$1,149

Source: BadgerCare Universe, MEDS Data Warehouse

The sum of all premiums collected in December 2007 was \$144,625. 2007 premiums totaled \$1.68 million. From January 2002 through December 2007, MAPP premiums have generated \$7.4 million.

Medicaid and MAPP

The vast majority of MAPP participants were Medicaid eligible prior to their enrollment in MAPP. Of the 12,136 individuals who were eligible for MAPP between January 2000¹⁶ and September 2007¹⁷, 63% were enrolled in Medicaid in the month prior to their MAPP enrollment. Just under 87% were enrolled in Medicaid at some point in time prior to their MAPP enrollment. Eighty-five percent of the MAPP participants eligible in December 2007 also had Medicare coverage.

¹⁶ While MAPP began in March of 2000, there were a number of individuals who had their initial eligibility backdated to January 2000. Under Medicaid policy, eligibility can be backdated three months from application if the individual would have met all eligibility criteria for those months.

¹⁷ Due to retroactive eligibility, December 2007 prior eligibility reports may be slightly inaccurate and so September 2007 data is used here instead.

From the program's inception through September 2007, 7,726 individuals have disenrolled from MAPP at least once. The majority of the individuals who disenroll from the program subsequently re-enroll in non-MAPP Medicaid. About 91%, or 6,996, of program participants with at least one disenrollment had at least one post-MAPP Medicaid eligibility segment.¹⁸ The majority of the post-MAPP Medicaid eligibility segments were under SSI-related eligibility criteria.

MRE and IRWEs¹⁹

MAPP participants are allowed to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and are able to deduct Medical & Remedial Expenses (MREs) for the purpose of calculating premiums amounts. Information on MREs and IRWEs is collected by ES Workers as part of the MAPP application process. Detailed lists of IRWEs and MREs can be found in Attachment E in Section IX Appendix.

Consistent with prior years, it appears that very few participants report MRE or IRWE expenses in 2007. December 2007 CARES data indicate that only 120 of 11,976 (1%) MAPP participants report IRWE expenses. The number of enrollees reporting IRWE expenses has remained about the same for the last three years; however, as enrollment grows, the percentage of those enrollees reporting IRWEs decreases each year.

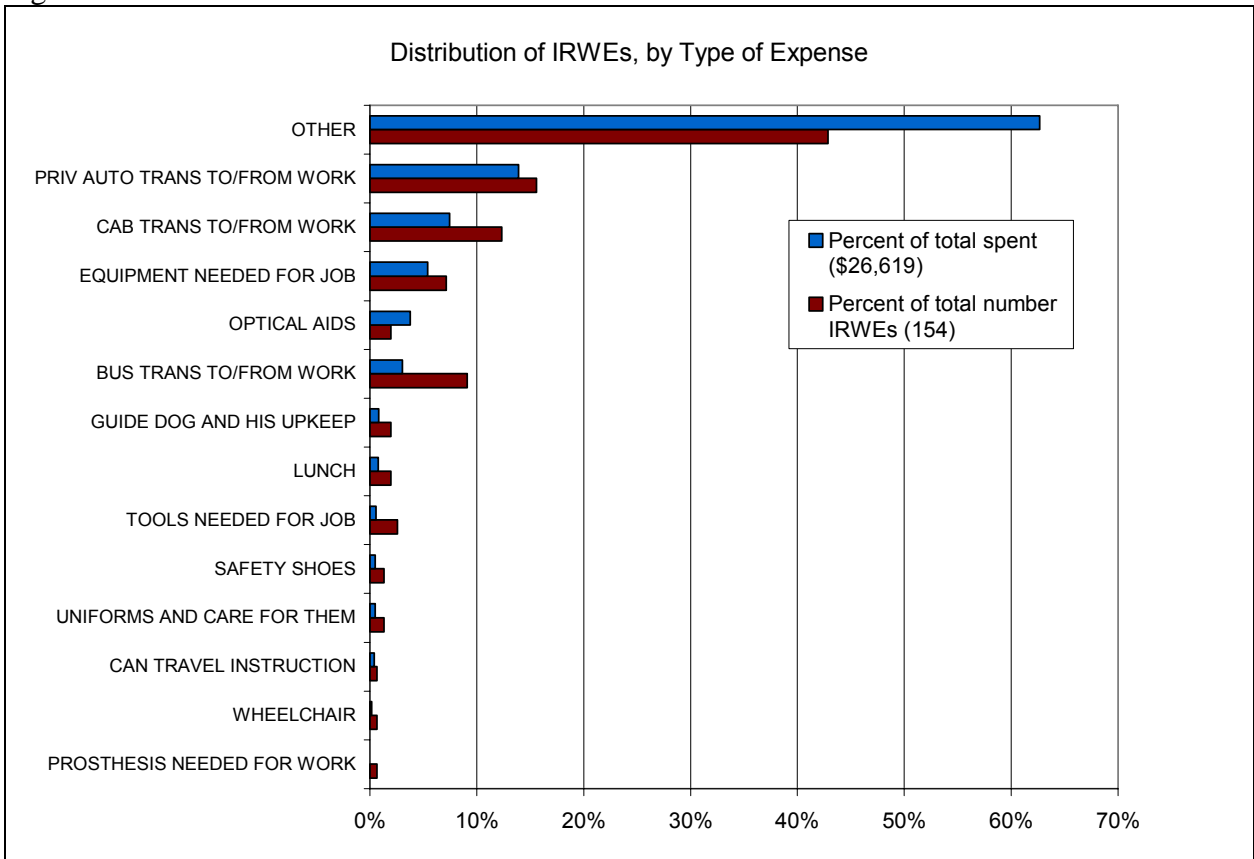
The minimum expense identified was \$.12 and the maximum was \$1,357. The average IRWE expense in 2007 was \$173 and the median was \$80, compared to \$204 and \$84 in 2006. It is possible that the lower than expected utilization of IRWEs and the reduced average reflects poor data quality rather than an underutilization of this benefit.

Figure 7 categorizes the 154 reported expenses, representing 120 participants, by category as reported in CARES. The frequency with which the "Other" category is used limits the ability to assess the needs of MAPP participants in terms of work-related supports, since it provides very little information. Transportation expenses (private car, bus, cab) accounted for just under 25% of all dollars spent on IRWEs. The remaining categories comprised 4% or less of the total number of individuals reporting IRWEs as well as 4% or less of the total dollars spent on IRWEs.

¹⁸ Please note that an individual may have more than one disenrollment and more than one post-MAPP eligibility segment. For example, as a result of changing income, a participant could have disenrolled from MAPP in February 2001; been on SSI-related Medicaid in March and April; re-enrolled in MAPP for May and June; disenrolled from MAPP and became eligible for non-MAPP Medicaid a second time.

¹⁹ Source: CARES, December 2007

Figure 7



About 5% of participants reported MREs in December 2007, which is about the same percentage who reported MREs in December 2006. Prior to these last two years, a greater percentage of individuals reported MREs (e.g., 10% in 2002). The sum of all MREs reported in December 2007 was just under \$62,000. The average MRE was \$106 (median \$32), up from \$92 (median \$30) from one year ago. The minimum expense was less than \$1, and the maximum expense was \$3,661. The format of MRE data limits the type of analyses performed on it. ES Workers enter data into CARES as “out of pocket/remedial;” therefore, there is no way of identifying the types of expenses incurred by MAPP participants.

County ES workers have had seven years to become familiar with the IRWE benefit, yet its use has remained minimal. MREs are used throughout Medicaid in other sub-programs and therefore are likely more recognized among county workers. The data suggest that reporting IRWEs and MREs at the county level requires continued investigation to determine if the reporting process is flawed, or if participants are not taking advantage of this benefit.

Another possible explanation relates to the purpose of IRWE/MREs. IRWE/MREs are collected by ES workers to reduce the premium amount paid by a MAPP participant. However, since very few participants are assessed a premium, the reporting of these expenses may be seen as unnecessary.

The participant survey conducted in 2007 aimed to gather more information on IRWEs and is discussed in the Section VII of this report.

County Breakdown of Medicaid Recipients²⁰

Attachment F in Section IX Appendix shows the statewide count of Medicaid recipients with disabilities by county, as well as a count of MAPP enrollees by county. The first column reflects the percentage of people with disabilities who are enrolled in MAPP, by county. Although there is no maximum age for MAPP eligibility, all counts were limited to enrollees aged between 18 and 65.²¹

As of December 2007, the majority of Medicaid enrollees with disabilities between the ages of 18-65 resided in Milwaukee County (N = 31,186). Correspondingly, the largest percentage of MAPP enrollees also resided in Milwaukee County (N = 1,400), resulting in a MAPP enrollment percentage of 4.5%. After removing Milwaukee from the percentage calculations so as not to overwhelm the percentage calculations for the remaining counties, Green County has the largest percentage of individuals with disabilities on Medicaid who are enrolled in MAPP, with 31% of its disabled Medicaid population enrolled. Washburn and Iron Counties also have over one-quarter of their disabled Medicaid population enrolled in MAPP. Of counties with over 50 Medicaid recipients with disabilities, Menominee, Forest, Milwaukee, Racine, Oconto and Brown Counties have the lowest rate of MAPP enrollment at 5% or lower. Statewide including Milwaukee, 10% of Medicaid enrollees with disabilities between the ages of 18-65 were enrolled in MAPP, up from 8.5% in December 2006.

The five counties with the highest and lowest percentages of people with disabilities in Medicaid who are enrolled in MAPP were plotted on the Pathways to Independence Regional Initiatives map (see Figure 8)²². Four of the five counties with the highest percentages were clustered in the geographical northwestern area of the state (i.e., Burnett, Washburn, Iron and Price Counties), bridging Pathways' Northwestern and Northern regions. There was also a cluster of counties with higher percentages of people with disabilities in Medicaid enrolled in MAPP located in the South Central region (i.e., Waushara and Adams Counties) and along the Wisconsin-Illinois border.

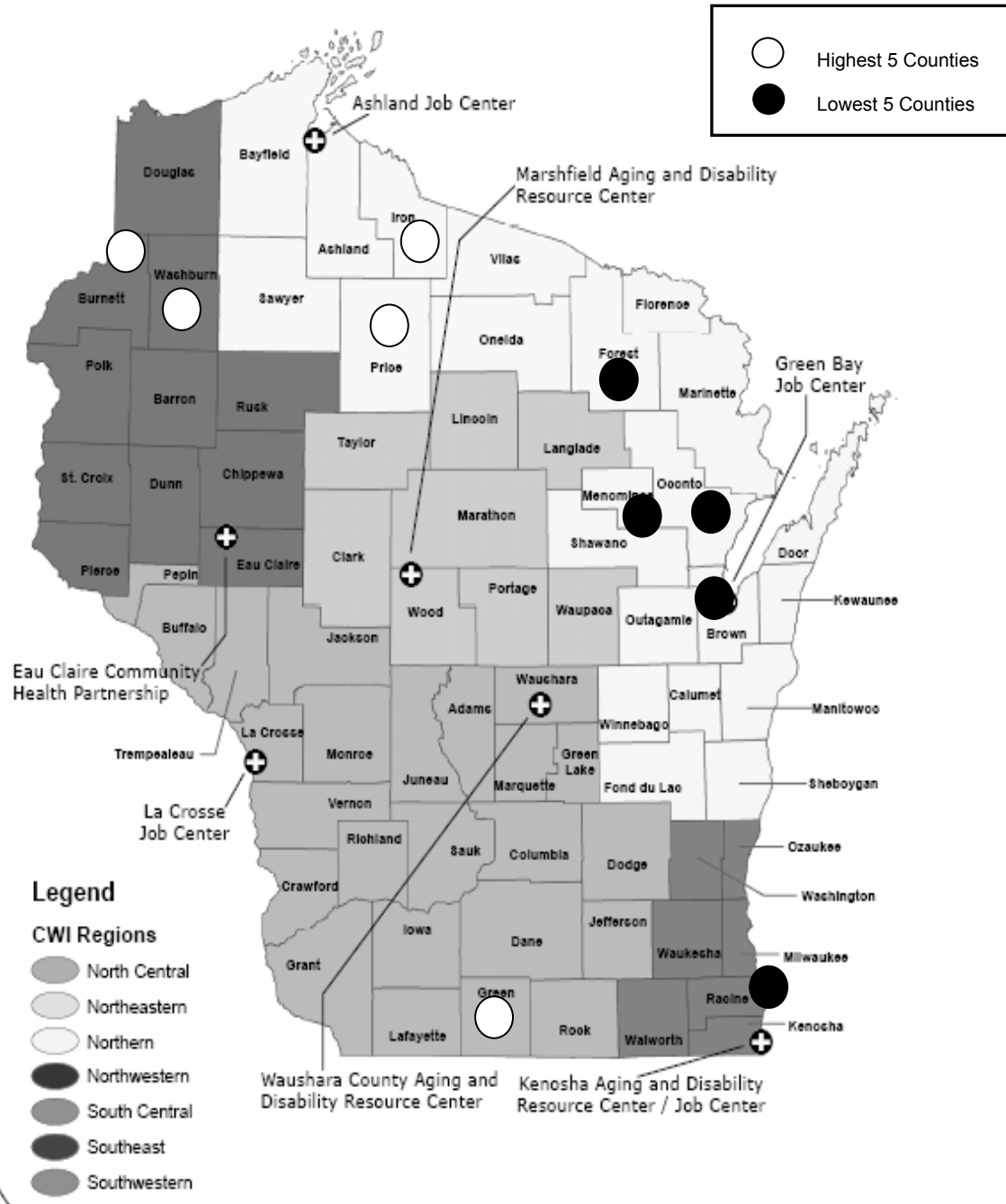
Four of the five counties with the lowest percentages of people with disabilities in Medicaid enrolled in MAPP were clustered in a band running from Forest County in the Northern region to Brown County in the Northeastern region.

²⁰ Source: Recipient Database, MEDS Data Warehouse.

²¹ The age restriction is used so that the denominator used in calculating percentages is more appropriate. Without the age restriction, the denominator becomes inappropriately inflated with disabled persons aged 65 years and older.

²² Excluding counties with less than 50 Medicaid recipients with a disability, and excluding Milwaukee.

Figure 8 High and Low MAPP Participation Rates, by County



Health Insurance Premium Payment (HIPP)²³

Under HIPP, Medicaid pays the “employee share” of the participant’s or the participant’s spouse’s employer sponsored health insurance premium if it is cost effective, thereby reducing Medicaid expenditures. This benefit became available to MAPP participants in October 2001. Employers include county governments, hospitals and large private employers.

Until 2006, HIPP participation was growing steadily if not rapidly. However, 2006 marked the first year in which HIPP participation decreased. As of December 2006, 70 MAPP enrollees were participating in the HIPP program, down from 88 in 2005. In December 2007, participation in HIPP rebounded to 91 individuals. However, as a percentage of MAPP enrollees, participation in HIPP continues to decline.

The low participation rate suggests that either employer sponsored health care insurance is not available to most MAPP participants, HIPP is not a cost effective alternative for most participants, or county workers are not familiar with the benefit. A comprehensive cost-effectiveness analysis of MAPP HIPP has been proposed which will investigate the cost effectiveness of HIPP for MAPP enrollees and the barriers to enrollment and utilization among MAPP participants.

V. MAPP Cohort Comparison

Questions have persisted regarding the differences and similarities of people who enrolled in MAPP at different points in time. In 2005, three groups of first time enrollees were compared: the original 2,000 (approximately) enrollees in MAPP (n = 2,109), the first 2,000 (approximately) first time enrollees post-automation (n = 2,109), and the group of first time enrollees from July 1, 2004 to December 31, 2004 (n = 1,634). The following is a replication of this analysis with an additional cohort – MAPP enrollees whose first enrollment date followed the implementation of Medicare Part D on January 1, 2006. Specifically, this fourth cohort comprises MAPP enrollees whose first enrollment date was in the last half of 2006 or first half of 2007 (n = 2,847).

Age

Table 2 compares recipients based on their age during their first month of eligibility for MAPP by enrollment period. The number of enrollees over the age of 50 has gradually increased from 38.4% in the first group, to 46% in the second, to nearly 50% in the third group, to 52% in the last cohort. This increase can be attributed to an increased percentage of new enrollees aged 50-59. The percentage of new enrollees aged 60 and older in the 2006/2007 cohort is about 2% less than in the 2004 cohort.

²³ Source: Recipient Database, MEDS Data Warehouse

Table 2

Age Categories	Original Enrollees		Post-automation Enrollees		Late 2004 Enrollees		Late 2006-Early 2007 Enrollees	
	#	%	#	%	#	%	#	%
<20	9	0.4%	6	0.3%	5	0.3%	17	0.6%
20-29	177	8.4%	171	8.1%	132	8.1%	244	8.6%
30-39	458	21.7%	389	18.4%	233	14.3%	375	13.2%
40-49	656	31.1%	573	27.2%	456	27.9%	726	25.5%
50-59	510	24.2%	586	27.8%	476	29.1%	948	33.3%
60-69	242	11.5%	315	14.9%	264	16.2%	419	14.7%
70-79	50	2.4%	59	2.8%	54	3.3%	92	3.2%
80+	7	0.3%	10	0.5%	14	0.9%	26	0.9%
	2,109	100%	2,109	100%	1,634	100%	2,847	100%

Over time the average age of MAPP enrollees has increased by 2.8 years. This may indicate that more people are being enrolled in MAPP to pay for age related health expenses than desire to work. Table 3 shows that the average age of new enrollees in the latter two cohorts are identical.

Table 3

	Original Enrollees	Post-automation Enrollees	Late 2004 Enrollees	Late 2006-Early 2007 Enrollees
Average Age	46.0	47.5	48.8	48.8

Gender

Table 4 shows that in the cohort of original enrollees, just under one half of enrollees (47.5%) were female. This slight imbalance has shifted over time, with females representing just over half of 2006/2007 enrollees (52.1%).

Table 4

Gender	Original Enrollees		Post-automation Enrollees		Late 2004 Enrollees		Late 2006-Early 2007 Enrollees	
	#	%	#	%	#	%	#	%
Female	1001	47.5%	1055	50.0%	830	50.8%	1482	52.1%
Male	1108	52.5%	1054	50.0%	804	49.2%	1365	47.9%

Premium Payers

Table 5 shows the percentage of premium payers has decreased from 17.1% in the initial enrollee group to 7.8% in the late 2004 enrollee group. Although the decrease in percentage of premium paying enrollees has been documented in monthly reports, this analysis clearly shows that it is the more recent enrollees who are entering the program under non-premium paying Medstat codes.

Table 5

	Original Enrollees	Post-automation Enrollees	Late 2004 Enrollees	Late 2006- Early 2007 Enrollees
Premium Payers	17.1%	12.4%	9.1%	7.8%
Non-premium Payers	82.9%	87.4%	90.9%	92.2%

There are eight medical status codes to identify MAPP recipients. Table 6 shows the medical status codes of enrollees based on their initial enrollment status. The percentage of enrollees in nursing homes (Medstat codes M9 and MP) is somewhat incongruous with the goals of the program, as nursing home residents are typically thought of as retired and not seeking employment.

Table 6

Age Categories	Original Enrollees		Post-automation Enrollees		Late 2004 Enrollees		Late 2006-Early 2007 Enrollees	
	#	%	#	%	#	%	#	%
M3	308	14.6%	233	11.0%	133	8.1%	199	7.0%
M4	1671	79.2%	1679	79.6%	1393	85.3%	2403	84.4%
M5	44	2.1%	29	1.4%	14	0.9%	21	0.7%
M6	73	3.5%	151	7.2%	77	4.7%	193	6.8%
M7	2	0.1%	0	0.0%	0	0.0%	1	0.0%
M8	3	0.1%	3	0.1%	3	0.2%	2	0.1%
M9	2	0.1%	11	0.5%	13	0.8%	27	0.9%
MP	6	0.3%	3	0.1%	1	0.1%	1	0.0%
	2,109	100%	2,109	100%	1,634	100%	2,847	100%

Med Stat Code Definition:

- M3 – >150%, Premium
- M4 – <150%, No premium
- M5 – Community Waivers, >150%, Premium
- M6 – Community Waivers, <150%, No Premium
- M7 – BIW, > 150%, Premium
- M8 – BIW, < 150%, No premium
- M9 – Nursing Home, <150%, No Premium
- MP – Nursing Home, >150%, Premium

Race

Looking at Table 7, the percentage of African American recipients had increased more than four times (2.1% to 9.5%) from the original group to the late 2004 group, and then dipped to 8.1% in the 2006/2007 cohort. During the same period of time the percentage of Caucasian enrollees has decreased from 88.8% to 81.1%.

Table 7

Race Code	Original Enrollees		Post-automation Enrollees		Late 2004 Enrollees		Late 2006-Early 2007 Enrollees	
	#	%	#	%	#	%	#	%
Caucasian	1,873	88.8%	1,840	87.2%	1,358	83.1%	2309	81.1%
African American	44	2.1%	100	4.7%	155	9.5%	231	8.1%
American Indian or Alaskan Native	9	0.4%	9	0.4%	12	0.7%	18	0.6%
Asian	1	0.0%	4	0.2%	6	0.4%	16	0.6%
Hispanic or Latino	3	0.1%	18	0.9%	19	1.2%	58	2.0%
Native Hawaiian/Other Pacific Islander	0	0.0%	0	0.0%	3	0.2%	2	0.1%
Hispanic or Latino and One or More Races	37	1.8%	26	1.2%	22	1.3%	33	1.2%
More Than One Race	5	0.2%	2	0.1%	4	0.2%	9	0.3%
Unknown	137	6.5%	110	5.2%	55	3.4%	171	6.0%
	2,109	100%	2,109	100%	1,634	100%	2,847	100%

VI. Evaluation of MAPP Expenditure and Utilization

APS conducted an evaluation of MAPP expenditure and utilization which analyzed patterns of Medicaid spending for MAPP enrollees since the start of the program in 2000. The following is a summary of the report. Please refer to Attachment G Section IX Appendix for all tables.

MAPP Expenditure and Utilization

The Medicaid expenditure and utilization of MAPP participants was compared to those of a group matched on several variables. The comparison group comprised Medicaid enrollees who

were matched to the MAPP group on age, gender, Medicare participation, geographic area, and Medicaid eligibility status group. Compared to this group, the MAPP participants had \$50 - \$100 lower over-all average expenditures per member per month (PMPM).

Looking at Figure 9, total spending for both MAPP participants and a similar group of Medicaid enrollees rose by about \$300 per person per month between 2000 and 2005 (nominal dollars, not adjusted for inflation), and dropped by about \$300 per person per month from 2005 to 2006, when Medicare Part D prescription drug coverage was implemented. Managed care capitation payments began rising faster after 2005 when Wisconsin implemented managed care for adults with disabilities.

Figure 9

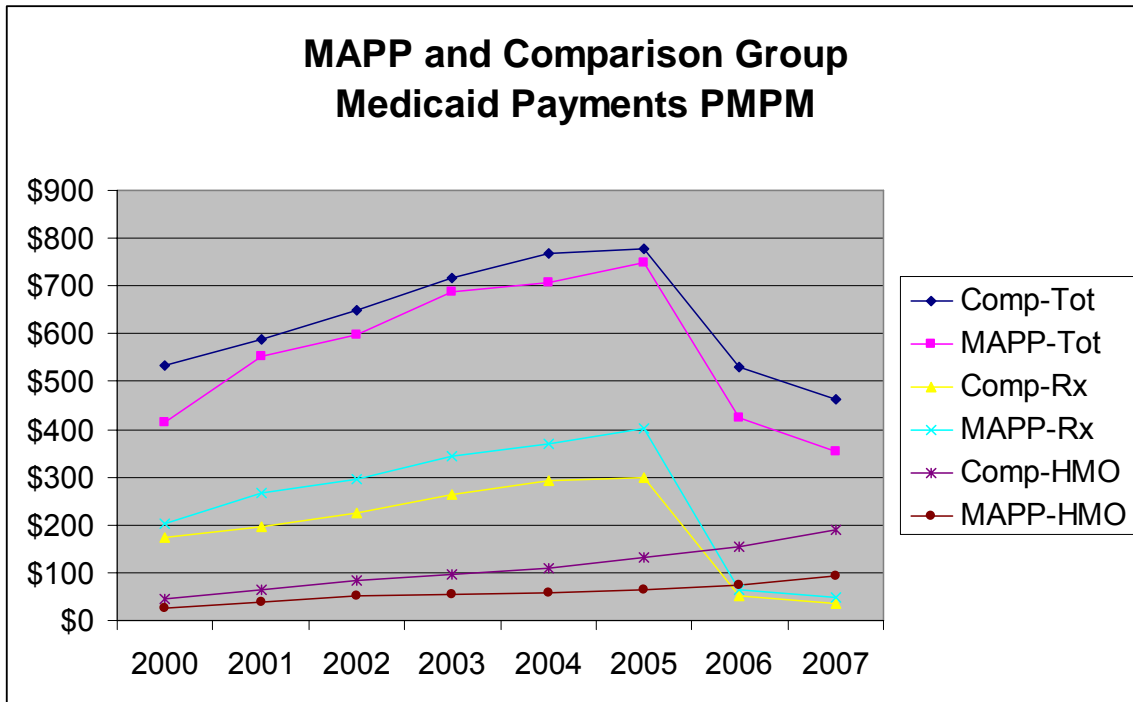


Table 8 breaks out expenditures per person per month by calendar year and category of service.

Table 8

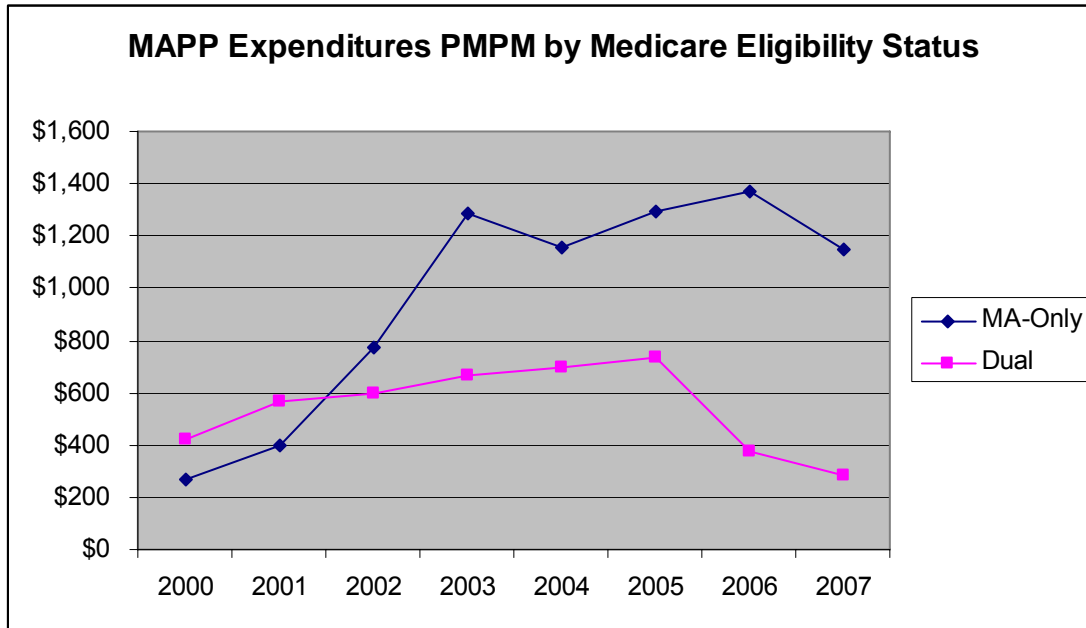
MAPP expenditures per person per month by calendar year and category of service								
	2000	2001	2002	2003	2004	2005	2006	2007
Drug	\$202	\$266	\$297	\$344	\$370	\$403	\$63	\$48
Physician	\$90	\$99	\$97	\$106	\$106	\$107	\$108	\$80
Inpatient	\$38	\$61	\$50	\$75	\$65	\$61	\$67	\$46
HH, etc.*	\$34	\$57	\$62	\$65	\$74	\$76	\$79	\$61
HMO Capitation	\$25	\$40	\$51	\$55	\$57	\$63	\$73	\$92
Other**	\$25	\$31	\$42	\$41	\$36	\$38	\$36	\$28
Total PMPM	\$415	\$554	\$599	\$686	\$708	\$749	\$426	\$355
*Home Health, DME, Transportation, Vision, Therapy, Misc.								
**Outpatient, Dental								

The following charts reflect sub-group analyses that were conducted to determine differences within the MAPP group only.

Medicaid-only v. Medicare/Medicaid dual-eligibles

MAPP participants eligible for Medicaid-only may spend \$500 - \$1,000 more PMPM. Dually eligible enrollees had a large drop in PMPM in 2006 due to Part D drug coverage, which does not affect the Medicaid-only enrollees. Utilization may be about the same for the groups, but claims paid by Medicare are not included in the Medicaid paid claim database which explains why the dual-eligible PMPM appears to be lower.

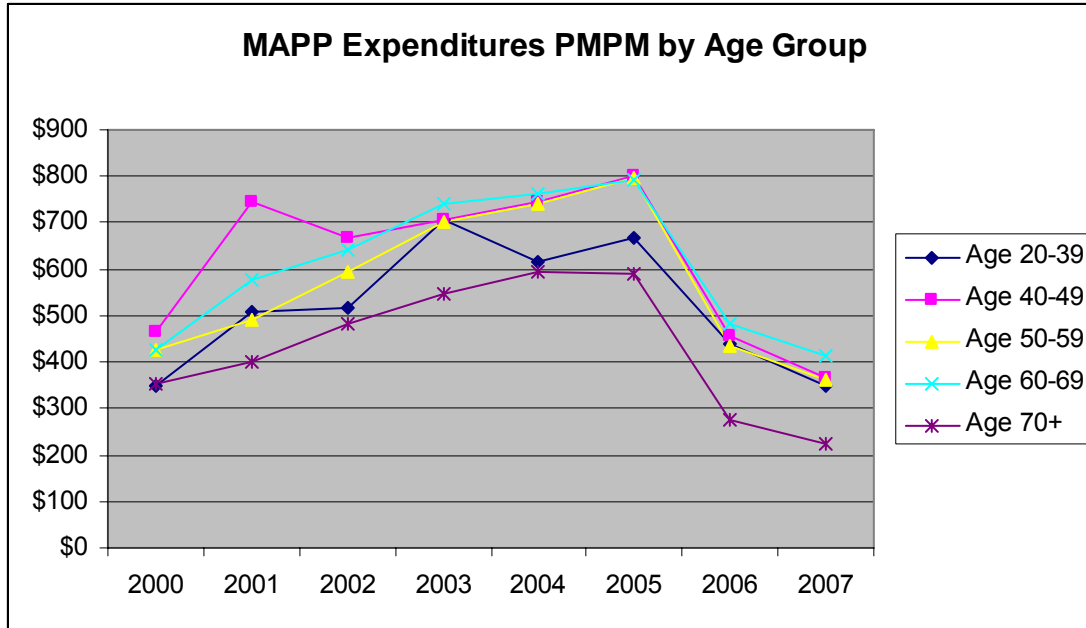
Figure 10



Age Groups

In Figure 11 below, it appears that the youngest (age 20-39) and oldest (age 70+) MAPP enrollees have the lowest expenditures PMPM. The younger enrollees may be in better general health, while the older enrollees have a higher mix of Medicare eligibility, which reduces amounts paid by Medicaid.

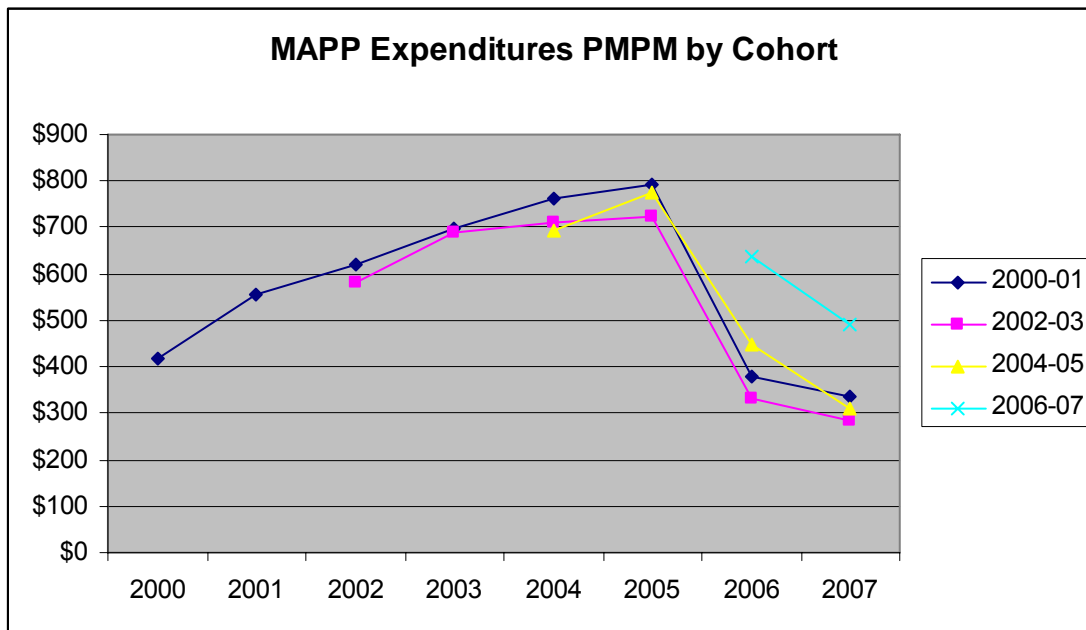
Figure 11



Enrollment Cohorts

Comparing different cohorts of MAPP enrollees, it appears that cohorts in more recent years have higher average spending than earlier cohorts who enrolled in 2000 through 2003.

Figure 12

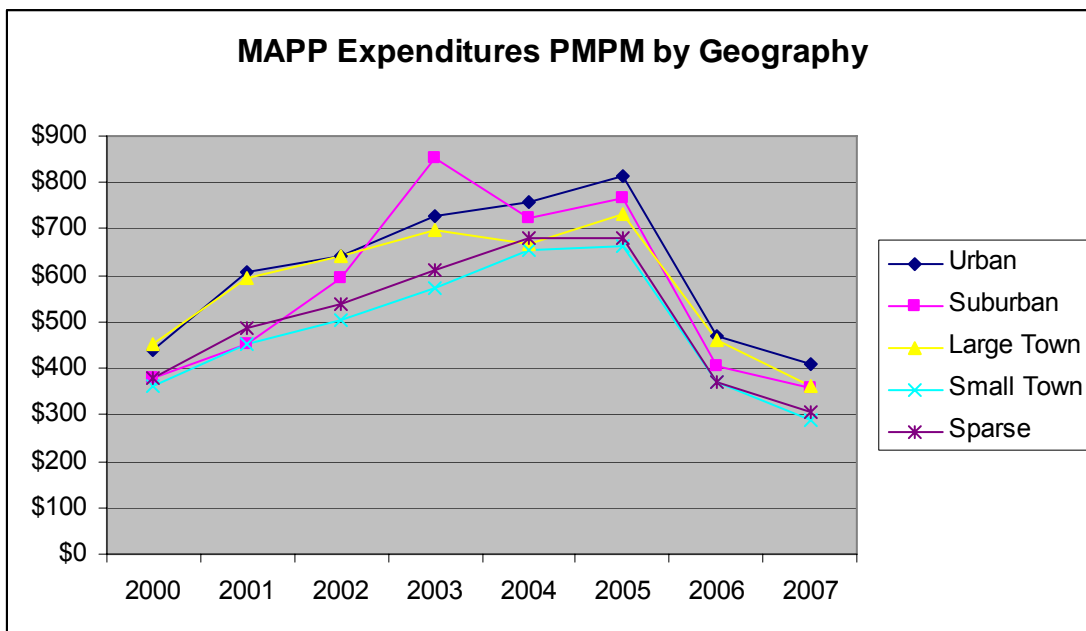


Rural v. Urban

Figure 13 shows that MAPP participants who reside in urban or suburban areas spend approximately \$100 more PMPM compared with residents in small towns or sparse rural areas. Exploring this issue, it was found that urban residents had higher HMO capitation payments PMPM (\$99 urban, \$19 rural), higher home health, etc. (\$88 urban, \$60 rural), and higher physician payments (\$110 urban, \$100 rural), which accounts for the difference in total expenditures PMPM.

It is unclear whether this difference is due to a difference in total utilization of services, perhaps due to less readily available access to health care in rural areas, or because of differences in pricing for services, or a different mix of services being used.

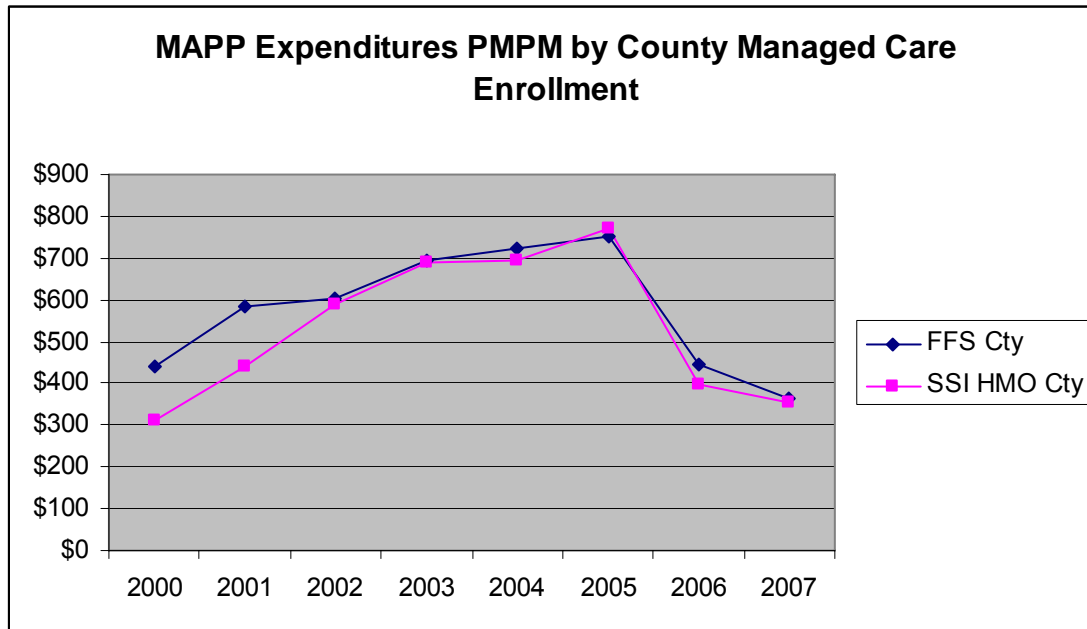
Figure 13



SSI-Managed Care

Figure 14 shows that there was no major difference in MAPP expenditure PMPM in counties that began enrolling SSI adults with disabilities into managed care in 2005 (Milwaukee, Racine, Kenosha, Waukesha) compared with the remaining counties where only FFS Medicaid is available for adults with disabilities.

Figure 14



Multiple Regression Analysis of MAPP Expenditures in 2006

Group differences were analyzed using multiple regression, which can separate the effects of different variables that might otherwise be confounded. For example, the lower PMPM values for the group of MAPP enrollees aged 70 and older, evaluated alone would lead to the spurious assumption that age is a primary driver for costs when the difference is more likely related to their dual-eligibility for Medicaid and Medicare. When all these variables are taken into account simultaneously, the following results are found. Please refer to Attachment G Section IX Appendix for the output table.

- No age groups have significantly different expenditures PMPM than the group aged 60-69, except the group aged 40-49, which does have significantly higher expenditures.
- The dual Medicaid/Medicare eligible population has much lower expenditures PMPM than the Medicaid-Only population of MAPP enrollees in 2006.
- There are no significant differences in expenditures between urban, suburban, or large towns, but small towns and sparse rural areas have significantly lower expenditures PMPM.
- In 2006, MAPP enrollees in the four SSI-Managed Care counties (Milwaukee, Racine, Kenosha, Waukesha) had lower expenditures PMPM than MAPP enrollees in the rest of the state.
- The 2000 through 2003 MAPP enrollment cohorts tended to have lower expenditures PMPM (significantly lower for the 2002 & 2003 cohorts) than the more recent cohorts, and the most recent 2006 & 2007 cohorts have higher expenditures PMPM than the 2004-2005 cohort, but not significantly higher.

VII. MAPP Recipient Survey

Background

In 2006, The Office of Independence and Employment (OIE) and APS began planning a participant survey to measure the program's progress in meeting its goals of supporting employment and independence.

With the overarching goals of the MAPP program in mind, survey goals were developed. These goals were set as follows:

1. Determine differences between different types of earners:
 - a. Person characteristics (e.g., type of disability, region, earnings trajectory group)
 - b. Mediating factors (e.g., level of support services required and used)
 - c. Outcomes (e.g., hours worked, dollars earned)
2. Assess level of understanding of Impairment Related Work Expenses (IRWEs) as well as anticipated usage
3. Characterize outreach efforts and outcomes by assessing how well recipients understand verbal and written information they are given
4. Assess impact of Medicare Part D on MAPP enrollees

Earnings Trajectories

The primary variable of interest was an individual's level of success in the program. That is, once a person enrolled in MAPP, did earnings increase, decrease, or remain the same? And further, what factors relate to one's success in MAPP? This concept of "earnings trajectory" – that is, the classification of a person based on their earnings before and then after enrolling in MAPP – was used to capture one's relative success in the program, and served as the main variable by which survey respondents were compared. The main advantage of grouping respondents by earnings trajectory is that it captures movement (or, lack of) over time.

It was expected that an analysis based on earnings trajectories would reveal relationships between the characteristics of a person (e.g., attitude toward work, type of disability(ies), type of employment) and success in the program (e.g., level of earnings, satisfaction with employment, perceived health). For example, it might be expected that there are differences in how barriers are perceived by someone who moves from a high earnings category to a low earnings category as compared to someone who moves in the opposite direction. The level of support services required and used might also be similarly related to one's success in the program. It was also hoped that more could be learned about which types of disabilities are more likely to be associated with greater success in the program.

Earnings trajectories were based on Wisconsin unemployment insurance (UI) wage data. Wage data is collected from employers for unemployment insurance tracking and is compiled on a quarterly basis. UI wage data is a convenient source of earnings data that is easily linked to other data from the MEDS data warehouse via social security number.

UI wage data also has some limitations. UI wage data excludes earnings from those who are self employed, those who are employed by the federal government, and those who work in a bordering state. Additionally, because UI employment is reported quarterly, it is impossible to know the specific time period (e.g., months) during which an individual was actually employed.

Using UI wage data, all MAPP enrollees who were sent a survey were classified according to the following categories based on their average wage during the pre-MAPP enrollment period and the post-MAPP enrollment period.²⁴

1. *Null-Low*: Change in earnings from pre-MAPP to post-MAPP
2. *Null-High*: Change in earnings from pre-MAPP to post-MAPP
3. *Low-Null*: Change in earnings from pre-MAPP to post-MAPP
4. *Low-High*: Change in earnings from pre-MAPP to post-MAPP
5. *High-Low*: Change in earnings from pre-MAPP to post-MAPP
6. *High-Null*: Change in earnings from pre-MAPP to post-MAPP
7. *Null-Null*: No change in earnings from pre-MAPP to post-MAPP
8. *Low-Low*: No change in earnings from pre-MAPP to post-MAPP
9. *High-High*: No change in earnings from pre-MAPP to post-MAPP

Null indicates no earnings for that particular time period, *Low* indicates lower than average earnings, and *High* indicates higher than average earnings. For example, a person categorized as “*Low-High*” indicates that his or her pre-period average earnings were below average and increased to above average over the course of his or her post-period.

Few participants were classified as “*Null-High*.” Therefore, these individuals were grouped with “*Low-High*” individuals whose numbers were also far lower than in other categories. Additionally, the average pre- and post-period wage of “*Null-High*” individuals was most similar to those of individuals in the “*Low-High*” group.

Survey Administration

The survey was available in both paper and online formats. The paper version was mailed out to all recipients in the spring of 2007. At this time, the online version was also made available. The survey’s cover letter informed potential participants that they could provide their responses either by mailing back the enclosed paper survey or by visiting the MAPP survey website. A second survey was mailed out approximately eight weeks later to those enrollees who had not yet responded to either the paper or online survey. Please refer to Attachment H, which is in PDF format accompanying this report, for a copy of the survey.

The survey was mailed to all MAPP enrollees who had been enrolled in MAPP as of December, 2006, and who had six months or more of MAPP enrollment in 2005 and 2006 combined. There were 9,667 individuals who met these criteria.

The current report excludes online responses, which will be examined in 2008.

²⁴ The quarter immediately following MAPP enrollment was included in the post-MAPP time period. Null indicates zero earnings or no record of earnings; low indicates lower than average earnings; and high indicates higher than average earnings.

Statistical methods

Item by item results were analyzed primarily according to earnings trajectory group. For each close-ended survey item with a categorical response set chi-square significance tests were performed to determine if there is an association between earnings trajectory group and responses. For some items – including multiple response items – basic descriptive statistics (e.g., frequencies) were used.

Response rate

The table below shows how many individuals responded, had a bad address, refused to participate, and simply did not respond.

Table 10

Response counts	
Category	Count
Online response	167
Paper response	3,613
Bad address	434
Refusal	114
No response	5,339
Total	9,667

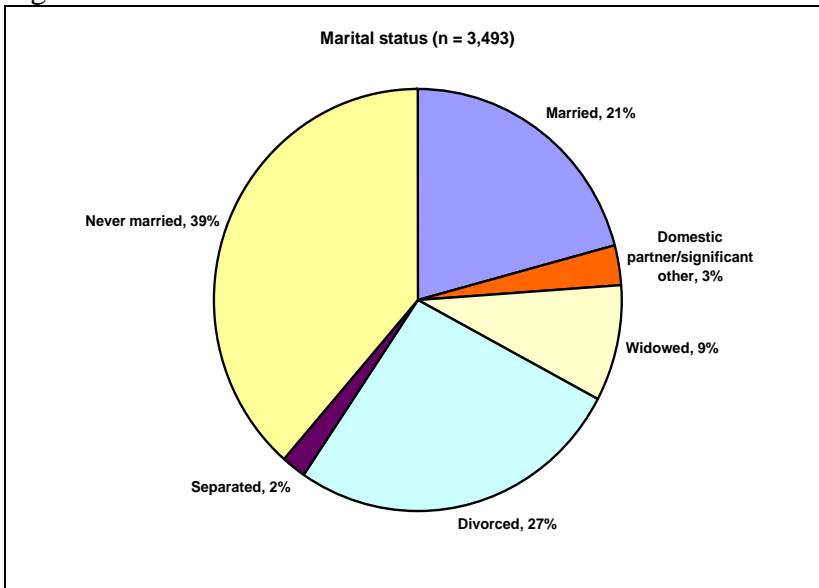
There were 3,613 paper responses and 167 online for a total of 3,780/9,233 responses – a 41% response rate, of which 4.4% were completed online.

MAPP participant demographics

Marital status

Figure 15 shows the marital status of survey respondents. About 25% of respondents indicated that they had a partner. About 40% of respondents report never having been married.

Figure 15.



Note: Item response rate 96.7%

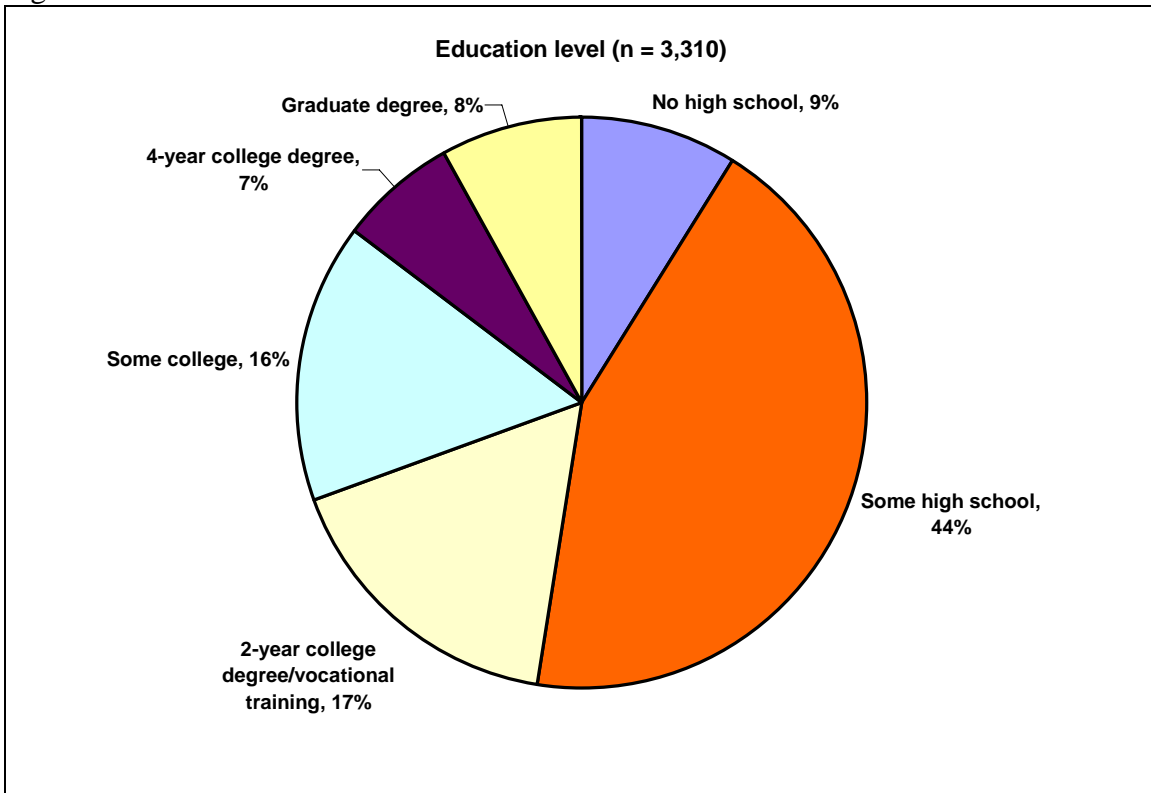
Those enrollees earning a wage appear less likely to be married ($\leq 19\%$). Those with earnings also appear slightly more likely to have a domestic partner/significant other than those without earned income. These two findings, although statistically untested, may suggest that being married is detrimental to some benefits at higher levels of earned income. Further supporting this, the highest earners are the most likely to report having never been married. Overall, 39% of survey respondents reported having never been married while about 55% of high earners reported this.

Education

Figure 16 shows that 44% of respondents said that “some high school” was the highest level of education achieved. It is assumed that people who completed high school might also have selected this option²⁵. Overall, 48% of respondents report having education beyond high school. This is significantly lower than the Wisconsin state average of 57% as reported in the most recent Wisconsin Family Health Study (2005)²⁶.

High earners are the most likely to have graduate degrees. Those enrollees with no earnings prior to MAPP enrollment and no earnings after (i.e., Null-Null) had the highest percentage of respondents report not having any high school education (12% as compared to $\leq 8\%$ for other groups).

Figure 16.



Note: Item response rate 91.6%

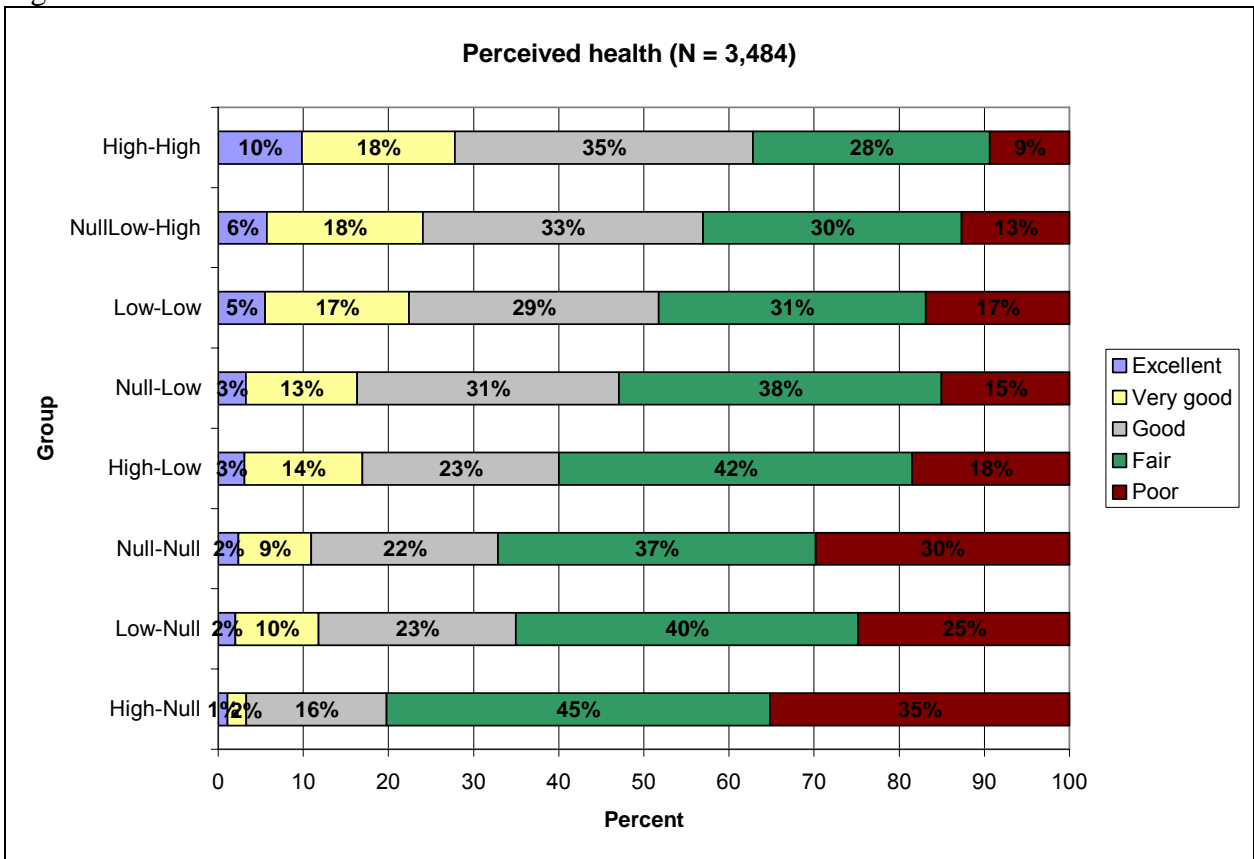
²⁵ The option “completed high school” was inadvertently omitted from the paper survey.

²⁶ The Wisconsin Family Health Study, 2005, DHFS website

Perceived health

Figure 17 shows that individuals earning at high levels following their MAPP enrollment were more likely to rate their health as excellent, very good or good. Those without earnings were considerably more likely to indicate fair or poor health. For example, 63% of High-High individuals rated their health as good or better, while only 19% of High-Null individuals rated their health good or better.

Figure 17.



Note: Item response rate 96.4%

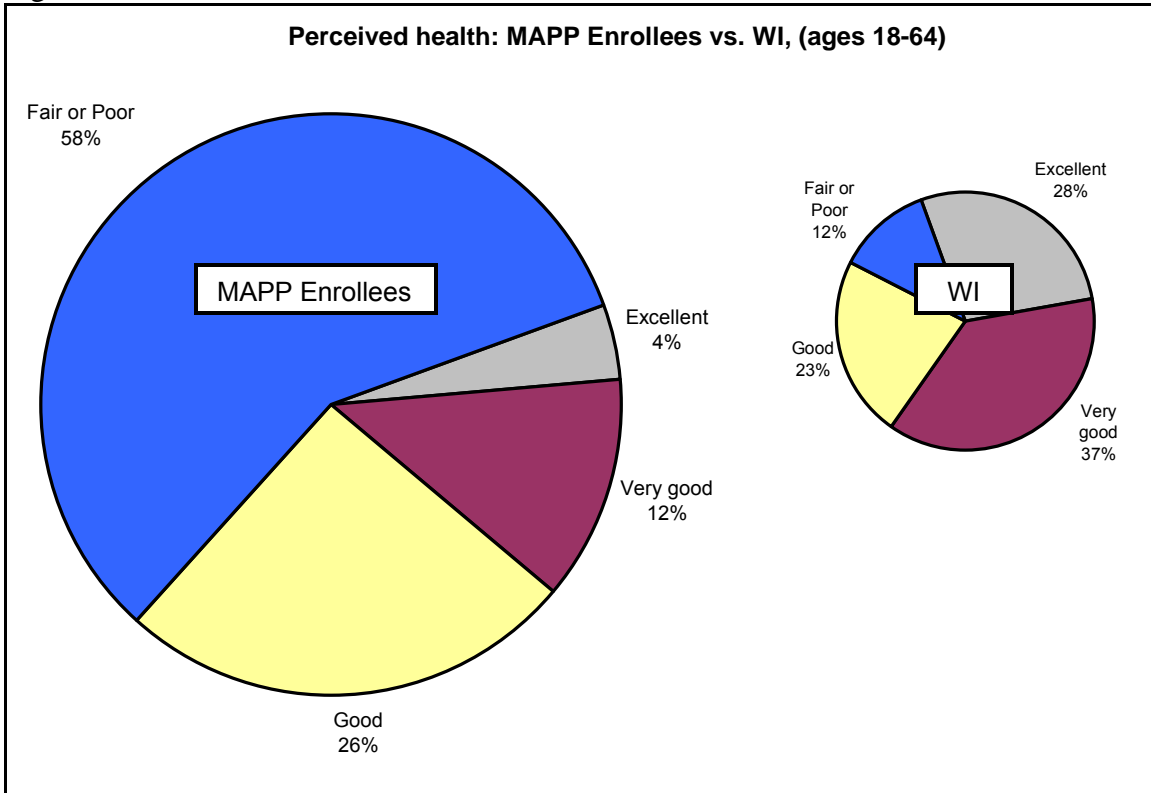
* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 260.93$, $df = 28$, $p < .001$)

Figure 18 displays a comparison of the perceived health status of respondents to the perceived health status of Wisconsin adults aged 18-64, as assessed in 2005 by the Wisconsin Family Health Study. MAPP enrollees over the age of 64 were excluded from this analysis for a closer comparison. The samples differ substantially in perceived health. Whereas 12% of Wisconsin adults rated their health as fair or poor, nearly 60% of MAPP enrollees did. Just over a quarter of Wisconsin adults rated their health as excellent, while a mere 4% of MAPP survey respondents did.

The differences in perceived health are not unexpected; MAPP is a program for people with disabilities and so it follows that its participants will have disabilities and lower perceived health.

The relationship between income and health is well-documented in research and so it was not surprising to see this relationship supported in this analysis. However, a causal relationship cannot be inferred from the results of the chi-square test; that is, it does not show that low income causes poor health, or that poor health causes low income. It merely shows that the two variables are related.

Figure 18.



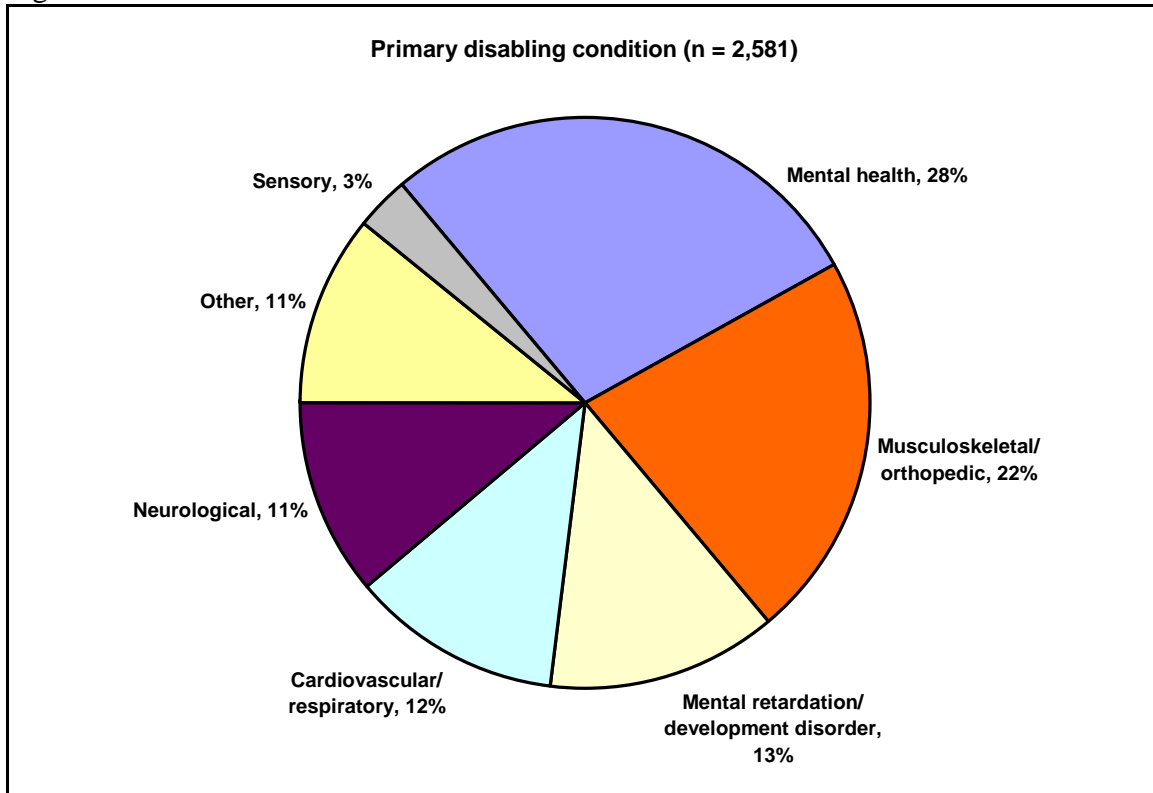
Note: Wisconsin data from 2005 Wisconsin Family Health Study. MAPP enrollee data based on respondents between the ages of 18 and 64 who provided response to this question (n = 3,009).

Disability

From a list of eight conditions, respondents were asked to select the one that best represents their primary disabling condition. The number of respondents choosing alcohol or drug abuse as their primary disabling condition represented less than 1% of total respondents, and so this condition was included in “other.”

Figure 19 below shows the frequency with which each of the listed disabilities was selected as one’s primary disability. Overall, 28% of respondents said that a mental health condition (e.g., depression or schizophrenia) was their primary disabling condition. Musculoskeletal or orthopedic conditions (e.g., back injury or arthritis) were the second most likely type of primary disabling condition, with 22% of respondents choosing this answer.

Figure 19.

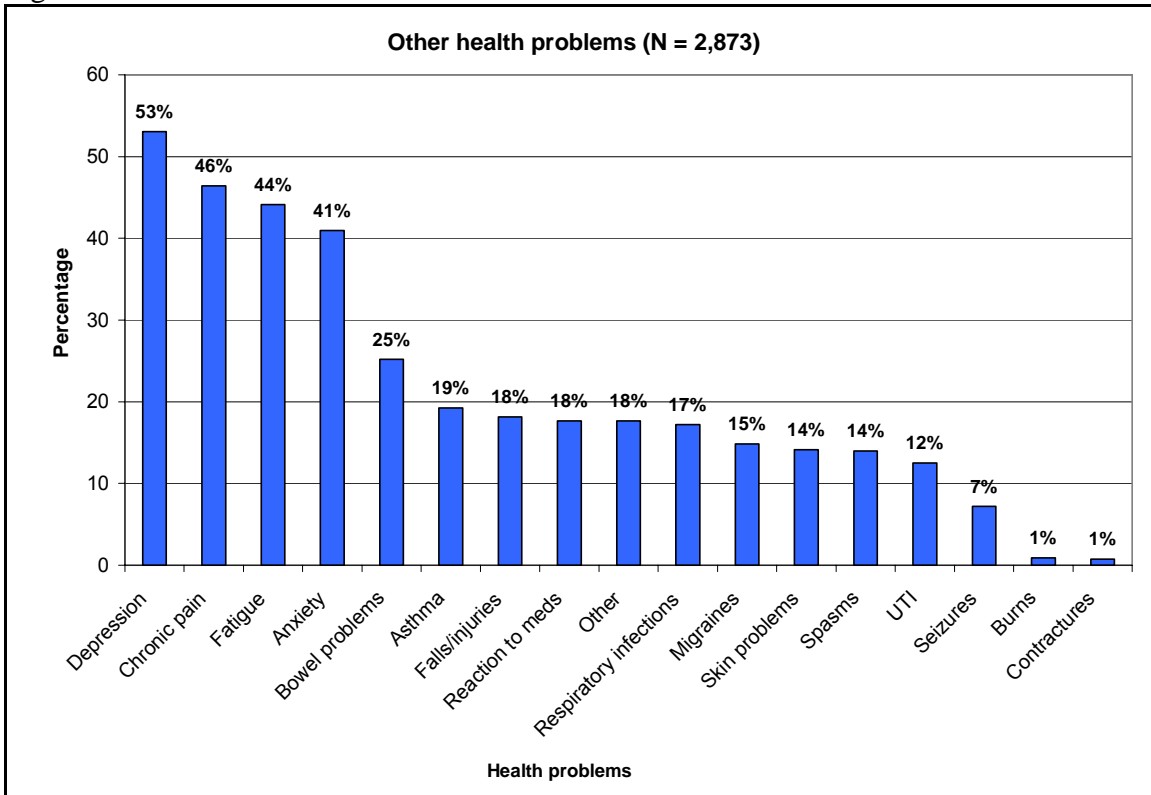


Note: Item response rate 71.4%

A follow up question presented a list of 17 health problems from which respondents were asked to select all that applied. Figure 20 shows, in descending order, the percentage of respondents selecting each health problem.

The most frequently cited health problem was depression, with 53% of respondents reporting this. As such, even though 28% of respondents chose “mental health” as their primary disabling condition (as indicated previously), Figure 6 shows that over 50% of respondents – and likely even more than that – suffer from depression and anxiety. Chronic pain, fatigue and anxiety were each selected by over 40% of respondents with 25% reporting bowel problems. The remaining health problems were chosen by about 20% or less of respondents.

Figure 20.

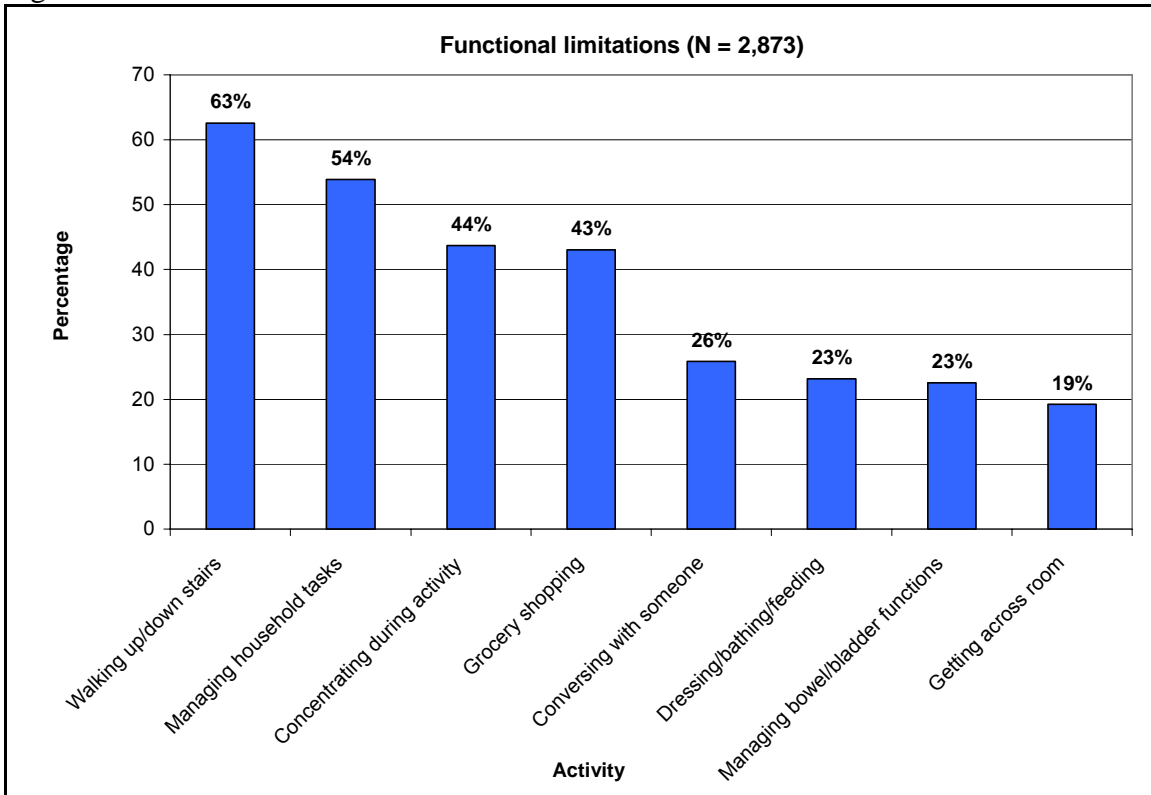


Note: Item response rate 79.5%

A multiple response question was included to assess the functional limitations of respondents. Selected activities of daily living (ADLs) and instrumental activities of daily living (IADLs) were included in a list of eight activities. Respondents were instructed to choose activities from the list with which they have had difficulty in the past 12 months.

Figure 21 shows, in descending order, the percentage of respondents selecting each activity with which they had difficulty in the last year. Walking up and down stairs was the most selected challenging activity: of the 2,873 respondents who answered this question, 63% indicated having difficulty with stairs. Another 54% indicated having difficulty managing household tasks, like cooking, cleaning or paying bills.

Figure 21.



Note: Item response rate 79.5%

Knowledge of enrollment in MAPP

About 70% of respondents indicated that they are aware they are enrolled in MAPP. Another 17% indicated that they did not know this, and a further 12% said they were unsure. Of course, there is also the possibility that a substantial number of enrollees who did not reply to the survey were people who were not aware of being enrolled in MAPP and so discarded the survey.

As documented earlier in this report, a high percentage of MAPP enrollees were previously enrolled in other Medicaid programs. Participants may be unaware of their enrollment in MAPP because their county worker switched them from regular Medicaid to MAPP without notifying them of the change. Because the health benefit packages for MAPP and regular Medicaid are identical, county workers may not inform the participant of the change to MAPP, despite the work requirement. This finding may also support the notion that some county workers use MAPP, despite its employment requirement, to qualify people for Medicaid who had lost previous coverage and would not otherwise qualify by noting that they do some type of in-kind work.

The Null-Null and Low-Null groups were the least likely to know that they were enrolled in MAPP (68% and 69%, respectively), while individuals in the High-Null group were the most likely to know (78%). One might expect those with no reported earnings during both the pre- and post-period (i.e., Null-Null) to be the least likely to know they are enrolled in MAPP, as MAPP

generally requires employment.²⁷ It follows that those with high earnings in either time period would be more aware of their enrollment in a work incentive program, as they might be enrolled in the program to increase or maintain a high level of earnings.

The intent of MAPP is to provide people with disabilities who are working or would like to work, with an opportunity to work more, save more and receive the same benefits from work that are available to the non-disabled population, without fear of losing their health benefits. That many survey respondents are unaware of their enrollment – and therefore likely unaware of the work requirement – raises the persistent question about whether the program is currently serving the original target population. This finding is supported by the large number of zero and very low wage earners found in MAPP.

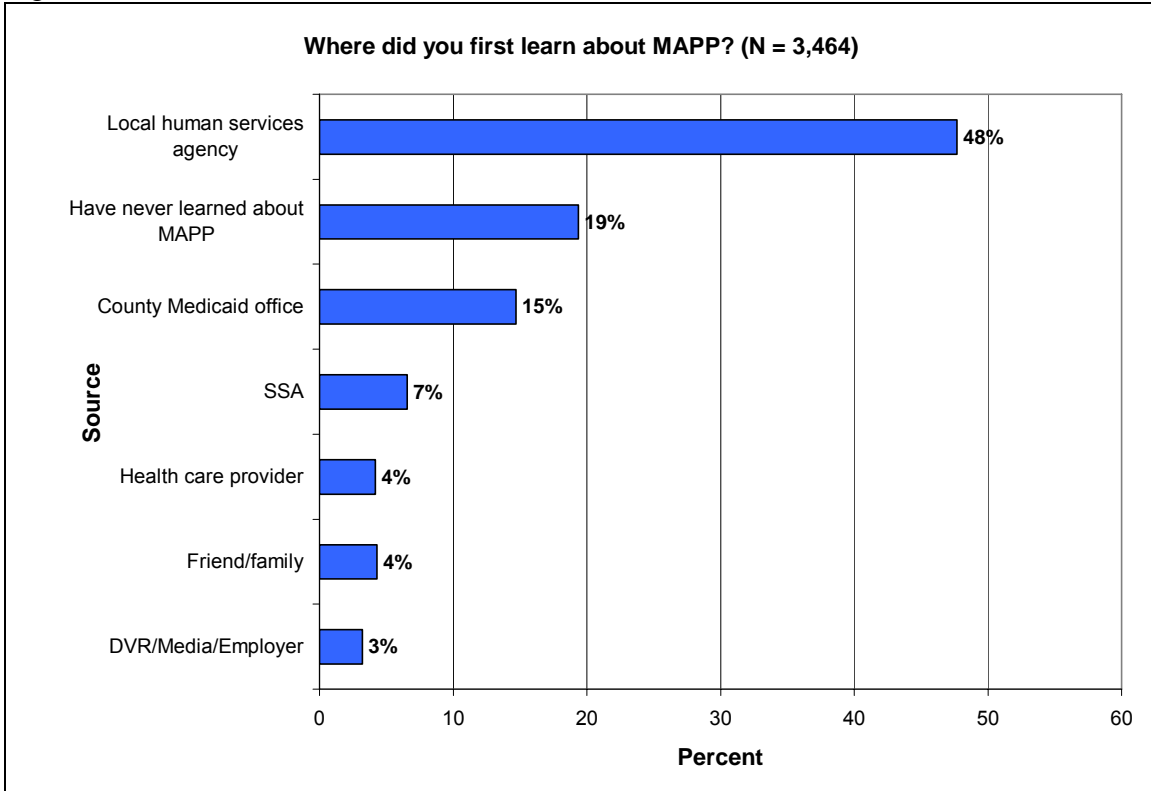
Respondents were also asked to choose the source from which they first learned about MAPP. Due to very low counts, the response categories “State vocational rehab agency (DVR),” “Media,” and “Employer” as each category represented less than 3% of responses. The chi-square test was statistically significant, indicating that there is a relationship between earnings group and responses.

Looking at Figure 22, about half of all respondents said that they first learned about MAPP from their local human services agency. The response chosen with the second highest frequency was “I have never learned about MAPP,” with 19% of all respondents choosing this option. This corresponds with the 17% who in said they did not know they were enrolled in MAPP.

The responses to this question show that regardless of group, most people in MAPP first learned about the program from their local human services agency. The chart also shows that the strong majority of survey respondents first learned about MAPP from a benefits-related agency (e.g., local human services agency, county Medicaid office) rather than from a health or employment-related entity (e.g., health care provider, DVR, employer). Relatively few enrollees first learned about the program through a state vocational rehabilitation agency, the media, or an employer. That few enrollees learned about MAPP from an employer or the media suggests that outside of government entities (e.g., human services agency, Medicaid office, SSA) there is the potential to increase awareness of MAPP and more proactively target those individuals for whom MAPP was originally intended.

²⁷ With the exception of those enrolled in a Health and Employment Counseling (HEC) program and those who are on an approved leave for health-related reasons.

Figure 22.



Note: Item response rate 96%

Employment and income among MAPP enrollees

Existing data sources, including UI wage data, do not reliably indicate a MAPP enrollee’s employment status because many MAPP participants have generally low earnings levels, receive in-kind compensation, or are self-employed. Nine questions were included in the survey to supplement these sources with employment data gleaned directly from enrollees. The first question in this section was used to determine which MAPP enrollees were employed. Only those indicating current employment were asked to complete the remaining questions in the section.

Employment status

Looking at Table 11, 70% of respondents indicated that they had one or more jobs, with the majority (66%) stating that they had one job. Just under one third of respondents (30%) said that they did not have a job.

Logically, it was expected that groups with low or high earnings in the post-period would be more likely to have a job as the earnings group should be closely related to one’s employment status²⁸. Earnings groups with no earnings following their first MAPP enrollment date (i.e., Null-Null, Low-Null, High-Null) were most likely to report that they did not have a job. Accordingly, these same groups were the least likely to report having one or more jobs, with only 57% of the High-Nulls reporting having one or more jobs.

²⁸ By survey design, “current employment status” refers to one’s post period, as survey was administered during all participants’ post-enrollment period.

Table 11.

Do you currently work at a job(s) for which you are paid money or get something else in compensation?*							
Group	Yes, I have one job		Yes, I have more than one job		No, I do not have a job		Total
	Count	%	Count	%	Count	%	
High-High	348	83%	23	5%	49	12%	420
NullLow-High	129	79%	9	6%	25	15%	163
Low-Low	360	74%	43	9%	82	17%	485
High-Low	88	68%	7	5%	34	26%	129
Null-Low	99	65%	11	7%	42	28%	152
Null-Null	1,078	60%	38	2%	679	38%	1,795
Low-Null	148	60%	9	4%	89	36%	246
High-Null	47	55%	2	2%	37	43%	86
Total	2,297	66%	142	4%	1,037	30%	3,476

Note: Item response rate 96.2%

* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 224.6$, $df = 14$, $p < .001$)

The two earnings groups with a post-period categorization of “high” were the most likely to report having a job. About 85% of the NullLow-High respondents said they had one or more jobs, and about 88% of High-High respondents said they had one or more jobs.

One would expect enrollees with a post-period categorization that is not null (i.e., low or high) to report having at least one job, since their categorization was based on having wages earned in this period. There are a number of possible explanations for this seemingly inconsistent finding: first, the post-period categorization was based on eight quarters of data, whereas this question asked only about one’s *current* employment situation. Second, it is possible that respondents were not wholly truthful in answering the question. Some non-working respondents might be inclined to report having a job simply because they are aware of the work requirement in MAPP. There is also the possibility that respondents did not fully understand that the question was also asking about in-kind earnings and so discounted this type of employment when choosing their answer.

Self-employment

The collection of self-employment data was of particular interest as these individuals are not required to report their earnings for UI purposes. Table 12 shows that 80% of employed respondents have an employer, while 16% are self-employed²⁹. A further 4% indicated that they were both self-employed and had an employer.

Almost all (97%) of the High-High and 92% of NullLow-High individuals said they were employed by someone else. It appears that following MAPP enrollment, enrollees are likely to have higher wages with an employer than they would through self-employment.

Table 12.

²⁹ Table includes only those responses provided by individuals who reported being employed on the previous question (n = 2,439).

Do you work for yourself or for someone else?*							
Group	Self-employed		Employed by someone else		I am both self-employed and employed by someone else		Total
	Count	%	Count	%	Count	%	
High-High	3	1%	352	97%	7	2%	362
NullLow-High	6	5%	123	92%	4	3%	133
Low-Low	31	8%	356	89%	11	3%	398
High-Low	7	8%	81	89%	3	3%	91
Null-Low	9	8%	92	86%	6	6%	107
High-Null	12	25%	36	75%	0	0%	48
Low-Null	34	23%	108	72%	9	6%	151
Null-Null	281	26%	750	69%	50	5%	1,081
Total	383	16%	1,898	80%	90	4%	2,371

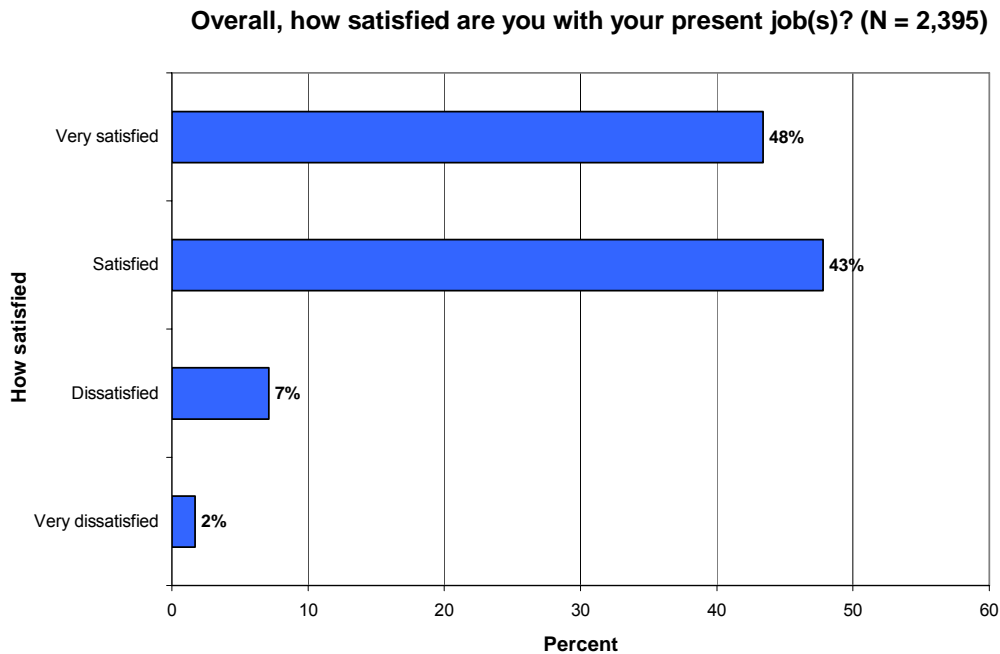
Note: Item response rate 97.2%

* Chi Square test statistically significant at $\alpha = .05$ ($X^2 = 209.82$, $df = 14$, $p < .001$)

Job satisfaction

There was no clear relationship between earnings group and job satisfaction. Figure 23 shows that the majority of all respondents (91%) reported being either very satisfied or satisfied with their job(s). Overall, extreme dissatisfaction is uncommon, being reported by less than 2% of respondents.

Figure 23.



Note: Item response rate 98.2%

Hours worked

Table 13 shows that of all respondents who work³⁰, over half (54%) work 1-10 hours a week. Just over one-fifth (21%) of respondents work upward of 21 hours per week. Not surprisingly, respondents in the High-High category were more likely than other respondents to report working 31 or more hours per week (19% vs. <10% for all other earnings groups). However, it is interesting to note that respondents in the NullLow-High group do not report working this many hours with the same frequency as their High-High counterparts; only 8% of NullLow-High respondents said they worked more than 31 hours per week.

Perhaps the most notable finding is that post-period high earners were less likely than other respondents to report having worked between 1-10 hours per week. While less than 20% of post-period high earners report working between 1-10 hours per week, more than 50% of all other respondents chose this answer. This is not surprising, though – generally speaking, the greater number of hours worked, the higher the weekly wage.

Table 13.

How many total hours do you work in a typical week at the job(s) you have?*									
Group	1-10		11-20		21-30		31+		Total
	Count	%	Count	%	Count	%	Count	%	
Low-Null	107	71%	26	17%	10	7%	8	5%	151
Null-Null	728	68%	169	16%	111	10%	68	6%	1076
Low-Low	239	61%	104	26%	39	10%	13	3%	395
High-Null	27	57%	9	19%	7	15%	4	9%	47
Null-Low	55	51%	25	23%	19	18%	8	7%	107
High-Low	47	51%	33	35%	8	9%	5	5%	93
NullLow-High	24	18%	69	51%	32	24%	11	8%	136
High-High	43	12%	178	49%	74	20%	69	19%	364
Total	1270	54%	613	26%	300	13%	186	8%	2,369

Note: Item response rate 97.1%

* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 479.69$, $df = 21$, $p < .001$)

Compensation

In-kind compensation – that is, the receipt of rent, food or other valuables for one’s work – can satisfy MAPP’s work requirement. About 80% of all respondents who work indicated that they are paid money. A further 13% indicated that they received some other type of compensation for their work, including rent, food or other valuables. Six percent of respondents indicated working for both money and another type of compensation.

The three groups with post-period null categorization (i.e., Null-Null, Low-Null and High-Null) were more likely to report having worked for non-monetary compensation. Over 20% of all respondents in these categories reported having worked for non-monetary compensation, while 5% or less of all other respondents reported this. This finding supports one of the weaknesses of relying on wage data for proof of employment, as it shows that those with no record of earnings may in fact be working, albeit for an alternative type of compensation.

³⁰ According to previous question on the survey.

Individuals in earnings groups with High post-period categorization (i.e., NullLow-High and High-High) were the most likely to work for money, with 95% and 97% reporting this respectively. This is unsurprising as these individuals had the highest post-period earnings in the wage data.

Looking at Table 14, the High-High and NullLow-High groups had the highest mean hourly wage, as expected (\$8.68 and \$8.10, respectively). Accordingly, the post-period Low groups had the second highest mean hourly wages and the post-period Null groups had the lowest hourly wages.

Table 14. Self-reported mean hourly wage

Group	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
High-High	339	\$8.68	2.44	0.13	8.42	8.94	2.00	21.00
NullLow-High	124	\$8.10	2.09	0.19	7.72	8.47	1.00	18.00
High-Low	77	\$7.60	2.91	0.33	6.93	8.26	1.00	22.00
Low-Low	320	\$7.33	3.67	0.21	6.93	7.73	0.00	45.00
Null-Low	84	\$6.97	2.57	0.28	6.41	7.53	0.50	15.52
High-Null	28	\$6.61	3.28	0.62	5.33	7.88	1.50	12.00
Low-Null	94	\$5.92	2.82	0.29	5.34	6.5	0.00	12.00
Null-Null	599	\$5.87	4.27	0.17	5.53	6.21	0.00	44.71
Total	1,665	\$7.04	3.64	.09	6.86	7.21	.00	45.00

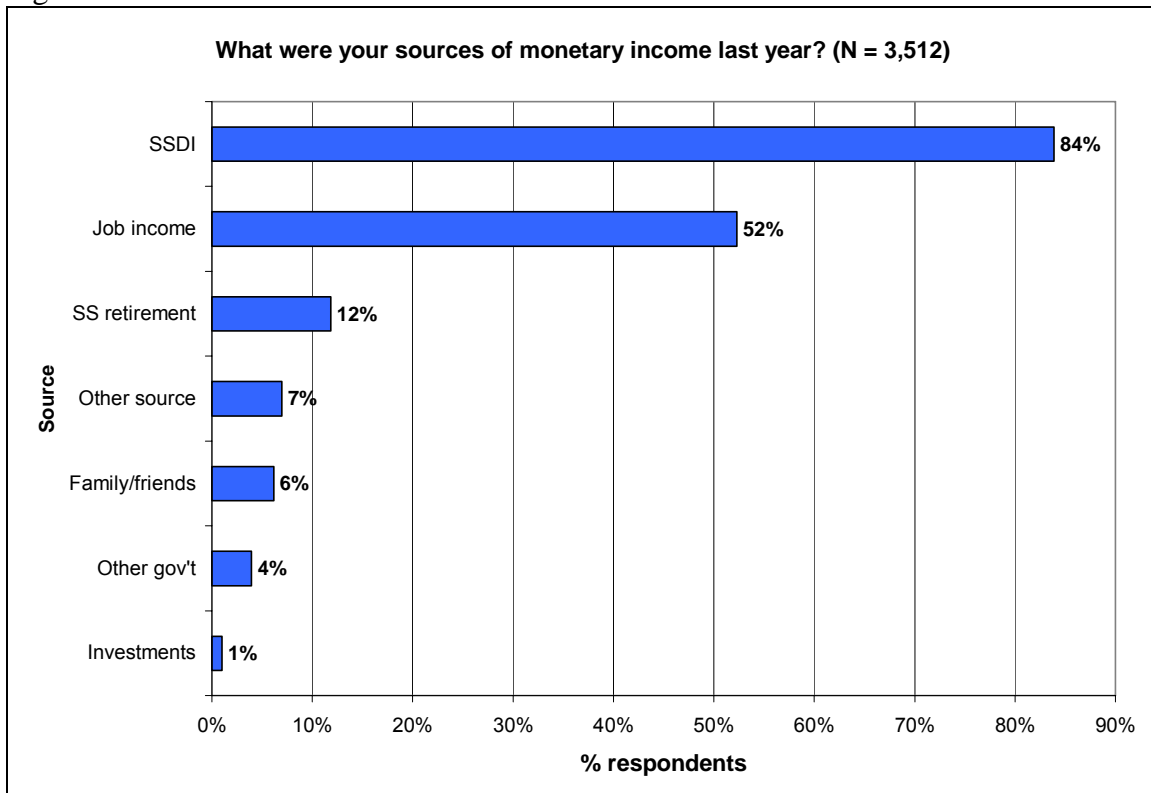
Respondents were provided a list of sources of monetary income and were asked to select all responses that applied. Figure 24 shows the percentage of respondents who selected each source of income.

By far, the most frequently cited source of income was Social Security disability payments, with 84% of respondents indicating that they received this type of payment³¹. Just over 50% of respondents said that they received an income from one or more jobs. Substantially fewer respondents selected any of the remaining income categories. This finding suggests that workers with disabilities still depend heavily on their disability benefits for support.

Sources of other financial government support, as indicated in the first open-ended portion of this question, included widows' benefits, veterans' benefits, social security, FoodShare, Section 8 housing assistance, and pensions. Sources of other general financial support (i.e., not from a governmental entity) included a spouse's income, child support and alimony.

³¹ Although it was expected that fewer high earners would have disability insurance payments, there were no differences between cohorts suggesting that "high" earners is more of a relative label.

Figure 24.



Note: Item response rate 97.2%

Employment support

A third group of questions asked about employment supports, barriers, and attitude toward work. As a work incentive program, these areas are of particular importance as they focus on the interaction between employment, disability and health care.

Experience with professionals who work with people with disabilities

One of the main goals of the survey was to learn more about outreach efforts and outcomes by assessing how well recipients understand verbal and written information they are given by professionals who work with people with disabilities (e.g., DVR staff, benefits specialists and county case managers).

Overall, about half of all respondents reported that they had talked about employment issues with a professional. Looking at Table 15, respondents in any of the three groups with no earnings recorded in their post-period were the least likely to have talked to a professional (40-44%). Respondents in the two High post-period categories were among the most likely (61-62%). Over 60% of respondents in the Low-Low and Null-Low groups also said they had talked about employment issues with a professional.

That earners were more likely to have talked to a professional about employment suggests a positive effect of these encounters. Of course the table highlights only a relationship between the two variables, and not causality. It is just as likely that the higher earners sought out help from these professionals. It is also interesting to note that about 60% of those who maintained or

increased earnings had talked about employment with a professional while those with a decrease in earnings were less likely to have talked to a professional.

Table 15.

Have you ever talked about employment issues with a professional who works with people with disabilities?*					
Group	Yes		No		Total
	Count	%	Count	%	
NullLow-High	100	62	61	38	161
Low-Low	298	62	183	38	481
High-High	254	61	163	39	417
Null-Low	96	61	62	39	158
High-Low	59	46	70	54	129
Low-Null	110	44	139	56	249
Null-Null	745	42	1,041	58	1,786
High-Null	35	40	53	60	88
Total	1,697	49%	1,772	51%	3,469

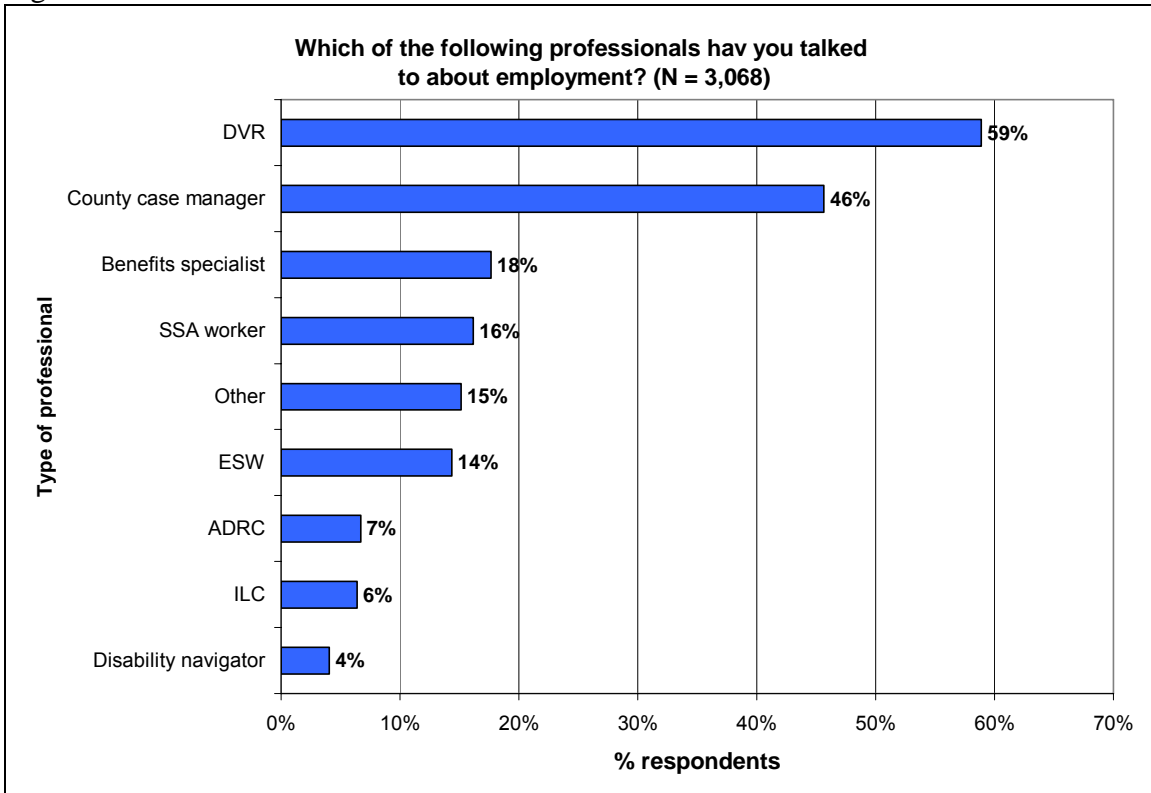
Note: Item response rate 96%

* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 119.61$, $df = 7$, $p < .001$)

Figure 25 shows the types of professionals who are available to discuss employment issues. Nearly 60% of respondents said they had discussed employment issues with Division of Vocational Rehab staff (DVR). The next most frequently selected professional was “County case manager” with 46% of respondents selecting this answer. The percentage of respondents choosing the remaining answers decreases significantly, with the third highest percentage (18%) choosing “Benefits specialist.” The least frequently selected answer was, “Disability Navigator,” with only 4% of respondents choosing this answer.

The “Other” category comprised 15% of responses. Provided in the open-ended portion of the question, some recurrent responses included social workers, supported employment agency and sheltered workshops, various health care professionals, job coaches and various employment agencies.

Figure 25.



Note: DVR = Division of Vocational Rehab; SSA worker = Social Security Administration worker; ESW = County economic support worker; ADRC = Aging & Disability Resource Center; ILC = Independent Living Center
 Note: Item response rate 97.8%

Overall, almost 70% of respondents said they understood either most or all of what professionals explained to them regarding employment. It is somewhat counterintuitive that the three earnings groups with no earnings in the post-period (i.e., post-period Null) were the most likely to report having understood everything that was explained to them. Of course perceived, self-reported understanding does not assure actual understanding, which is a more difficult concept to measure on a survey.

Just over half of the respondents (52%) reported having understood all or most of the written information given to them by professionals. The high post-period groups (i.e., High-High and NullLow-High) were the least likely to report having understood all of the written information that was given to them. They were also the least likely to report having understood all of the verbal information provided by professionals. Low or non-earners may not require the same level of understanding as their higher-earning counterparts, as their lower (or non-present) earnings lower their risk of losing benefits. Higher earners, however, might be at a higher risk of losing benefits and might be required to understand more comprehensive or detailed information.

Overall, about one-quarter (26%) of respondents said that a professional had discussed new benefits or programs that were available. The remaining three-quarters of individuals were either not told of such programs or were not sure.

Three-quarters of respondents said that information provided by a professional(s) was either useful or very useful, with most choosing “useful” (57%). Ten percent of individuals claimed that information was not useful at all, or that they were not given any. The three groups with no post-period earnings were the most likely to have reported that information was not useful at all, or that no information was given.

Seventy percent of respondents rated the quality of support as good or better while 23% rated support fair or poor. A further 5% of respondents reported that they did not obtain any services within their county.

Table 16 displays results. Although the relationship is not easily discernable among the data, it appears that those who moved from high to either low or no earnings were the least likely to rate the support received as “excellent.”

Table 16.

In the county where you live, how would you rate the quality of support you have received from professionals regarding employment issues?*													
Group	Excellent		Very good		Good		Fair		Poor		Did not obtain services in my county		Total
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%	
Low-Null	29	27%	25	23%	18	17%	18	17%	9	8%	8	8%	107
Null-Low	25	27%	31	33%	21	23%	9	10%	5	5%	2	2%	93
High-High	59	24%	66	27%	56	23%	37	15%	21	9%	8	3%	247
Low-Low	55	19%	80	28%	64	23%	42	15%	26	9%	17	6%	284
NullLow-High	18	18%	30	30%	21	21%	16	16%	13	13%	1	1%	99
Null-Null	129	18%	196	28%	172	24%	113	16%	56	8%	48	7%	714
High-Low	10	17%	14	24%	24	41%	5	9%	5	9%	0	0%	58
High-Null	2	6%	10	30%	8	24%	8	24%	2	6%	3	9%	33
Total	327	20%	452	27%	384	23%	248	15%	137	8%	87	5%	1,635

Note: Item response rate 96.3%

* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 49.85$, $df = 35$, $p < .05$)

Barriers to working or earning more

This survey question comprised five groups of barriers from which respondents were asked to select all applicable responses. These groups were health reasons, other commitments, fear of losing benefits, lack of things necessary for work, and other reasons. The intent of this question was to assess perceptions of barriers that impede MAPP enrollees from working or earning at higher levels.

Figure 26 shows how MAPP enrollees perceive health reasons as barriers to working or earning more. In this set of reasons, “physical limitations” was the most frequently chosen, with about one-third of respondents selecting it. “Poor mental/emotional health” was also a frequently chosen response, with about one-quarter of all respondents choosing it.

Figure 26.

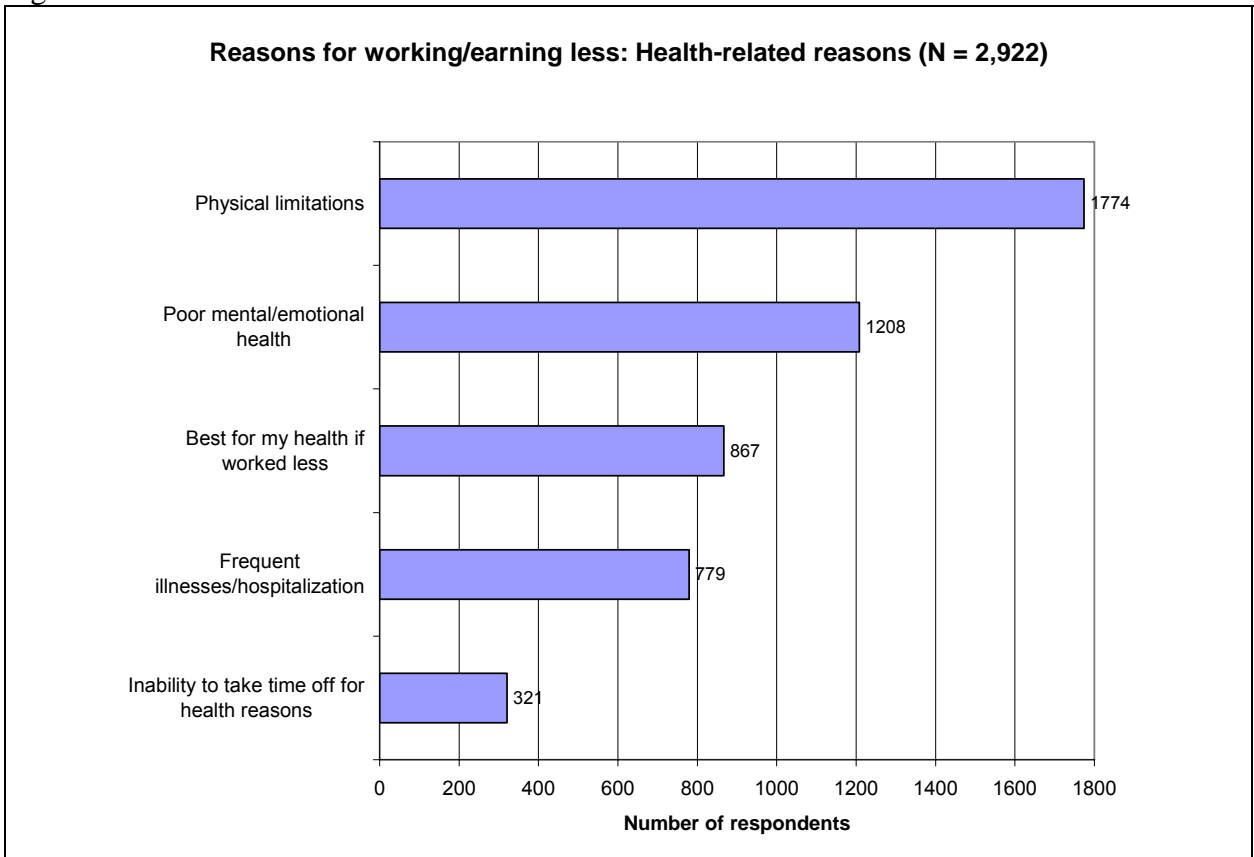


Figure 27 shows how 878 MAPP enrollees perceive other commitments as barriers to working or earning more. “I would not have enough time for personal needs” was the most frequently chosen response for all but one earnings group. “Caring for someone else” and “Doing volunteer work” were selected by about one-quarter of respondents. The least frequently selected response was “Enrolled in school or training program.”

Figure 27.

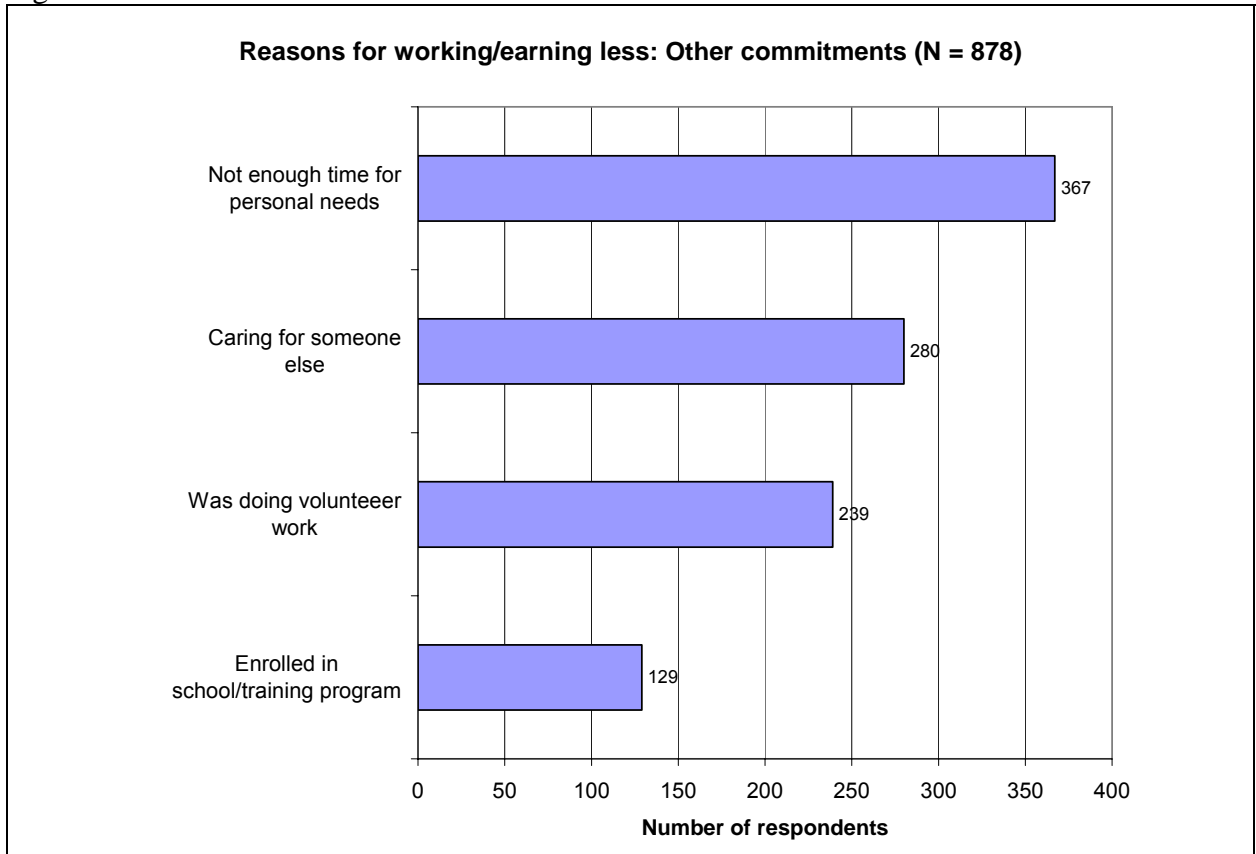
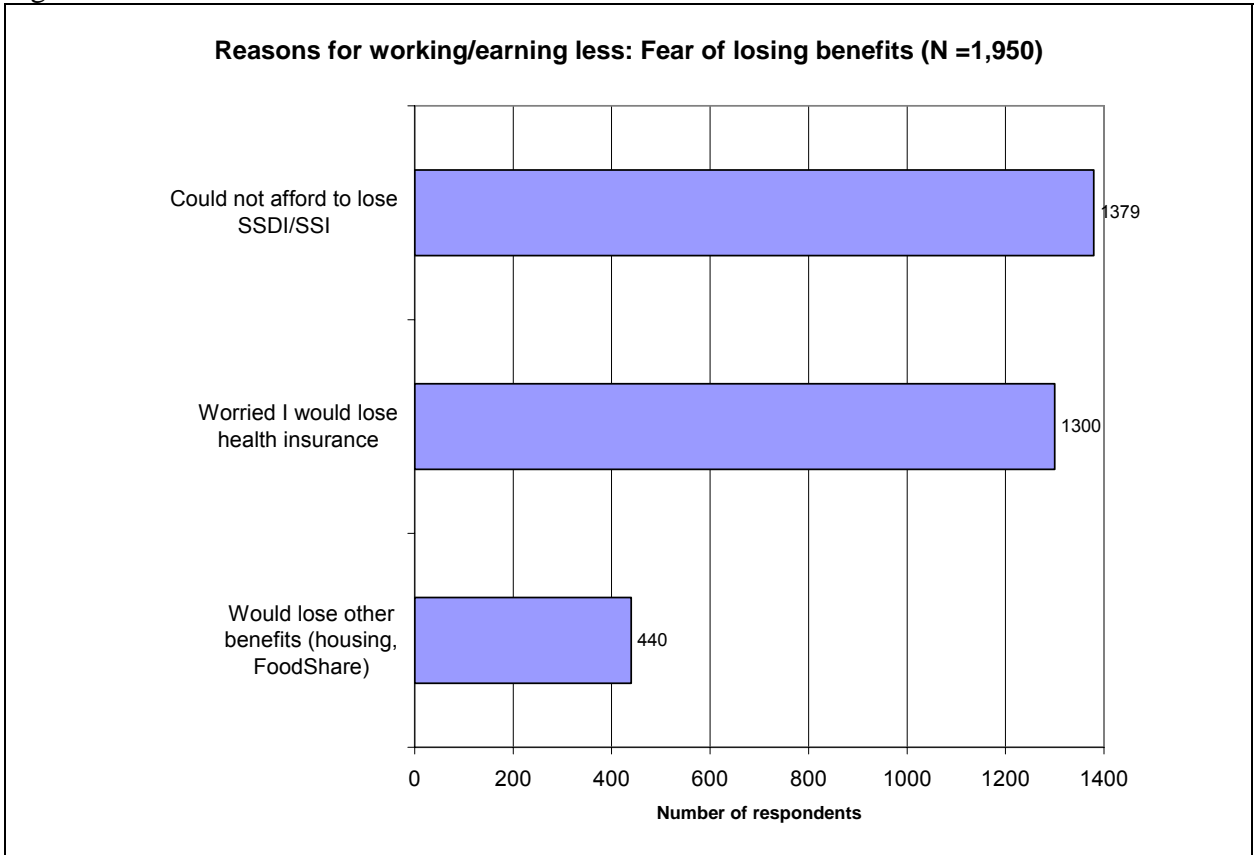


Figure 28 shows how MAPP enrollees perceive the fear of losing benefits as a barrier to working or earning more. Historically, losing benefits has been a frequently cited reason for not working more. The percentages shown in the chart are based on 1,950 respondents who answered this portion of the question.

Across all earnings groups, “Could not afford to lose SSDI/SSI cash benefit” and “Worried about losing health insurance” were closely matched in selection frequency. At least 60% of all respondents said that they were worried about losing health insurance, and at about 70% of respondents said that they could not afford to lose their SSDI or SSI cash benefit. About one-quarter of respondents said they were afraid of losing other benefits such as housing subsidies and FoodShare.

These findings corroborate what has been known anecdotally for some time – the majority of MAPP enrollees worked or earned less because they did not want to lose health and cash benefits.

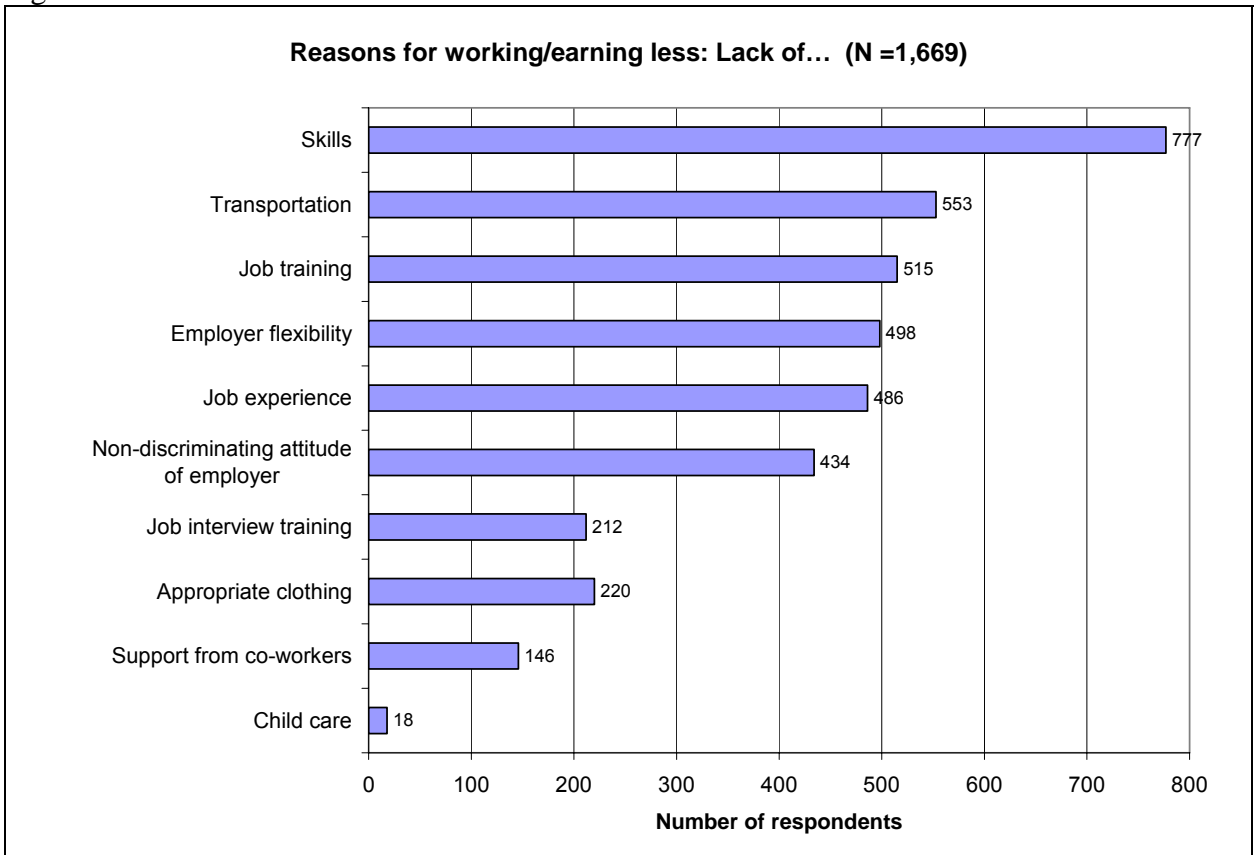
Figure 28.



The fourth set of answers listed ten items and services that MAPP enrollees may lack which can then serve as barriers to earnings or working more. Figure 29 displays the percentages of respondents who chose each response, based on the 1,669 respondents who answered this portion of the question.

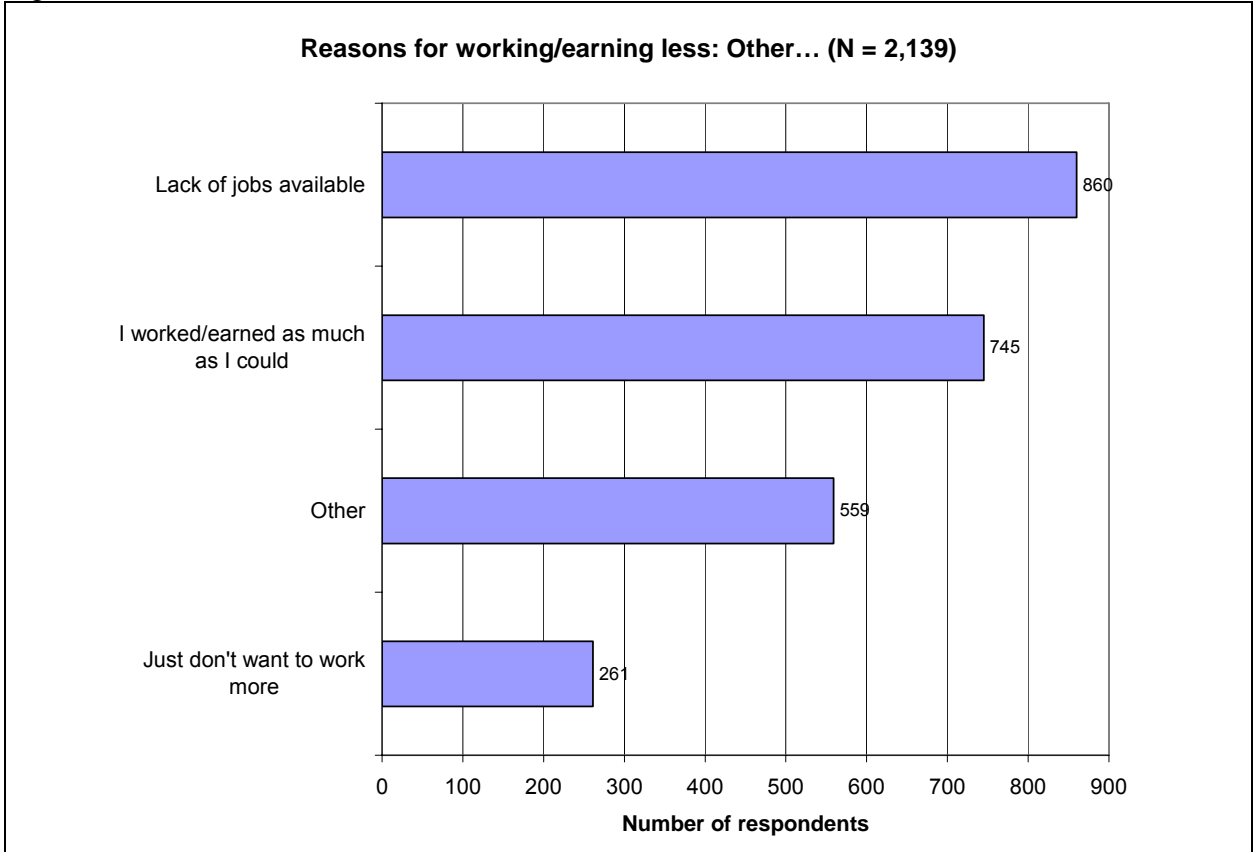
The most frequently chosen answer was “lack of skills,” with at least 35% choosing it. Many of the other listed items were selected frequently, including lack of transportation, lack of employer flexibility, and lack of job training and experience. About one-third of respondents also claimed that their employer had a discriminatory attitude toward people with disabilities. Child care was the least frequently selected answer.

Figure 29.



The final set of answers was designed to capture other reasons for working or earning less. Figure 30 below shows the percentages of respondents in each earnings group who selected each response (n = 2,139).

Figure 30.



Attitude toward work

Survey participants were presented with eight statements about work and were instructed to choose one response per statement that best described the level to which they agreed with the statement (strongly agree, somewhat agree, somewhat disagree, strongly disagree, not sure)³². Respondents were given a score, based on their responses to each statement³³. The score was calculated by adding the individual scores from each statement, and then dividing by the number of statements the individual responded to. Lower scores represent more positive attitudes toward work.

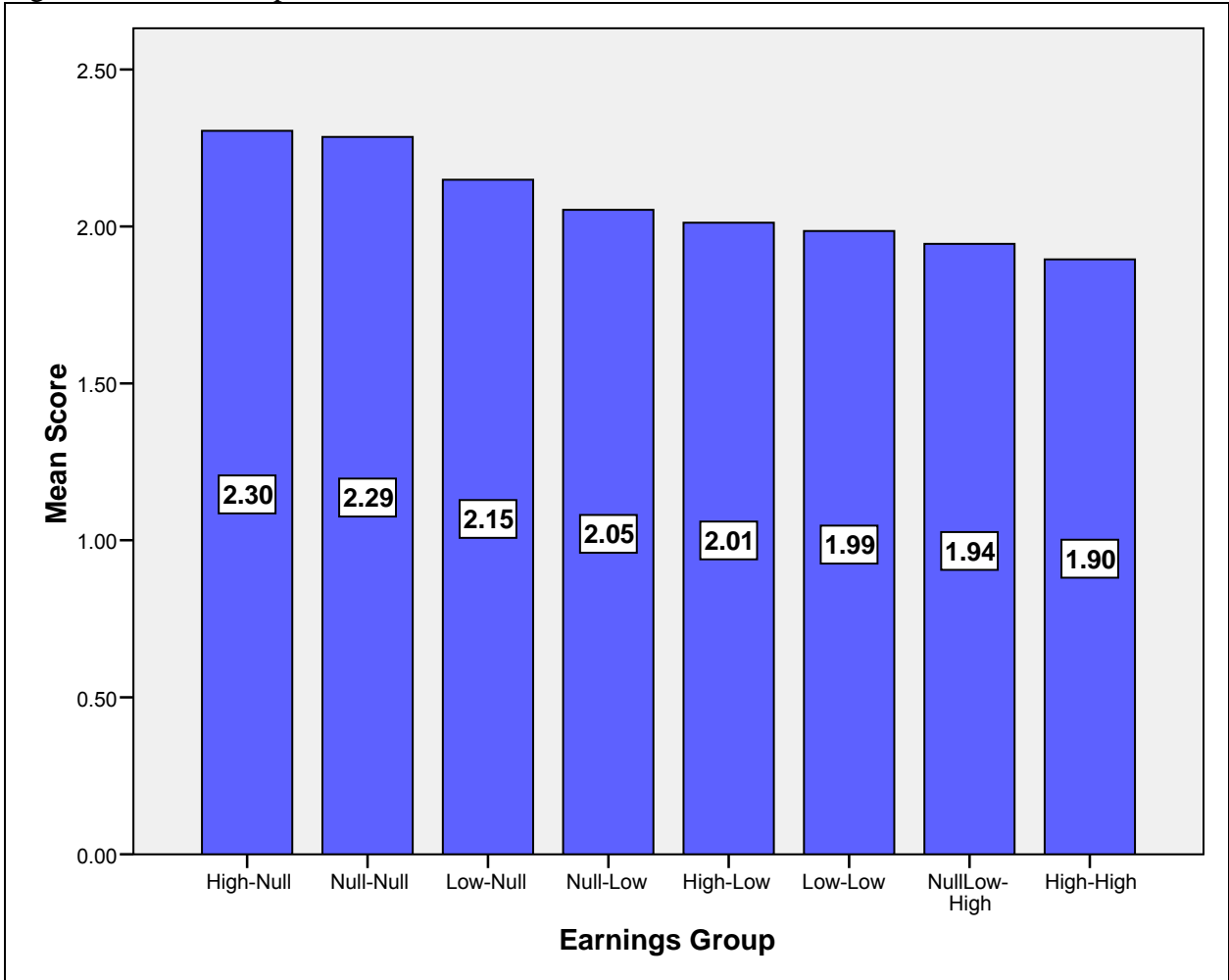
Figure 31 shows the mean overall scores. As with other questions, earnings groups with the same post-period category (i.e., null, low or high) cluster together. The three Null groups scored the highest, suggesting a less positive attitude toward work. The High groups scored the lowest, suggesting a more positive attitude toward work. This finding shows that one’s current employment status may have some influence on attitude toward work, which is not entirely

³² Items for this question were derived from Oregon Health Policy Institute's "Employment Barriers Survey," 1999.

³³ The first item in this question was not included in the composite score as its endorsement did not necessarily reflect a positive attitude toward work. Responses of "unsure" were excluded from scoring.

surprising. If an individual is currently employed, he or she may feel more optimistic about the benefits of working; conversely, if an individual is unemployed, he or she may have a different outlook on the benefits of working. Alternatively, an individual with a more positive attitude toward work might be more inclined to work. These scores reflect only a correlation between attitude and earnings group; therefore, no causal statements can be made.

Figure 31. Mean composite score

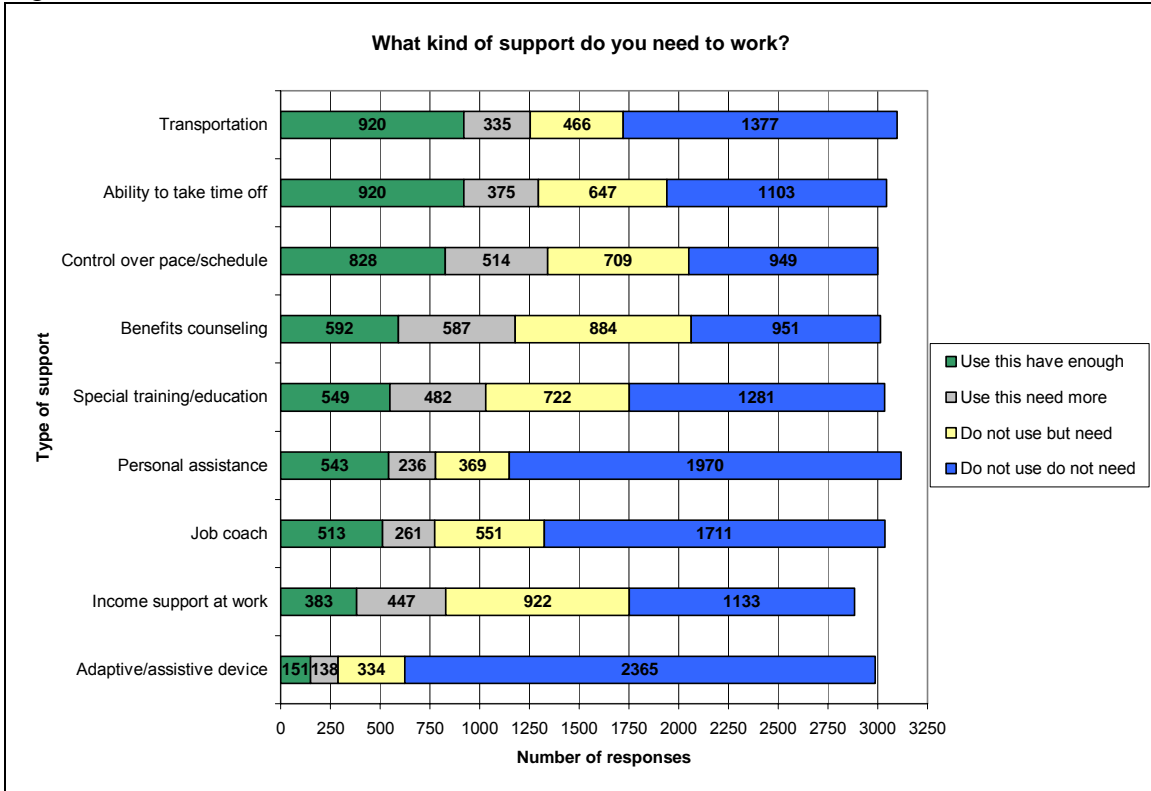


Note: Item response rate 89.6%

Employment support

Lack of support may serve as a barrier to working or earning more. Nine types of support that people might need to work were presented to respondents who were asked to choose the statement that best described how they felt about each type of support. Figure 32 presents how enrollees rated each type of support.

Figure 32.



Assuming that use of a support reflects need, the first three possible response statements capture need (i.e., use this need more, use this have enough, do not use but need). Therefore, to better understand overall need of a particular support, these three bar segments can be interpreted as one. For example, looking at personal assistance, 1,970 (or 63%) respondents said they did not use this type of support and did not need it. Looking at the three leftmost bar segments as one, we can infer that about 37% of respondents *do* need this type of support. The middle two bar segments – grey and yellow – represent unmet needs.

The greatest need appears to be for ability to take time off, income support at work (i.e., long term disability insurance), control over one’s pace and schedule, and benefits counseling. Of these, benefits counseling had the largest unmet need (i.e., 49% - the percentage of those who selected “use this and need more” plus those who selected “do not use but need”).

Impairment Related Work Expense (IRWE)

Previous analyses (e.g., using CARES data) have shown that the IRWE benefit is used infrequently. This may be due to individuals being unaware of the benefit, but it is also likely the result of it being inapplicable to the majority of MAPP enrollees. If an individual does not have any earned income (and hence, no premium), there is no need to apply an IRWE.

Table 17.

Have you heard of IRWE before?*							
Group	Yes		No		Not sure		Total
	Count	%	Count	%	Count	%	
High-High	74	18%	259	62%	84	20%	417
NullLow-High	24	15%	107	67%	30	19%	161
High-Low	17	13%	94	72%	19	15%	130
Null-Low	20	13%	103	67%	31	20%	154
Low-Low	49	10%	342	72%	85	18%	476
Low-Null	21	9%	176	72%	46	19%	243
Null-Null	147	8%	1,293	73%	321	18%	1,761
High-Null	4	5%	64	73%	20	23%	88
Total	356	10.4%	2,438	71.1%	636	18.5%	3,430

Note: Item response rate 94.9%

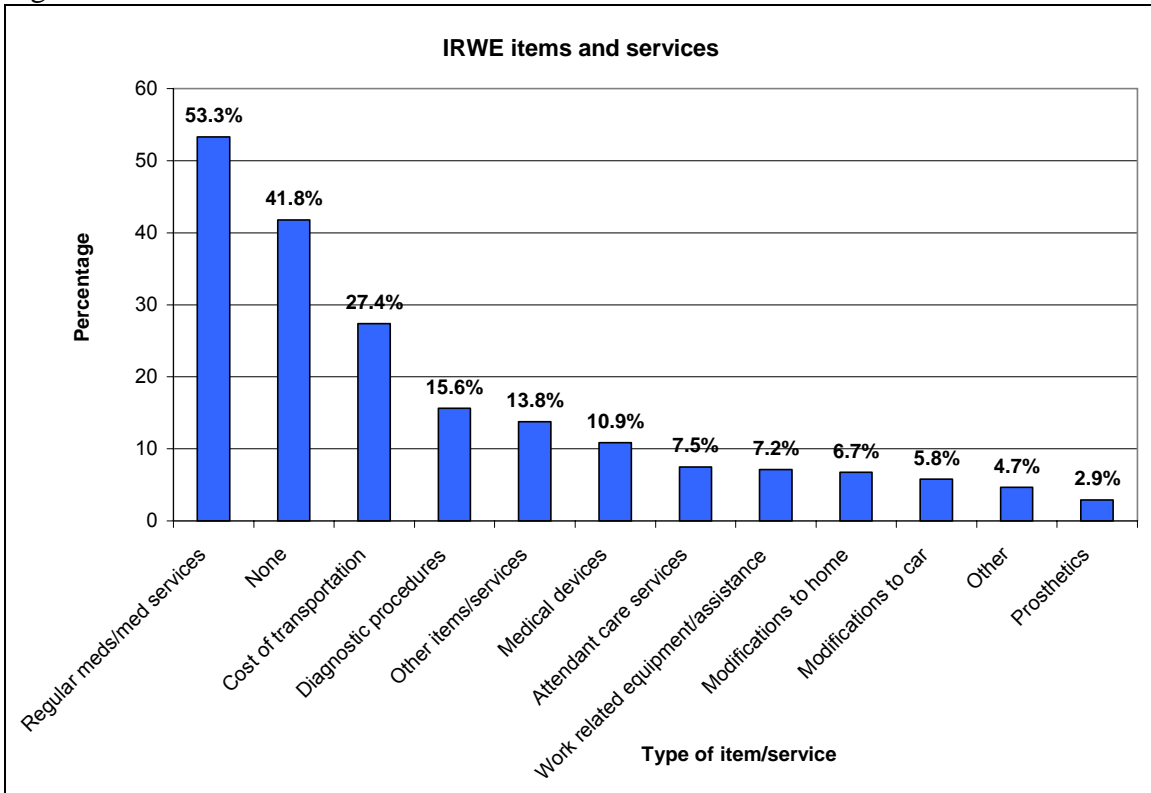
* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 47.55$, $df = 14$, $p < .001$)

Looking at Table 17, overall, just over 10% of respondents said they had heard of IRWE before. About 87% said they had not heard of IRWE before or were unsure. The low awareness corroborates findings from previous CARES analyses. As might be expected, those individuals with higher than average earnings following their MAPP enrollment were more likely than others to have heard of IRWE. Those with no earnings following their MAPP enrollment were the least likely to have heard of IRWE, and lower than average earners were clustered between the high earners and null earners. This pattern has been seen in other questions, which strengthens the theory that responses are related more to one’s post-period earnings category than to their pre-period category.

An additional question was included to assess how the IRWE benefit could potentially be used. It should be emphasized that an IRWE-qualifying item or service will only be beneficial to those MAPP enrollees who are earning at or above certain levels. For enrollees who have not heard of IRWEs, this question may have served a more educational purpose, informing them of a benefit that could be available to them.

Figure 33 is based on the multiple responses of 3,132 individuals who responded to this question. From the 12 available answers, these individuals selected a total of 6,186 responses.

Figure 33.



Note: Item response rate 86.7%

Just over 50% of respondents said they expected to pay out of pocket in the next year for regular medications or routine medical services. The second most frequently selected answer was “none,” or that the individual did not expect to pay for any items or services in the next year that would qualify as an IRWE. Just over one-quarter of respondents anticipated having transportation costs that would qualify as an IRWE.

If a respondent chose “other,” he or she was asked to specify the item or service in the space provided. Often, respondents would reiterate items or services here that were included in other responses. For example, some individuals included a comment about transportation, medications or assistive devices when these items and services could have been accounted for elsewhere in the list. Some respondents also used the space to simply comment, “none,” suggesting that the frequency for “other” is slightly inflated.

Transition to Medicare Part D

Medicare Part D was implemented January 1, 2006. MAPP enrollees who were eligible for both Medicaid and Medicare began receiving prescription drug coverage through this program. Seven questions about Medicare Part D were included to assess the impact of this new program on MAPP enrollees, many of whom were enrolled when it was implemented in January 2006.

About 83% said they were enrolled in Medicare Part D and about 17% said they were not. This finding is supported by administrative data (i.e., MEDS data warehouse) which show that 85% of individuals enrolled in MAPP in 2007 were dually eligible. Table 18 displays results.

Table 18.

Are you enrolled in Medicare Part D?*					
Group	Yes		No		Total
	Count	%	Count	%	
Null-Low	125	90%	14	10%	139
NullLow-High	131	88%	18	12%	149
Low-Low	375	87%	54	13%	429
Null-Null	1,400	84%	263	16%	1,663
High-High	310	79%	82	21%	392
High-Low	99	79%	27	21%	126
Low-Null	175	78%	49	22%	224
High-Null	58	68%	27	32%	85
Total	2,673	83.3%	534	16.7%	3,207

Note: Item response rate 88.8%

* Chi Square test statistically significant at $\alpha = .05$ ($\chi^2 = 38.13$, $df = 7$, $p < .001$)

Due to the complexity of switching people from one plan (Medicaid) to another (Medicare Part D) for their prescription drug coverage, outreach efforts were made prior to implementation and continued throughout early stages of implementation. Two questions sought to assess the impact of these outreach efforts.

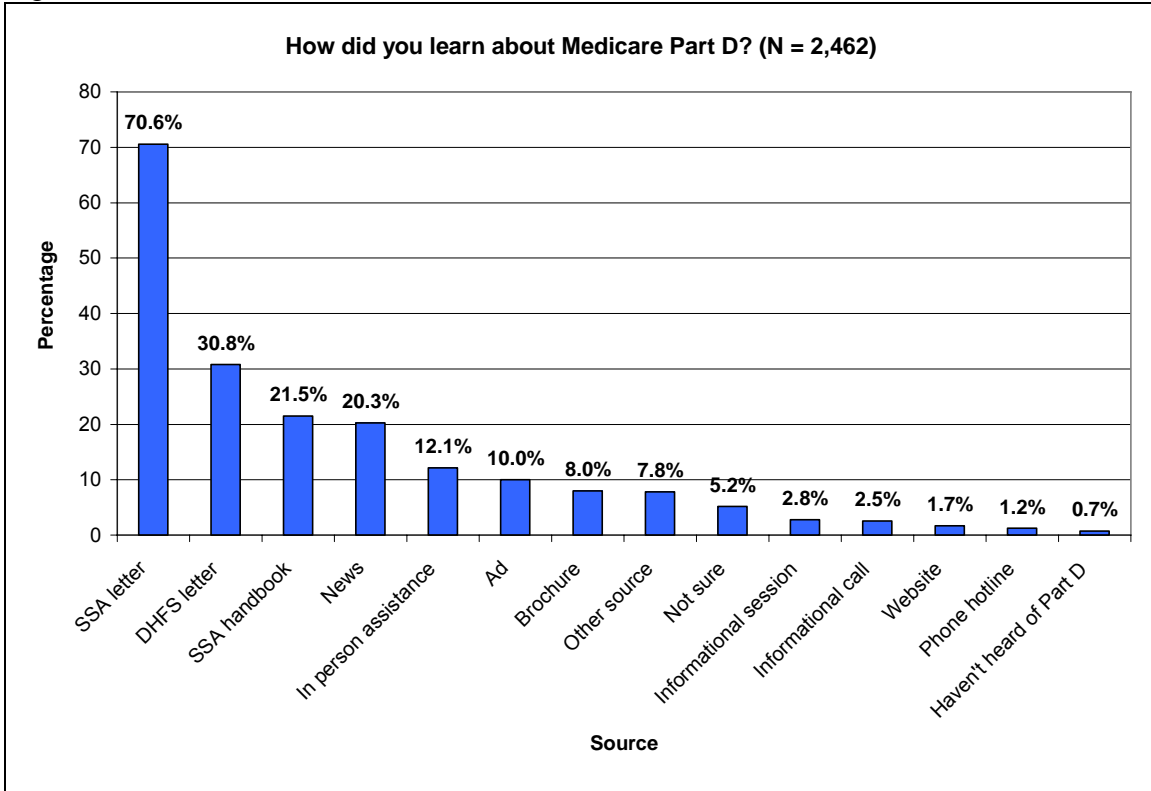
Respondents were asked to select from a list all sources from which they learned about Medicare Part D. Figure 34 shows the frequency with which respondents chose these options.

Most respondents – about 70% - said that they learned about Medicare Part D from a letter sent by the Social Security Administration (SSA)³⁴. Another 31% said they learned about it from a letter sent by the Department of Health and Family Services (DHFS). About 20% learned about Medicare Part D from the SSA’s handbook and 20% learned about it from the news. The remaining sources from which enrollees may have learned about Medicare Part D were chosen by 12% or less of respondents.

Some “other” sources include pharmacies, case managers, benefit specialists, and AARP.

³⁴ Only respondents enrolled in Part D, as assessed on the previous item, were instructed to answer this multiple response question. Of the 2,673 respondents enrolled in Part D, 2,642 answered Question 25, providing a total of 5,159 responses.

Figure 34.



Note: Item response rate 98.8%

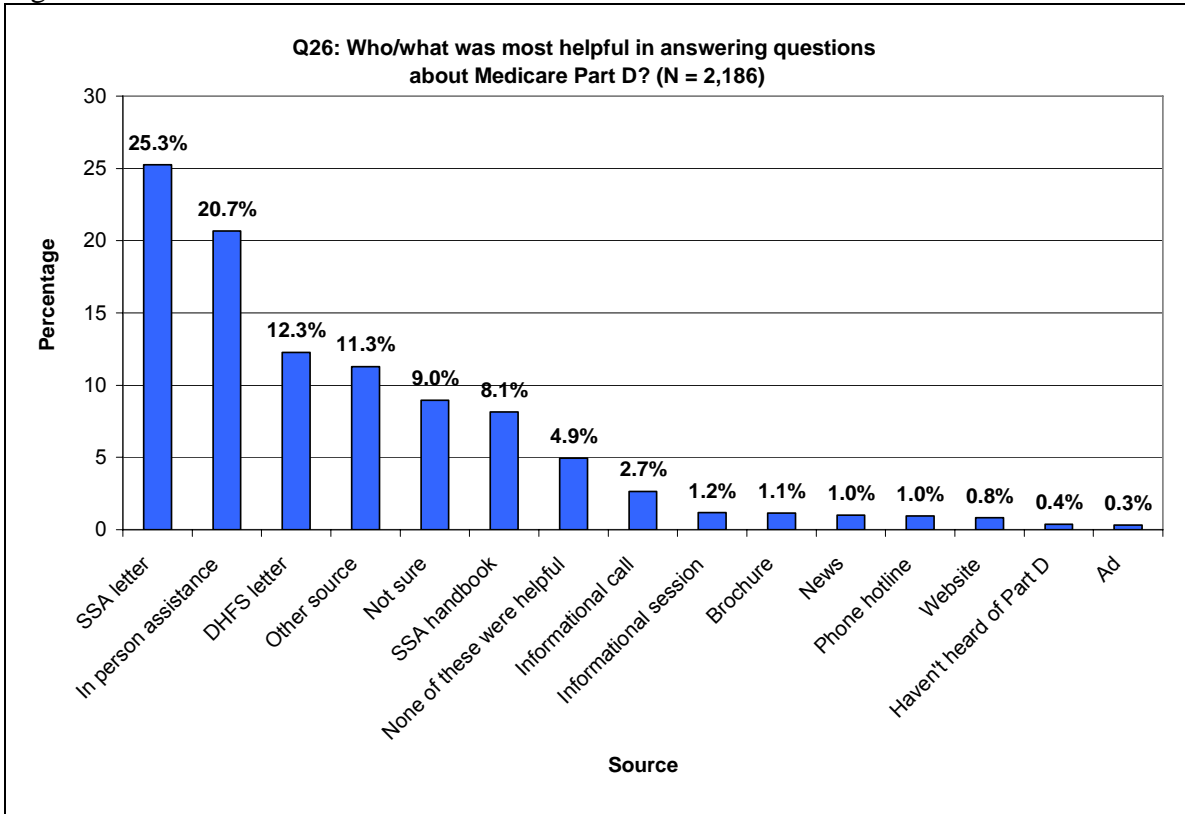
Respondents were then asked to choose the single most helpful source from a list of sources identical to those provided in Question 25. Of the 2,673 respondents who said they were enrolled in Medicare Part D (as per Question 23), 82% responded to Question 26. This is far fewer than the 98.8% who responded to Question 25. It is likely that a greater percentage did in fact respond to the question; however, because they were instructed to choose only one response, those who chose more than one response were treated as missing³⁵.

Figure 35 shows, in descending order, the percentage of respondents who selected each source as the most helpful in answering questions about Medicare Part D.

- Just over one-quarter of respondents said that the letter received from the SSA was the most helpful in answering questions. In person assistance was considered the next most helpful source, with the letter from the DHFS being cited by only 12% as the most helpful source of information.
- Media sources – including ads, websites and news – were considered among some of the least helpful sources.
- Some of the “other” sources considered the most helpful included pharmacy staff and case managers.

³⁵ Due to coding, the number of individuals choosing more than one option is not available; however, based on the response rate from the previous question (98.8%), we can estimate that approximately 15% survey respondents chose more than one source as being most helpful (i.e., the response rate from the previous question minus the response rate from this question).

Figure 35.



Note: Item response rate 81.8%

It was anticipated that dually eligible MAPP enrollees would encounter difficulties filling certain prescriptions under Medicare Part D. Those respondents who indicated enrollment in Medicare Part D were asked if they had trouble filling any prescriptions under their current plan.

Responses suggest that any difficulty obtaining medication through Medicare Part D affects individuals about the same across all earnings groups. Overall, 1,967 (77%) of respondents said they did not have trouble filling prescriptions under Medicare Part D, while 577 (23%) said they did encounter problems³⁶.

Of those individuals citing problems filling prescriptions (n = 577), 549 provided a total of 752 responses when asked to provide more information about the nature of these problems. Figure 36 shows the percentage of these 549 individuals who selected each type of problem.

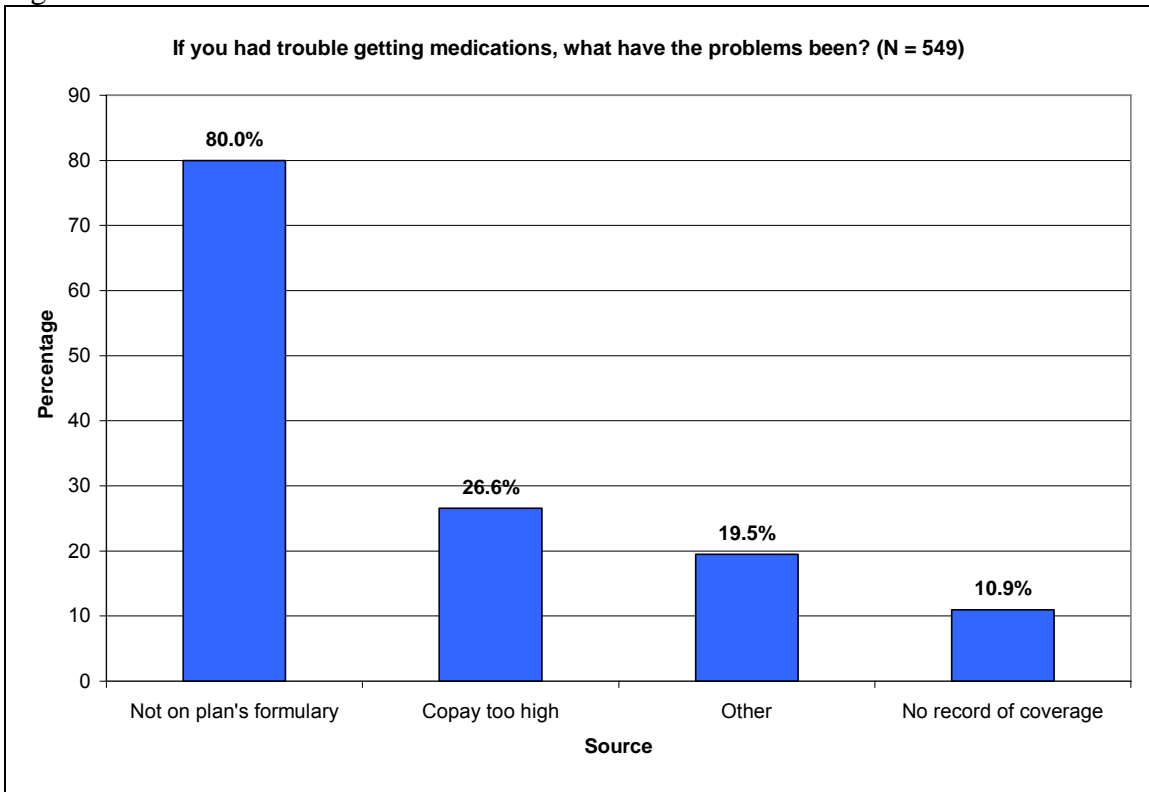
By far, the most often cited problem with getting medication was due to the medication not being on the plan’s formulary, with 80% of respondents selecting it. One quarter of respondents said the co-pay was too high, and about 11% said there was no record of coverage.

Just under 20% of respondents chose “other.” Many of the responses provided in this open-ended section of the question reiterated or elaborated on problems already captured in another response.

³⁶ Based on 2,544 respondents who answered this question.

Therefore, the “other” category likely overestimates the frequency of other problems as often the responses are only repeating what has already been indicated.

Figure 36.



Note: Item response rate 95.1%

A second follow up question shows that about 45% (n = 253) of respondents who had problems filling a prescription stopped taking the medication due to difficulty obtaining it.

In the larger context, 253 individuals out of 2,673 respondents enrolled in Medicare Part D (9%) stopped taking medication due to difficulty obtaining it. If we apply this percentage to the entire dually eligible MAPP population, there could be upward of 900 enrollees in a similar situation³⁷. Clearly, the implementation of Medicare Part D has at least in part contributed to a sizeable number of MAPP enrollees stopping their medication(s) due to the challenges encountered while trying to obtain it.

All Medicare Part D enrollees were asked if Medicare Part D had in any way impacted their ability to work. Of the 2,673 respondents instructed to answer this question, 2,462 provided a response for a response rate of 92%.

After analyzing all Medicare Part D questions, it is clear that the impact of Medicare Part D is felt equally among MAPP enrollees regardless of how much they earn. Overall, 4% (or 101 individuals) said that the switch to Medicare Part D affected their ability to work.

³⁷ Based on overall enrollment of 12,000, with 85% (10,200) dually eligible.

Again, in the larger context, there could be upward of 400 dually eligible MAPP enrollees whose ability to work has been negatively impacted by the implementation of Medicare Part D³⁸.

Table 19 below summarizes the level of impact that Medicare Part D has had on dually eligible MAPP enrollees.

Table 19.

Medicare Part D: Summary of impact		
	Number of respondents	Percent of respondents
Enrolled in Medicare Part D	2,673	83.3%
Problems filling prescription(s)	577	21.6%*
Stopped taking medication(s) due to difficulty obtaining it	253	9.5%*
Has affected ability to work	101	3.8%*

* Percentages based on number of participants reporting enrollment in Medicare Part D (n = 2,673).

Conclusions

This survey was undertaken to help answer some persistent questions about MAPP and to serve as a data source for future projects.

Some of the main findings were as follows:

- About 70% of MAPP enrollees are aware they are enrolled in the program. About half of all respondents first learned about MAPP from their local human services agency.
- Almost 30% of respondents considered a mental health condition (e.g., depression) as their primary disabling condition. Just over 20% considered a musculoskeletal or orthopedic condition (e.g, arthritis) as their primary disabling condition. Over half the respondents suffered from depression, even if this was not considered their primary disabling condition.
- Physical limitations, poor mental or emotional health, fear of losing health insurance, fear of losing SSDI/SSI benefits and lack of available jobs matching one’s skills and interests were considered the top five barriers to working or earning more.
- In terms of work support, the greatest need is for the ability to take time off, income support at work (i.e., long term disability insurance), control over one’s pace and schedule, and benefits counseling. Of these, benefits counseling had the largest unmet need.
- 83% said they were enrolled in Medicare Part D. Most respondents – about 70% - said that they learned about Medicare Part D from a letter sent by the Social Security Administration (SSA). Another 31% said they learned about it from a letter sent by the

³⁸ Based on 4% of 10,200 dually eligible MAPP enrollees.

Department of Health and Family Services (DHFS). The SSA letter was considered the most helpful source of information by a quarter of respondents, the DHFS letter by only 12%.

- About one-quarter of respondents enrolled in Medicare Part D reported having problems getting medication. By far, the most often cited problem with getting medication was due to the medication not being on the plan's formulary.

VIII. Future Analyses

Based on the findings from year seven of the MAPP evaluation, OIE, in conjunction with APS, has developed a detailed list of 2008 activities and analyses to be conducted as part of the year five MAPP evaluation. These activities are designed to strengthen the findings presented in this report, but more importantly, to fill gaps where specific program and policy questions remain unanswered.

- Develop additional analyses based on participant survey data, including but not limited to:
 - Examine data gathered online to compare differences between respondents who responded online and those who responded by mail.
 - Self-employment and the receipt of in-kind income among MAPP customers have been difficult to examine in the past, due to lack of data. With survey data now available, the questions surrounding self-employment and in-kind income can now be examined. In addition to determining the number of MAPP consumers who are self-employed and/or work for in-kind income, the data will be used to gain a better understanding of who these customers are.
 - One of the main objectives of the survey was to collect data to learn more about employment outcomes and barriers among certain subsets of MAPP consumers. Survey data will be used to determine characteristics of those earning at substantial levels as well as those with very low or no earnings.
 - Use data from IRWE questions to examine IRWE usage more thoroughly and consider outreach possibility.
 - Use data to more fully understand the nature of consumers' disabilities. Data was gathered about primary disability, other health problems, and functional limitations. More data was collected than could be presented in this summary report, and so further analyses are planned.
 - Data will also be used to inform various policy initiatives. For example, survey data may be used to help inform discussion about how spousal income should be regarded when determining eligibility for benefits.
- Conduct a cost comparison of enrollees using HIPP (Health Insurance Premium Payment).

- Collect more information on utilization of IAs (Independence Accounts), IRWEs (Impairment Related Work Expenses) and MREs (Medical & Remedial Expenses) – perhaps among a subset of MAPP consumers.
- Consider methods for collecting data on participants who earn at substantial levels but disenroll from MAPP
- Assess the need for development and implementation of a second survey of county economic support workers.

IX. Appendix

Attachment A: Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	To	Premium	From	To	Premium
\$0	\$10.00	\$0.00	500.01	525.00	500.00
10.01	25.00	\$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

Note: If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than \$1,000.00 per month, the premium shall be equal to the exact dollar amount of this sum.

Attachment B: Eligibility Trends for MAPP Participants

Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Jan-00	32	7	21.9%	24	75.0%	14	0	32
Feb-00	14	5	35.7%	10	71.4%	9	1	13
Mar-00	40	19	47.5%	32	80.0%	22	0	40
Apr-00	40	17	42.5%	34	85.0%	26	0	40
May-00	61	32	52.5%	51	83.6%	34	3	58
Jun-00	113	66	58.4%	94	83.2%	57	1	112
Jul-00	133	81	60.9%	117	88.0%	73	3	130
Aug-00	107	59	55.1%	93	86.9%	64	3	104
Sep-00	104	53	51.0%	91	87.5%	52	6	98
Oct-00	124	72	58.1%	108	87.1%	64	6	118
Nov-00	116	75	64.7%	96	82.8%	55	9	107
Dec-00	131	106	80.9%	120	91.6%	63	14	117
Jan-01	159	88	55.3%	134	84.3%	87	8	151
Feb-01	95	57	60.0%	79	83.2%	42	7	88
Mar-01	99	61	61.6%	85	85.9%	48	13	86
Apr-01	76	46	60.5%	66	86.8%	36	16	60
May-01	85	56	65.9%	78	91.8%	43	19	66
Jun-01	78	49	62.8%	62	79.5%	43	20	58
Jul-01	80	54	67.5%	68	85.0%	36	13	67
Aug-01	76	44	57.9%	66	86.8%	37	9	67
Sep-01	92	57	62.0%	79	85.9%	37	18	74
Oct-01	80	43	53.8%	68	85.0%	40	25	55
Nov-01	94	56	59.6%	82	87.2%	48	18	76
Dec-01	80	45	56.3%	64	80.0%	37	16	64
Jan-02	185	115	62.2%	158	85.4%	83	23	162
Feb-02	293	224	76.5%	262	89.4%	104	18	275
Mar-02	241	156	64.7%	211	87.6%	107	33	208
Apr-02	230	149	64.8%	194	84.3%	89	28	202
May-02	243	155	63.8%	202	83.1%	106	40	203
Jun-02	235	150	63.8%	205	87.2%	127	42	193
Jul-02	264	173	65.5%	220	83.3%	115	50	214
Aug-02	207	127	61.4%	173	83.6%	86	41	166
Sep-02	211	135	64.0%	184	87.2%	89	35	176
Oct-02	233	143	61.4%	199	85.4%	104	40	193
Nov-02	196	123	62.8%	171	87.2%	85	46	150
Dec-02	200	134	67.0%	173	86.5%	83	46	154
Jan-03	285	188	66.0%	253	88.8%	119	68	217
Feb-03	212	133	62.7%	178	84.0%	80	57	155
Mar-03	241	161	66.8%	202	83.8%	101	60	181
Apr-03	219	137	62.6%	188	85.8%	79	67	152
May-03	201	126	62.7%	172	85.6%	66	46	155
Jun-03	222	145	65.3%	191	86.0%	92	55	167
Jul-03	237	142	59.9%	194	81.9%	80	52	185
Aug-03	229	145	63.3%	192	83.8%	96	89	140
Sep-03	247	143	57.9%	205	83.0%	82	68	179
Oct-03	223	143	64.1%	183	82.1%	96	72	151
Nov-03	241	135	56.0%	193	80.1%	96	62	179
Dec-03	220	133	60.5%	179	81.4%	96	98	122
Jan-04	283	196	69.3%	259	91.5%	115	81	202
Feb-04	307	203	66.1%	265	86.3%	105	90	217
Mar-04	226	134	59.3%	187	82.7%	79	79	147

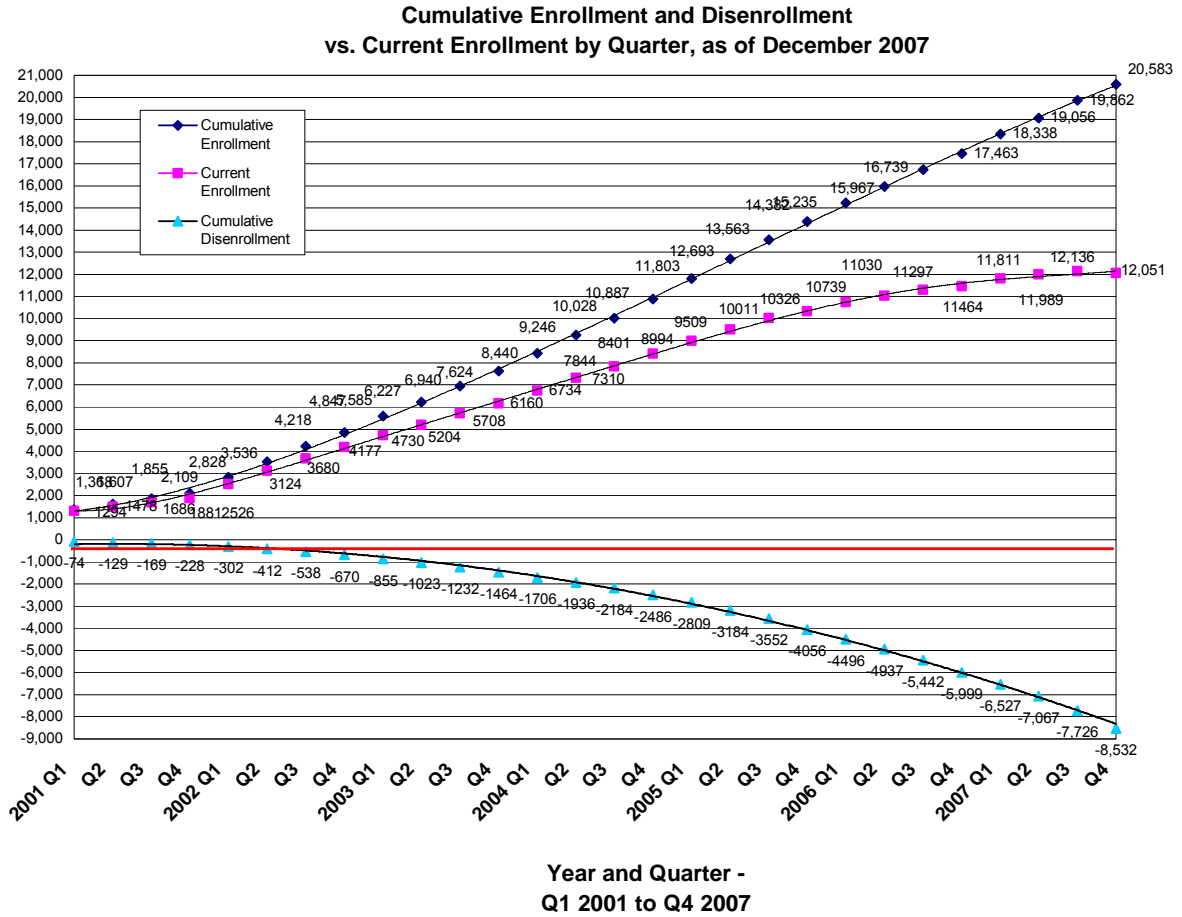
Month/ Year	New MAPP Enrollees	# With Elig. Prior Month	% With Elig. Prior Month	# With Any Prior Elig.	% With Any Prior Elig.	# With Post MAPP Elig.	# MAPP Disenroll	# MAPP Net Enroll
Apr-04	270	177	65.6%	242	89.6%	98	76	194
May-04	283	199	70.3%	240	84.8%	102	72	211
Jun-04	253	168	66.4%	213	84.2%	90	86	167
Jul-04	262	184	70.2%	230	87.8%	91	81	181
Aug-04	266	174	65.4%	222	83.5%	100	88	178
Sep-04	254	162	63.8%	223	87.8%	75	89	165
Oct-04	269	170	63.2%	229	85.1%	84	94	175
Nov-04	260	163	62.7%	220	84.6%	87	111	149
Dec-04	330	253	76.7%	295	89.4%	111	104	226
Jan-05	354	242	68.4%	314	88.7%	111	109	245
Feb-05	279	189	67.7%	243	87.1%	75	119	160
Mar-05	283	181	64.0%	239	84.5%	82	113	170
Apr-05	287	192	66.9%	247	86.1%	78	142	145
May-05	284	185	65.1%	240	84.5%	85	134	150
Jun-05	319	221	69.3%	276	86.5%	97	126	193
Jul-05	275	184	66.9%	232	84.4%	76	125	150
Aug-05	302	192	63.6%	258	85.4%	73	155	147
Sep-05	293	184	62.8%	249	85.0%	63	123	170
Oct-05	289	190	65.7%	243	84.1%	69	177	112
Nov-05	255	164	64.3%	221	86.7%	65	187	68
Dec-05	274	186	67.9%	240	87.6%	71	181	93
Jan-06	335	212	63.3%	282	84.2%	113	132	203
Feb-06	240	166	69.2%	206	85.8%	76	137	103
Mar-06	278	181	65.1%	241	86.7%	83	171	107
Apr-06	236	142	60.2%	201	85.2%	57	126	110
May-06	240	152	63.3%	206	85.8%	68	158	82
Jun-06	256	169	66.0%	220	85.9%	70	157	99
Jul-06	245	157	64.1%	210	85.7%	60	175	70
Aug-06	256	161	62.9%	220	85.9%	68	162	94
Sep-06	271	173	63.8%	237	87.5%	82	168	103
Oct-06	249	157	63.1%	215	86.3%	74	171	78
Nov-06	219	144	65.8%	191	87.2%	66	166	53
Dec-06	256	160	62.5%	222	86.7%	57	220	36
Jan-07	334	210	62.9%	303	90.7%	74	149	185
Feb-07	282	185	65.6%	248	87.9%	40	182	100
Mar-07	259	170	65.6%	239	92.3%	45	197	62
Apr-07	227	137	60.4%	195	85.9%	42	188	39
May-07	235	147	62.6%	202	86.0%	31	196	39
Jun-07	256	145	56.6%	223	87.1%	39	156	100
Jul-07	257	158	61.5%	221	86.0%	39	223	34
Aug-07	287	163	56.8%	245	85.4%	31	220	67
Sep-07	262	165	63.0%	227	86.6%	16	216	46
Oct-07	259	165	63.7%	230	88.8%	15	258	1
Nov-07	227	138	60.8%	199	87.7%	8	236	-9
Dec-07	235	170	72.3%	210	89.4%	9	312	-77
	20,583	13,184	64.1%	17,704	86.0%	7,028	8,532	12,051

* Source: Eligibility trends spreadsheet

- 1 The minimum MAPP enrollment date for an individual
- 2 Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date
- 3 Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date
- 4 Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date. The assigned month represents the first month of the non-MAPP eligibility segment.

- 5 The maximum MAPP end date for an individual (most recent disenrollment). Disenrollees include all MAPP enrollees that have not re-enrolled in MAPP as of the month of this report.
- 6 New MAPP enrollees minus MAPP disenrollees for each month

Attachment C: Cumulative Enrollment vs. Current Enrollment by Month



Attachment D: MAPP Enrollment by Premium Status

MAPP Enrollment by Premium Status & Premium Collections					
January 2000-December, 2007					
Month/Year	Number with Premium Medstat	Number with Non-premium Medstat	Total	Percent with Premium Medstat	Actual Premium Collections for Benefit Month
Jan-00	4	28	32	12.5%	\$325
Feb-00	5	39	44	11.4%	\$400
Mar-00	7	74	81	8.6%	\$695
Apr-00	9	109	118	7.6%	\$920
May-00	21	156	177	11.9%	\$1,465
Jun-00	41	244	285	14.4%	\$3,555
Jul-00	67	350	417	16.1%	\$6,485
Aug-00	87	433	520	16.7%	\$7,675
Sep-00	103	507	610	16.9%	\$7,995
Oct-00	124	597	721	17.2%	\$11,025
Nov-00	147	678	825	17.8%	\$12,615
Dec-00	165	776	941	17.5%	\$14,235
Jan-01	191	883	1074	17.8%	\$19,585
Feb-01	207	941	1148	18.0%	\$21,400
Mar-01	226	1010	1236	18.3%	\$23,115
Apr-01	234	1051	1285	18.2%	\$24,500
May-01	239	1104	1343	17.8%	\$26,130
Jun-01	238	1149	1387	17.2%	\$26,350
Jul-01	239	1196	1435	16.7%	\$29,385
Aug-01	245	1252	1497	16.4%	\$31,585
Sep-01	257	1313	1570	16.4%	\$33,950
Oct-01	256	1358	1614	15.9%	\$33,215
Nov-01	261	1410	1671	15.6%	\$33,865
Dec-01	263	1458	1721	15.3%	\$29,465
Jan-02	238	1611	1849	12.9%	\$34,870
Feb-02	283	1810	2093	13.5%	\$38,200
Mar-02	354	1962	2316	15.3%	\$47,875
Apr-02	387	2097	2484	15.6%	\$56,025
May-02	391	2314	2705	14.5%	\$55,825
Jun-02	399	2485	2884	13.8%	\$58,100
Jul-02	419	2666	3085	13.6%	\$57,775
Aug-02	429	2784	3213	13.4%	\$56,950
Sep-02	434	2933	3367	12.9%	\$58,975
Oct-02	443	3106	3549	12.5%	\$59,975
Nov-02	446	3265	3711	12.0%	\$60,250
Dec-02	466	3387	3853	12.1%	\$60,950
Jan-03	517	3572	4089	12.6%	\$69,125
Feb-03	493	3701	4194	11.8%	\$67,450
Mar-03	514	3844	4358	11.8%	\$73,075
Apr-03	506	4020	4526	11.2%	\$71,500
May-03	496	4141	4637	10.7%	\$73,025
Jun-03	499	4294	4793	10.4%	\$73,575
Jul-03	518	4438	4956	10.5%	\$75,850

MAPP Enrollment by Premium Status & Premium Collections					
January 2000-December, 2007					
Month/Year	Number with Premium Medstat	Number with Non-premium Medstat	Total	Percent with Premium Medstat	Actual Premium Collections for Benefit Month
Aug-03	545	4588	5133	10.6%	\$78,316
Sep-03	546	4729	5275	10.4%	\$76,700
Oct-03	547	4862	5409	10.1%	\$78,725
Nov-03	549	5012	5561	9.9%	\$79,550
Dec-03	565	5147	5712	9.9%	\$81,000
Jan-04	604	5295	5899	10.2%	\$89,800
Feb-04	604	5509	6113	9.9%	\$93,293
Mar-04	597	5632	6229	9.6%	\$91,918
Apr-04	553	5854	6407	8.6%	\$86,068
May-04	565	6052	6617	8.5%	\$88,118
Jun-04	585	6225	6810	8.6%	\$90,493
Jul-04	583	6390	6973	8.4%	\$90,925
Aug-04	599	6550	7149	8.4%	\$96,499
Sep-04	644	6649	7293	8.8%	\$101,949
Oct-04	652	6810	7462	8.7%	\$102,399
Nov-04	677	6933	7610	8.9%	\$106,374
Dec-04	717	7131	7848	9.1%	\$111,724
Jan-05	673	7420	8093	8.3%	\$101,584
Feb-05	692	7531	8223	8.4%	\$107,259
Mar-05	695	7696	8391	8.3%	\$113,209
Apr-05	731	7831	8562	8.5%	\$122,446
May-05	727	7969	8696	8.4%	\$123,094
Jun-05	718	8161	8879	8.1%	\$122,094
Jul-05	724	8317	9041	8.0%	\$125,519
Aug-05	722	8479	9201	7.8%	\$127,244
Sep-05	729	8620	9349	7.8%	\$128,432
Oct-05	738	8800	9538	7.7%	\$129,863
Nov-05	743	8913	9656	7.7%	\$129,138
Dec-05	762	8993	9755	7.8%	\$130,713
Jan-06	660	9236	9896	6.7%	\$116,461
Feb-06	655	9354	10009	6.5%	\$113,714
Mar-06	743	9395	10138	7.3%	\$131,543
Apr-06	731	9445	10176	7.2%	\$133,118
May-06	751	9543	10294	7.3%	\$133,043
Jun-06	754	9619	10373	7.3%	\$132,518
Jul-06	736	9723	10459	7.0%	\$128,943
Aug-06	762	9777	10539	7.2%	\$136,743
Sep-06	774	9863	10637	7.3%	\$138,843
Oct-06	787	9944	10731	7.3%	\$138,442
Nov-06	778	9980	10758	7.2%	\$136,642
Dec-06	790	10014	10804	7.3%	\$141,717
Jan-07	717	10,346	11,063	6.5%	126,569
Feb-07	740	10,460	11,200	6.6%	129,481
Mar-07	761	10,562	11,323	6.7%	142,263
Apr-07	743	10,651	11,394	6.5%	138,936

MAPP Enrollment by Premium Status & Premium Collections					
January 2000-December, 2007					
Month/Year	Number with Premium Medstat	Number with Non-premium Medstat	Total	Percent with Premium Medstat	Actual Premium Collections for Benefit Month
May-07	746	10,742	11,488	6.5%	137,538
Jun-07	775	10,801	11,576	6.7%	143,050
Jul-07	791	10,962	11,753	6.7%	142,825
Aug-07	783	11,078	11,861	6.6%	145,400
Sep-07	767	11,180	11,947	6.4%	145,350
Oct-07	751	11,298	12,049	6.2%	143,897
Nov-07	757	11,325	12,082	6.3%	140,912
Dec-07	769	11,395	12,164	6.3%	144,625

Attachment E: IRWE and MRE Examples

Examples of Impairment Related Work Expenses (IRWE):

- Attendant care services (at work, for transportation, other)
- Diagnostic procedures
- Durable medical equipment (plus installation, maintenance, and associated repair costs)
- Essential non-medical appliances and devices (electric air cleaner, etc.)
- Exterior home modifications that allow access to the street or to transportation (ramps, railings, pathways, etc.)
- Interior home modifications which create a work to accommodate impairment (enlargement of doorway, etc.)
- Interpreter (at workplace)
- Job Coach
- Medical devices
- Measuring instruments
- Mileage allowance (to and from work)
- Modified audio/visual equipment (enlarged monitor, speech activated computer, etc.)
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Regularly prescribed medical treatment or therapy and physician's fees associated with this treatment
- Respirators
- Routine prescription drugs
- Special work tools
- Traction equipment, braces
- Typing aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs
- Work animal and associated costs (plus food, maintenance, and veterinary services)
- Workspace modifications (adjustable desk, etc.)
- Work subsidy (increased supervision, etc.)

Examples of Medical Remedial Expenses

- Abdominal supports; Back supports
- Acupuncture
- Artificial teeth, eyes, limbs
- Attendant care (at workplace or other)
- Audio/visual equipment, such as screen magnifiers
- Automobile or van modification
- Automobile modified equipment; Autoette
- Bathtub/Shower accessibility modifications and related adaptive hardware
- Bed pads; Bed boards
- Chiropractor
- Computer/desk modifications
- Convalescent home
- Diapers
- Dietician/Nutritionist Services or Information
- Elevator
- Eyeglass prescriptions
- Excess energy costs related to a medical condition
- Handrails
- Healing services
- Health institute fees
- Health spa
- Hearing aids
- Home improvements made for medical reasons: air conditioning system, bathroom on the first floor, ramps, doorway modifications, etc.
- Hydrotherapy
- Inclinator or other device for managing stairs
- Invalid chair
- Job coach
- Life-care fee (medical portion only)
- Lodging on trips to obtain medical care
- Medicaid co-payments
- Medical supplies
- Modified clothing
- Modified eating utensils
- Outstanding medical bills
- Practical/other nonprofessional nurse for med services
- Prescription drugs
- Private health insurance premiums
- Reclining chairs
- Registered nurse
- Rental of medical equipment
- Repair of special medical equipment
- Respite care
- Special mattresses
- Special plumbing fixtures
- Special telephone equipment and associated repair costs
- Special technology needs
- Transportation costs for medical visits
- Vitamin Supplements
- Wheelchair; other equipment
- Wages of guide/assistant
- Whirlpool
- Work animals and associated maintenance costs (plus food, maintenance, and veterinary services)

Attachment F: County Breakout of Medicaid Recipients with Disabilities, MAPP Participants, Ranked by Rate of Participation in MAPP (as of December, 2007)

Percent of Disabled Medicaid Enrollees Participating in MAPP		Total Medicaid Enrollees With Disabilities** (including MAPP)		Total MAPP Enrollment, as of December, 2007	
Percent	County	Count	Percent of Total	Count	Percent of Total
42.1%	BAD RIVER RNIP	19	0.0%	8	0.1%
31.1%	GREEN	576	0.8%	179	1.9%
30.5%	IRON	187	0.2%	57	0.6%
28.9%	WASHBURN	495	0.7%	143	1.5%
24.5%	BURNETT	343	0.5%	84	0.9%
24.3%	PRICE	395	0.5%	96	1.0%
24.2%	WAUSHARA	538	0.7%	130	1.4%
23.8%	LAFAYETTE	261	0.3%	62	0.6%
22.9%	TAYLOR	323	0.4%	74	0.8%
22.6%	BARRON	1136	1.5%	257	2.7%
22.1%	ASHLAND	551	0.7%	122	1.3%
22.1%	ADAMS	548	0.7%	121	1.3%
21.0%	PEPIN	124	0.2%	26	0.3%
20.9%	IOWA	320	0.4%	67	0.7%
20.5%	KEWAUNEE	273	0.4%	56	0.6%
19.9%	OZAUKEE	597	0.8%	119	1.2%
19.7%	TREMPEALEAU	519	0.7%	102	1.1%
19.5%	MARQUETTE	328	0.4%	64	0.7%
19.3%	GREEN LAKE	327	0.4%	63	0.7%
19.2%	CALUMET	343	0.5%	66	0.7%
18.5%	BUFFALO	243	0.3%	45	0.5%
18.3%	CLARK	585	0.8%	107	1.1%
17.5%	VERNON	530	0.7%	93	1.0%
17.5%	FLORENCE	114	0.2%	20	0.2%
17.3%	WINNEBAGO	2604	3.5%	450	4.7%
16.7%	SOKAOGON RNIP	6	0.0%	1	0.0%
16.6%	WAUPACA	931	1.2%	155	1.6%
16.6%	RUSK	380	0.5%	63	0.7%
16.1%	PORTAGE	1060	1.4%	171	1.8%
15.7%	KENOSHA	3177	4.2%	498	5.2%
15.5%	GRANT	824	1.1%	128	1.3%
15.3%	POLK	647	0.9%	99	1.0%
15.2%	WOOD	1541	2.1%	234	2.4%
14.7%	COLUMBIA	775	1.0%	114	1.2%
14.1%	DOUGLAS	1431	1.9%	202	2.1%
13.8%	WALWORTH	1258	1.7%	173	1.8%
13.7%	ST. CROIX	650	0.9%	89	0.9%
13.7%	LACROSSE	2569	3.4%	351	3.7%
13.6%	SAUK	823	1.1%	112	1.2%
13.6%	BAYFIELD	265	0.4%	36	0.4%

Percent of Disabled Medicaid Enrollees Participating in MAPP		Total Medicaid Enrollees With Disabilities** (including MAPP)		Total MAPP Enrollment, as of December, 2007	
13.3%	WAUKESHA	2984	4.0%	398	4.2%
13.0%	RICHLAND	470	0.6%	61	0.6%
13.0%	WASHINGTON	1010	1.3%	131	1.4%
12.6%	SAWYER	422	0.6%	53	0.6%
12.5%	CRAWFORD	368	0.5%	46	0.5%
12.3%	DANE	7069	9.4%	870	9.1%
12.2%	LANGLADE	484	0.6%	59	0.6%
12.2%	SHEBOYGAN	1701	2.3%	207	2.2%
11.8%	LINCOLN	536	0.7%	63	0.7%
11.7%	JEFFERSON	1329	1.8%	155	1.6%
11.4%	MARATHON	2143	2.9%	245	2.6%
11.4%	CHIPPEWA	1158	1.5%	132	1.4%
11.2%	DUNN	751	1.0%	84	0.9%
11.1%	EAU CLAIRE	2189	2.9%	243	2.5%
10.9%	MANITOWOC	1327	1.8%	145	1.5%
10.7%	ONEIDA	791	1.1%	85	0.9%
10.6%	MARINETTE	924	1.2%	98	1.0%
10.4%	OUTAGAMIE	2187	2.9%	227	2.4%
10.3%	JACKSON	418	0.6%	43	0.4%
10.1%	FOND DU LAC	1551	2.1%	157	1.6%
10.1%	DOOR	346	0.5%	35	0.4%
9.8%	DODGE	885	1.2%	87	0.9%
9.6%	MONROE	803	1.1%	77	0.8%
8.1%	PIERCE	346	0.5%	28	0.3%
7.6%	ROCK	3531	4.7%	267	2.8%
7.4%	SHAWANO	624	0.8%	46	0.5%
7.3%	VILAS	287	0.4%	21	0.2%
6.7%	ONEIDA RNIP	15	0.0%	1	0.0%
5.9%	JUNEAU	576	0.8%	34	0.4%
5.0%	BROWN	4021	5.4%	203	2.1%
5.0%	RACINE	4095	5.5%	206	2.2%
4.9%	OCONTO	532	0.7%	26	0.3%
0.5%	FOREST	193	0.3%	1	0.0%
0.0%	LAC DU FLAMBEAU	37	0.0%	0	0.0%
0.0%	MENOMINEE	143	0.2%	0	0.0%
0.0%	RED CLIFF RNIP	14	0.0%	0	0.0%
0.0%	STOCKBRIDGE RNIP	2	0.0%	0	0.0%
100%		72,351		8,540	

* Excluding Milwaukee, as per request. If included in the denominator of percentage calculations, Milwaukee's relatively large population of people with disabilities (N = 31,186) and number of MAPP enrollees (N = 1,400) reduces the degree to which differences can be seen between other counties.

** Medicaid recipients between the ages of 18 and 65 with disabilities include individuals with the following med stat codes:

07,10,11,12,13,14,15,16,17,19,21,22,23,24,25,26,28,5C,5D,6C,6D,90,91,92,93

BD,DC,DD,DN,IC,IM,L1,L2,L3,L4,L5,L6,L7,L8,M3,M4,M5,M6,M7,M8,M9,MP,Q1,Q2,QN,QR,QW

SB,W2,W4,W5,W6,WA,WB,WC,WI,WP,WR,WW,ZN,ZZ

Attachment G: Tables for MAPP Expenditure and Utilization Evaluation

Table of MAPP Medicaid paid claims, member months and enrollment by calendar year

	Paid Claims**	Member Months	PMPM	Enrolled***
2000	\$1,974,283	4,759	\$415	1,012
2001	\$9,398,604	16,956	\$554	2,037
2002	\$20,998,264	35,084	\$599	4,511
2003	\$40,217,908	58,595	\$686	6,763
2004	\$58,308,143	82,348	\$708	9,193
2005	\$80,407,232	107,302	\$749	11,646
2006	\$53,177,886	124,917	\$426	13,177
2007*	\$40,225,157	113,357	\$355	13,260
*Through September, 2007				
**Excludes nursing home and nursing home crossovers				
***Number enrolled at any time during the calendar year				

Table of MAPP Expenditures by Medicare Eligibility Status.

Eligible Year	Dual	CountOfID	SumOfPaid	CountOfMM	PMPM
2000	MA-Only	38	\$41,334	156	\$265
2001	MA-Only	77	\$228,282	577	\$396
2002	MA-Only	206	\$1,012,962	1,310	\$773
2003	MA-Only	365	\$3,144,983	2,446	\$1,286
2004	MA-Only	466	\$3,966,536	3,423	\$1,159
2005	MA-Only	636	\$5,774,246	4,465	\$1,293
2006	MA-Only	1,034	\$9,854,638	7,207	\$1,367
2007	MA-Only	1,337	\$11,479,128	10,023	\$1,145
2000	Dual	975	\$1,944,986	4,604	\$422
2001	Dual	1,960	\$9,219,548	16,382	\$563
2002	Dual	4,305	\$20,103,148	33,775	\$595
2003	Dual	6,398	\$37,367,071	56,149	\$665
2004	Dual	8,727	\$54,990,165	78,928	\$697
2005	Dual	11,010	\$75,468,847	102,838	\$734
2006	Dual	12,143	\$44,336,540	117,724	\$377
2007	Dual	11,923	\$29,647,346	103,348	\$287

Table of MAPP Expenditures PMPM by Age Group

Eligible Year	AGEGRP	CountOfID	SumOfPaid	CountOfMM	PMPM
2000	Age 20-39	70	\$113,988	325	\$351
2001	Age 20-39	142	\$526,237	1,034	\$509
2002	Age 20-39	354	\$1,287,450	2,485	\$518
2003	Age 20-39	580	\$3,226,932	4,556	\$708
2004	Age 20-39	865	\$4,384,857	7,120	\$616
2005	Age 20-39	1,120	\$6,405,721	9,624	\$666
2006	Age 20-39	1,344	\$5,104,273	11,662	\$438
2007	Age 20-39	1,420	\$3,989,350	11,445	\$349
2000	Age 40-49	218	\$444,362	958	\$464
2001	Age 40-49	441	\$2,711,014	3,637	\$745
2002	Age 40-49	948	\$4,908,367	7,334	\$669
2003	Age 40-49	1,364	\$8,387,110	11,869	\$707
2004	Age 40-49	1,819	\$12,035,086	16,164	\$745
2005	Age 40-49	2,240	\$16,403,461	20,529	\$799
2006	Age 40-49	2,562	\$10,903,290	23,933	\$456
2007	Age 40-49	2,583	\$8,002,606	21,846	\$366
2000	Age 50-59	295	\$607,084	1,428	\$425
2001	Age 50-59	582	\$2,437,994	4,950	\$493
2002	Age 50-59	1,210	\$5,805,442	9,770	\$594
2003	Age 50-59	1,814	\$11,081,947	15,762	\$703
2004	Age 50-59	2,486	\$16,546,520	22,364	\$740
2005	Age 50-59	3,158	\$23,445,596	29,409	\$797
2006	Age 50-59	3,614	\$14,876,766	34,357	\$433
2007	Age 50-59	3,676	\$11,388,418	31,357	\$363
2000	Age 60-69	275	\$557,066	1,303	\$428
2001	Age 60-69	563	\$2,727,707	4,738	\$576
2002	Age 60-69	1,300	\$6,561,073	10,196	\$643
2003	Age 60-69	2,003	\$12,904,205	17,432	\$740
2004	Age 60-69	2,748	\$19,003,332	24,925	\$762
2005	Age 60-69	3,588	\$26,594,561	33,505	\$794
2006	Age 60-69	4,115	\$19,070,806	39,602	\$482
2007	Age 60-69	4,156	\$14,945,402	36,139	\$414
2000	Age 70+	155	\$263,821	746	\$354
2001	Age 70+	309	\$1,044,878	2,600	\$402
2002	Age 70+	699	\$2,553,778	5,300	\$482
2003	Age 70+	1,002	\$4,911,860	8,976	\$547
2004	Age 70+	1,275	\$6,986,906	11,778	\$593
2005	Age 70+	1,540	\$8,393,755	14,236	\$590
2006	Age 70+	1,542	\$4,236,043	15,377	\$275
2007	Age 70+	1,425	\$2,800,699	12,584	\$223

Table of MAPP Expenditures PMPM by Enrollment Cohort

Eligible Year	Cohort	CountOfID	SumOfPaid	CountOfMM	PMPM
2000	2000-01	1,013	\$1,986,320	4,760	\$417
2001	2000-01	2,037	\$9,447,831	16,959	\$557
2002	2000-01	1,774	\$11,384,210	18,380	\$619
2003	2000-01	1,543	\$11,489,626	16,517	\$696
2004	2000-01	1,432	\$11,830,664	15,526	\$762
2005	2000-01	1,343	\$11,497,488	14,528	\$791
2006	2000-01	1,247	\$5,153,031	13,587	\$379
2007	2000-01	1,163	\$3,597,326	10,663	\$337
2002	2002-03	2,737	\$9,731,900	16,705	\$583
2003	2002-03	5,220	\$29,022,428	42,078	\$690
2004	2002-03	4,498	\$33,853,003	47,687	\$710
2005	2002-03	3,920	\$30,401,014	42,098	\$722
2006	2002-03	3,511	\$12,354,711	37,447	\$330
2007	2002-03	3,151	\$8,189,203	28,803	\$284
2004	2004-05	3,263	\$13,273,034	19,138	\$694
2005	2004-05	6,383	\$39,344,591	50,677	\$776
2006	2004-05	5,350	\$24,836,939	55,302	\$449
2007	2004-05	4,371	\$12,136,683	39,006	\$311
2006	2006-07	3,069	\$11,846,497	18,595	\$637
2007	2006-07	4,575	\$17,203,262	34,899	\$493

Multiple Regression Output Table

Variable	Estimate	Std. Err.	t-value	P-value
Intercept	\$1,577	50.39	31.30	<.0001
Age 20-39 v. 60-69	-\$34	41.40	-0.82	0.4102
Age 40-49 v. 60-69	\$67	33.26	2.01	0.0446
Age 50-59 v. 60-69	\$4	30.09	0.15	0.8823
Age 70+ v. 60-69	-\$61	39.63	-1.55	0.1216
Dual v. MA-Only	-\$1,086	44.46	-24.43	<.0001
Suburban v. Urban	-\$9	48.34	-0.18	0.8557
Large Town v. Urban	-\$60	38.11	-1.58	0.1148
Small Town v. Urban	-\$148	34.88	-4.25	<.0001
Sparse v. Urban	-\$118	35.39	-3.33	0.0009
HMO Cty v. FFS Cty	-\$105	28.49	-3.68	0.0002
2000-01 v 2004-05	-\$73	41.54	-1.76	0.0782
2002-03 v 2004-05	-\$108	28.57	-3.78	0.0002
2006-07 v 2004-05	\$52	30.40	1.72	0.0853

Table of MAPP Expenditures PMPM by Urban/Rural Geographic Area

Eligible Year	RUCA	CountOfID	SumOfPaid	CountOfMM	PMPM
2000	Urban	532	\$1,045,836	2,387	\$438
2001	Urban	1,075	\$5,399,717	8,871	\$609
2002	Urban	2,317	\$11,613,662	18,106	\$641
2003	Urban	3,443	\$21,491,435	29,462	\$729
2004	Urban	4,652	\$31,137,585	41,162	\$756
2005	Urban	5,922	\$43,872,812	53,828	\$815
2006	Urban	6,647	\$28,970,391	61,545	\$471
2007	Urban	6,681	\$22,887,564	56,201	\$407
2000	Suburban	60	\$109,098	287	\$380
2001	Suburban	129	\$487,198	1,074	\$454
2002	Suburban	300	\$1,332,534	2,247	\$593
2003	Suburban	472	\$3,495,307	4,094	\$854
2004	Suburban	658	\$4,247,506	5,879	\$722
2005	Suburban	798	\$5,788,569	7,561	\$766
2006	Suburban	856	\$3,358,753	8,291	\$405
2007	Suburban	835	\$2,529,665	7,104	\$356
2000	Large Town	143	\$328,824	726	\$453
2001	Large Town	273	\$1,363,154	2,286	\$596
2002	Large Town	563	\$2,821,085	4,411	\$640
2003	Large Town	803	\$4,943,215	7,103	\$696
2004	Large Town	1,072	\$6,509,373	9,730	\$669
2005	Large Town	1,333	\$9,071,578	12,394	\$732
2006	Large Town	1,569	\$7,011,235	15,176	\$462
2007	Large Town	1,596	\$4,967,829	13,815	\$360
2000	Small Town	163	\$293,914	811	\$362
2001	Small Town	333	\$1,255,848	2,790	\$450
2002	Small Town	739	\$2,939,277	5,856	\$502
2003	Small Town	1,089	\$5,558,769	9,715	\$572
2004	Small Town	1,447	\$8,717,150	13,342	\$653
2005	Small Town	1,794	\$11,143,774	16,854	\$661
2006	Small Town	2,051	\$7,445,108	20,020	\$372
2007	Small Town	2,068	\$5,186,578	17,975	\$289
2000	Sparse	115	\$208,648	549	\$380
2001	Sparse	227	\$941,915	1,938	\$486
2002	Sparse	592	\$2,409,552	4,465	\$540
2003	Sparse	956	\$5,023,327	8,221	\$611
2004	Sparse	1,364	\$8,345,087	12,238	\$682
2005	Sparse	1,799	\$11,366,361	16,666	\$682
2006	Sparse	2,054	\$7,405,691	19,899	\$372
2007	Sparse	2,080	\$5,554,838	18,276	\$304

Table of MAPP Expenditures PMPM by County Managed Care Enrollment

Eligible Year	County	CountOfID	SumOfPaid	CountOfMM	PMPM
2000	FFS Cty	821	\$1,732,960	3,949	\$439
2001	FFS Cty	1,646	\$8,114,290	13,944	\$582
2002	FFS Cty	3,469	\$16,658,370	27,513	\$605
2003	FFS Cty	5,155	\$31,339,618	45,245	\$693
2004	FFS Cty	6,876	\$45,367,303	62,826	\$722
2005	FFS Cty	8,531	\$60,177,435	79,908	\$753
2006	FFS Cty	9,633	\$41,487,173	92,965	\$446
2007	FFS Cty	9,692	\$30,660,090	84,009	\$365
2000	HMO Cty	192	\$253,360	811	\$312
2001	HMO Cty	391	\$1,333,541	3,015	\$442
2002	HMO Cty	1,042	\$4,457,740	7,572	\$589
2003	HMO Cty	1,608	\$9,172,435	13,350	\$687
2004	HMO Cty	2,317	\$13,589,398	19,525	\$696
2005	HMO Cty	3,115	\$21,065,659	27,395	\$769
2006	HMO Cty	3,544	\$12,704,005	31,966	\$397
2007	HMO Cty	3,568	\$10,466,384	29,362	\$356