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# Promising Practices:
## Managing the Care of People with Disabilities

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## Executive Summary

People with disabilities represent a significant portion of the MassHealth population and an even greater proportion of MassHealth spending. Many people with disabilities on MassHealth have multiple chronic conditions and require more complex services than the general MassHealth membership. In recognition of these cost and service complexity issues, the Executive Office of Elder Affairs and Acute and Ambulatory Care Program in the Executive Office of Health and Human Services requested Commonwealth Medicine's Center for Health Policy & Research (CHPR) at the University of Massachusetts Medical School to identify promising practices from around the country associated with serving and coordinating the care of individuals with disabilities, especially programs that serve people with physical disabilities, mental retardation and other developmental disabilities, and chronic mental illness. To do so, CHPR conducted a literature search, a series of interviews with national experts, and a review of six promising practices for serving and managing the care of people with disabilities. In addition, the project will inform other related EOHHS initiatives, including the MCO re-procurement, the redesign of the PCC plan, and the Community First Policy interventions.

While no common definition of care coordination has been established, certain activities are critical to care coordination programs: risk screening, assessment, service plan development, service coordination, transition planning, monitoring, and reassessment. Programs engage in these activities in numerous ways and there is little consensus about the best way to coordinate the care of people with disabilities. Individuals programs are often targeted to specific needs or types of disabilities. Through the literature search and interviews with national experts, a number of programs across the country that could be considered promising practices in serving and coordinating the care for people with disabilities were identified. Six of these programs were selected for review in this project:

- Developmental Disabilities Health Alliance (serves people with mental retardation and other developmental disabilities);
- Independence Care System (serves people with physical disabilities);
- Minnesota Disability Health Options (serves people with physical disabilities);
- Texas STAR+PLUS (serves people with multiple types of disabilities);
- Vermont Medical Home Project (serves people with chronic mental illness); and
- Wisconsin Family Care (serves people with physical disabilities or developmental disabilities).

The six programs were reviewed through interviews with program staff and reviews of program documents. The following domains were included in the reviews: planning; implementation; eligibility; funding and authority; contracting; delivery system and services offered; care management and care coordination processes; evaluation and outcomes; and replication. The key findings for each of the domains are presented below.

### Planning

- Several years were spent developing, modifying, and refining each of the programs.
- Consumer involvement was critical throughout the planning process.
- Supporting legislation from the state, in several cases, was important to mandating or allowing the programs to be created.
- A general fear of managed care was a significant obstacle to planning for most programs.

### Implementation

- Enrollment was very quick for Texas STAR+PLUS, which is a mandatory program. Enrollment was slower in the other programs because of their voluntary nature.
- In the voluntary programs, education, outreach, and marketing were important to informing potential enrollees of the new program.
- Infrastructure development was a challenge in the programs that did not contract with large managed care organizations.

### Eligibility

- Programs that included multiple types of disabilities could achieve economies of scale by spreading the risk among more members, thereby increasing the attractiveness of the programs for managed care companies. Programs that limited eligibility to a single type of disability could become more specialized.
- Only two programs included children; the remaining programs only enrolled adults.
- Most programs required that enrollees meet basic Medicaid eligibility rules.
- Approximately 50 percent of enrollees in each program were dually-eligible for Medicare and Medicaid. Minnesota Disability Health Options was the only program reviewed that fully integrated funding for these individuals.

### Authority and Funding

- Each of the programs operated under different state-level and federal-level authority. There were several different types of federal authorities that could be used to operate the programs.
- Funding for all programs, except the Vermont Medical Home Project, was through capitation.

### Contracting

- In each program, the state was able to substantively control the features of service delivery and system design through the contracting process. Several different contracting strategies were used, ranging from the state contracting with only one large managed care organization to the state contracting with another governmental entity.

### Delivery System and Services

- Each program had a different set of covered services. One program included primary care and few long-term supports, two programs only included long-term supports, and two programs fully integrated long-term supports with acute care services.

- Programs reported that one benefit of integrating long-term supports with acute and primary care was that such integration reduces the fragmentation that currently exists within the system.
- Proper financing arrangements for covering nursing home care were critical for ensuring that contractors were appropriately reimbursed for individuals who required nursing home care, while encouraging the contractor to reduce nursing home utilization.

### Care Coordination

- While each program had a different care coordination model, all programs engaged in the critical activities of care coordination identified in the literature review.
- Two programs are moving toward a more flexible care coordination model, in which nurses are care managers for individuals with more medical needs, and social workers are care managers for individuals with more social needs.
- Information technology was used in several programs to facilitate the care coordination process.
- In one program, care coordination was being fully integrated with concepts of person-centered planning and self-directed supports.

### Evaluation and Outcomes

- The evaluation methodologies used by each of the programs differed significantly.
- Overall, it appeared that consumer satisfaction and access to services had improved in each of the programs.
- Few rigorous studies regarding cost and service utilization have been conducted on these programs. Initial information, however, indicated that the programs had the effect of reducing state expenditures for the population served. Whether the reduction in expenditures for services fully offset the increase in costs was unclear.

### Replication

- State characteristics, such as the structure of health and human services delivery systems, and Medicaid state plan differences can affect the replication of the programs in other states, including Massachusetts.

As Massachusetts moves forward in planning to better serve the population with disabilities in MassHealth, the information in this report will help to identify possibilities for program design. Massachusetts will need to determine several critical features of a new or modified service delivery model. The information in this report, and the detailed Appendices, illuminate how other states have approached such issues.

## 1. Introduction and Background

People with disabilities comprise a significant portion of the MassHealth[1] population. According to a recent report by the Massachusetts Medicaid Policy Institute (MMPI), more than 200,000 children and adults qualify for MassHealth coverage because of disabilities.[2] While this population represents 21 percent of all MassHealth members, nearly 38 percent of Medicaid spending in Massachusetts goes to providing services for this population.[3] Additionally, due to policy changes that Massachusetts has implemented to expand coverage to low-income people with disabilities, the number of MassHealth members who qualify by virtue of their disability is increasing.

The population of people with disabilities in MassHealth is very diverse. First, because of eligibility rules, the population is generally low-income, although some members can have higher incomes and "buy-in" to the MassHealth program through the CommonHealth program. Second, this population has a range of disability types, including mental illness, physical or sensory disabilities, mental retardation and other developmental disabilities, and other disabilities. Further, people with disabilities in MassHealth often have multiple chronic conditions. According to the MMPI report, approximately 45 percent of adult members with disabilities have three or more chronic conditions. Members with multiple conditions often require more complex and more costly medical and other services than the general membership of MassHealth.

In recognition of the impact of this population on the costs of the MassHealth program, and because of the more complex medical and support needs of members with disabilities, the Executive Office of Health and Human Services (EOHHS), through the Executive Office of Elder Affairs (EA) and Office of Disabilities and Community Services (ODCS), is interested in developing new approaches to serving this population. The MassHealth program has already developed innovative, coordinated, and integrated approaches to serving the elderly population through the Program of All-inclusive Care for the Elderly and the Senior Care Options program. MassHealth is interested in how lessons learned from these innovative programs can be applied to creating quality-driven and cost-effective approaches to serving the non-elderly MassHealth population with disabilities.

As one of the first steps in investigating such potential options for serving this population, EA and the Acute and Ambulatory Care Program within EOHHS, in collaboration with ODCS, requested Commonwealth Medicine's Center for Health Policy & Research (CHPR) at the University of Massachusetts Medical School to identify promising practices from around the country associated with serving and coordinating the care of individuals with disabilities. In particular, CHPR was asked to investigate programs that could be applied in a variety of potential financing and care delivery models to the MassHealth Medicaid-only and dually-eligible populations of adults with

[1] MassHealth is the Massachusetts Medicaid program.
[2] Massachusetts Medicaid Policy Institute. (2004, June). *Understanding MassHealth Members with Disabilities.* Available at http://www.massmedicaid.org/briefs.html.
[3] Ibid.

disabilities. Further, EOHHS was interested in learning about programs that served people with the disability types prevalent in the MassHealth population: people with chronic mental illness, people with physical disabilities, and people with mental retardation and other developmental disabilities. In addition, the project will inform other related EOHHS initiatives, including the MCO re-procurement, the redesign of the PCC plan, and the Community First Policy interventions. This project was part of the EOHHS Partnership with UMMS/Commonwealth Medicine.

## 2. Methods

In order to identify and investigate potentially promising practices for coordinating and managing the overall care for people with disabilities, the methods for this project were: a literature search to identify sentinel pieces of literature in care coordination for persons with disabilities; a set of interviews with national experts in the fields of disability services, managed care, and managed fee-for-service programs for people with disabilities; and reviews of six programs identified through the literature search and interviews with national experts that may be considered promising practices for serving people with disabilities.

### *2.1. Methods: Literature Search*

The methods for the literature search included:

- Searching the leading academic publication indexes, including PubMed and Ovid, for articles related to medical services for people with disabilities, managed care for people with disabilities, and care management for people with disabilities;
- General internet searches to identify unpublished materials on serving this population; and
- Discussions with leaders in the field to identify additional sentinel pieces of literature for serving this population.

### *2.2. Methods: Interviews with National Experts*

Six national experts were identified for interviews. These experts were identified because of their expertise and knowledge of programs that serve people with disabilities around the country. Criteria for selecting the experts included:

- Nationally-known for their work related to serving people with disabilities, as identified through publications, presentations, and other national work;
- Recommended by multiple other professionals/experts in the field of serving people with disabilities; and
- Had particular expertise in one of the disability types of interest: physical disabilities, chronic mental illness, or mental retardation.

The six experts that were selected for interviews and approved by staff from Elder Affairs are shown in Table 2-1 (see Appendix A for biographies).

**Table 2-1: National Experts**

| *Name* | *Organization* | *Area of expertise* |
|---|---|---|
| Sandy Blount | UMass Memorial Medical Center | Chronic mental illness and service integration |
| RoAnne Chaney | Michigan Disability Rights Coalition | Physical disabilities |
| Nikki Highsmith | Center for Health Care Strategies | General disabilities and managed care |
| Allen Jensen | George Washington University | General disabilities and managed care |
| Carol Tobias | Boston University Medicaid Working Group | Physical disabilities, general disabilities, and managed care |
| Kevin Walsh | Developmental Disabilities Health Alliance | Mental retardation and other developmental disabilities |

The interviews with national experts were organized around the following domains (see Appendix B for the complete interview template):

- Key issues for serving people with disabilities;
- Essential elements of successful programs that serve people with disabilities;
- Successful programs, practices, and strategies that states have developed;
- Replicability of the programs, practices, and strategies developed by states; and
- Other key experts in the field of developing programs for people with disabilities.

### *2.3. Methods: Interviews with Selected Programs*

Based on information gathered during the literature search and interviews with national experts, six programs were identified as potentially promising practices for serving and coordinating the care for people with disabilities. At least one program was selected in each of the disability types of interest: physical disabilities, chronic mental illness, and mental retardation and other developmental disabilities. The programs that were reviewed are shown in Table 2-2. The programs that were selected for review were approved by staff from the Executive Office of Elder Affairs.

**Table 2-2: Programs Reviewed**

| *Program Name* | *Location* | *Disability Type(s)* |
|---|---|---|
| Developmental Disabilities Health Alliance | Six sites in New Jersey | Mental retardation and other developmental disabilities |
| Independence Care System | Manhattan and Bronx, New York City | Physical disabilities |
| Minnesota Disability Health Options (MnDHO) | Four counties in Minnesota | Physical disabilities |
| Texas STAR+PLUS | Harris County in Texas | All disabilities (SSI and SSI-related disabilities) |
| Vermont Medical Home Project | Three sites in Vermont | Chronic mental illness |
| Wisconsin Family Care Program | Five counties in Wisconsin | Physical disabilities, developmental disabilities, and elders |

The program reviews were organized around the following domains (see Appendix C for the full review protocol/methodology):

- Planning;
- Implementation;
- Eligibility;
- Funding;
- Contracting;
- Delivery system;
- Services offered;
- Case management and care coordination;
- Evaluation;
- Quality;
- Consumer satisfaction;
- Other outcomes; and
- Replication potential.

## 3. Findings

This section of the report is divided into three major sections:

1. Findings from the literature search;
2. Findings from the interviews with national experts; and
3. Findings from the program reviews.

### *3.1. Findings: Literature Search*

A literature search using leading academic publication indexes and general internet searches was conducted to assist in framing the project. The literature search revealed the key elements of care coordination programs for serving people with disabilities. The literature search also helped to identify potential promising programs that could be included in the program reviews.

Care coordination is a generic term and can be used to mean case management, care management, and disease management. The coordination occurs along a continuum that includes both medical and social services, and is provided in different settings including independent care coordination agencies, provider agencies, health systems, group practices, and integrated networks.[4] Because the term is generic, and because care coordination can be provided in various settings, there is no agreed-upon definition or set of standards for care coordination. However, within the literature, certain activities have been identified that are considered necessary components of care coordination, including risk screening, assessment, service plan development, service coordination, transition planning, monitoring, and reassessment.[5]

Even though there are activities that are common to various care coordination programs, there are other aspects of care coordination that vary depending on the program. These aspects include:

- the level of training of the care coordinator;

[4] Gillespie, J., & Mollica, R.L. (2003, February). *Coordinating Care for the Chronically Ill: How Do We Get There From Here?* A report prepared for and informed by NASHP's Flood Tide Forum IV, Washington, DC.
[5] Chen, A., Brown, N., Archibald, N., Aliotta, S., & Fox, P.D. (2000, March). *Best Practices in Coordinated Care.* Mathematica Policy Research, Princeton, NJ; and Shalala, D.E. (2000, November). *Report to Congress: Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care.* U.S. Department of Health and Human Services, Washington, DC.

- whether or not the care coordinator is also providing services other than care coordination directly to the consumer;
- whether or not the care coordinator has the ability to authorize services for the consumer;
- the caseload size and the mix of clients; and
- whether the care coordinator coordinates services provided by a single agency or if s/he coordinates all services received by the consumer.[6]

It is important for care coordination programs that engage in the activities described above to:

- identify medical, functional, social, and emotional needs that increase members' risk of adverse health events;
- address the identified needs through education in self-care, optimization of medical treatment, and integration of care fragmented by setting or provider; and
- monitor participants for progress and early signs of problems.[7]

Although different care coordination programs may approach care coordination in different ways, each program attempts to reduce fragmentation of care for people with chronic conditions. Because the needs of people with chronic conditions are complex, care coordination is bound to remain a critical component of quality care for the growing number of people with chronic conditions and other disabilities.[8]

The literature search also identified possible programs to be considered for the program reviews. Table 3-1 displays the programs that were initially identified during the literature search as potentially promising practices in managing the care for people with disabilities.

[6] Sofaer, S., Kreling, B., & Carmel, M. (2000, December). *Coordination of Care for Persons with Disabilities Enrolled in Medicaid Managed Care: A Conceptual Framework to Guide the Development of Measures.* U.S. Department of Health and Human Services, Washington DC.
[7] Chen, A., et al. (2000, March).
[8] Gillespie, J., & Mollica, R.L. (2003, February).

**Table 3-1: Programs Identified as Potentially Promising Practices Through the Literature Search**

| Program Name and Location | Population(s) Served | Age(s) of Population Served | Capitated or fee-for-service? | Public-run or private-run? |
|---|---|---|---|---|
| Diamond State Long-Term Behavioral Health Plan (Delaware) | Chronic mental illness and substance abuse | Adults | Capitated | Private |
| Diamond State Long-Term Care Health Plan | Elderly and Physical Disabilities | Adults | Capitated | Private |
| Florida Chronic Disease Management Program | Medicaid enrollees with target diagnoses (HIV, Diabetes, Asthma, Hemophilia) | Adults | Other | Public |
| Georgia SOURCE program | Frail Elderly and Disabled Adults | Adults | Capitated | Private |
| Heartland Health Plan of Oklahoma - Oklahoma Health Care Authority | Aged, Blind, and Disabled | All | Capitated | Private |
| Minnesota Disability Health Options (MnDHO) | Physical disabilities | Adults/non-elderly | Capitated | Both |
| North Carolina Access II & III | Medicaid enrollees | Adults | Capitated | Public |
| Utah Department of Health LTC MC Initiative - Rural Health and Behavioral Health Components | Medicaid beneficiaries displaying serious, persistent disruptive behaviors resulting from organic diagnosis of chronic mental illness | Adults | Capitated | Public |
| Vermont Medical Home Project | Chronic illnesses, mental health, and physical disabilities | Adults | Other | Public |
| Wisconsin Partnership Program | Elderly & Physical Disability | Adults/Elders | Capitated | Private |

### *3.2. Findings: Interviews with National Experts*

Interviews were conducted with national experts in the field with the primary purpose of identifying the types of services people with disabilities need, programs that are in existence that do a good job of serving the populations, and the key elements of successful programs that could be replicated elsewhere. Interviewees were selected based upon the literature search and suggestions provided by staff at Elder Affairs, the

Center for Developmental Disabilities Evaluation and Research at the University of Massachusetts Medical School, and the Center for Health Care Strategies.

The experts provided general information regarding services for people with disabilities and elements of successful programs. The experts noted that people with disabilities need the same services as other people, they just need the services to be delivered through a system that caters to their needs. The experts remarked that care coordination is a critical aspect of any program. What is of specific importance is who is providing the care coordination, how it fits with the person's social supports and informal network, and the level of clinical understanding of co-morbidities. Any program that is designed or implemented must be person-centered, rather than program- or disability-centered. Finally, the experts stressed that a network of both medical and social providers that have special expertise in disability issues is critical, so that providers and consumers can have access to expertise in the community in terms of disability knowledge.

Based upon the area of expertise, some experts were able to provide specific information pertaining to specific populations. For example, one expert on developmental disabilities indicated that it was important not to assume that one program fits all developmental disability types and that it is essential to understand the specific subgroups and the needs of those subgroups. He also mentioned that many people with mental retardation/developmental disabilities (MR/DD) need behavioral supports, which is different from mental health services. Lastly, he said it is important for physicians working with people with MR/DD to have access to other physicians who have specialized knowledge of the specific disability type to answer questions as they arise.

Another expert was focused in the field of chronic mental illness. He indicated that integration with primary care services is one of the most important issues regarding this population. The integration can either be the mental health services being integrated into the medical setting or the medical services being integrated into the mental health setting. He also mentioned that co-morbidities are key to this population and that the prevention of co-morbidities is very important. For example, the anti-psychotic medications used by this population can cause obesity and therefore create a higher risk for diabetes, so providing education regarding diabetes is important in reducing the risk for this co-morbidity. Lastly, he indicated that specialty mental health care should be formally connected to medical/physical healthcare (for example, co-locating mental health and primary care clinicians in the same clinic).

In addition to the information provided about programs and the key elements needed for successful programs, the experts provided the names of contact people and programs that are considered promising practices in serving specific populations. Based upon the expert interviews, two of the programs previously identified through the literature search were identified as promising practices for serving this population and were included in the program reviews: MnDHO and Vermont Medical Home Project. Many of the other programs that were identified through the literature search were not well-established or

had not yet been implemented fully; therefore the national experts did not identify them as potentially promising practices. The experts did, however, identify four additional programs as promising practices. Based on the information provided by the experts and additional internet searches and agreement by staff from the Executive Office of Elder Affairs, these four programs were included in the program reviews: Developmental Disabilities Health Alliance, Independence Care System, Texas STAR+PLUS, and Wisconsin Family Care.

### *3.3. Findings from the Program Reviews*

Reviews were conducted of six programs around the country that were identified through the literature search and the interviews with national experts as potential promising practices for managing the care for people with disabilities. Each of these programs was selected because it offered a unique perspective on this topic. For example, two of the organizations are private, while the remaining four are programs developed by state agencies. Two of the programs utilize an entirely separate organization for care management through a contractual arrangement, while the other four include care management as a function managed by the actual program (rather than contracting to another organization).

This section of the report synthesizes the findings from the program reviews, and also discusses where findings from the program reviews overlap with findings from the literature review and the interviews with national experts. Detailed information on each of the domains for each of the programs reviewed is provided in Appendix D, which also provides information on the documents that were reviewed and the interviews that were conducted. As Massachusetts moves forward in determining how best to serve individuals with disabilities, the detailed program information may be helpful. For example, if Massachusetts decides to develop a specialized program for people with mental retardation and other developmental disabilities, the information from the Developmental Disabilities Health Alliance may be particularly useful.

This section first provides an overview of each program and key structural indicators for each program. Following this information, the report synthesizes information from each program within the domains of:

- planning and implementation;
- eligibility;
- funding and authority;
- contracting;
- delivery system and services offered;
- care management and care coordination processes;
- evaluation and outcomes; and
- potential for replication.

### 3.3.1. Overview of Programs Reviewed

**Developmental Disabilities Health Alliance, New Jersey**

Developmental Disabilities Health Alliance (DDHA) is a private statewide health care company in New Jersey that provides primary and mental health care and care management services to people with mental retardation and other developmental disabilities including Medicaid and dually-eligible managed care enrollees who qualify for services from the State Division of Developmental Disabilities. State agencies, managed care organizations, and health systems contract with DDHA to provide comprehensive medical services, care management, and coordination of care to adults and children with developmental disabilities. Table 3-2 displays key structural characteristics about DDHA.

**Table 3-2: Structural Characteristics of Developmental Disability Health Alliance**

| | |
|---|---|
| **Location** | Six sites throughout New Jersey |
| **Structure** | A private organization providing primary care and case management to people with developmental disabilities. HMOs contract with DDHA to provide primary care and care management to this population. |
| **Authority** | None required – private organization with contractual agreements with private HMOs. |
| **Eligibility** | Persons with developmental disabilities living in the community. They serve people who are referred from an HMO as well as people on a fee-for-service basis. Enrollment is voluntary. |
| **Enrollment** | Primary care: Approximately 750 clients from HMOs<br>Case management: Approximately 1,500 clients (Some are also primary care clients)<br>Fee-for-service: Approximately 800-1,000 clients |
| **Formal Coordination with Medicare** | Medicare is billed on a fee-for-service basis for dually-eligible clients. |
| **Care Coordination Model** | Case management is provided by nurse practitioners that are on-site at office locations. Doctors rotate among all offices. Case management model is evolving in order to provide appropriate management based on level of need. |
| **Care Coordination Eligibility** | As needed; all clients from HMOs are included in case management. |

### Independence Care System, New York

Independence Care System (ICS) is a private, nonprofit organization that operates a voluntary managed long-term care program for people with physical disabilities. ICS is a Medicaid managed care contractor and receives Medicaid capitation from the State of New York to operate the program. The program coordinates a wide array of medical and social supports for people with physical disabilities. Table 3-3 displays key structural characteristics of ICS.

**Table 3-3: Structural Characteristics of Independence Care System**

| | |
|---|---|
| **Location** | New York City: Manhattan and Bronx (expanding to Brooklyn in 2005) |
| **Structure** | A nonprofit organization that was started from a paraprofessional association that provides a wide range of consumer-directed long-term care services for people with physical disabilities, including care management. |
| **Authority** | None required – private organization that receives capitation from Medicaid. |
| **Eligibility** | Medicaid-eligible adults over age 21 with physical disabilities or chronic illnesses who live in New York City and are eligible for placement in a nursing home. Enrollment is voluntary. |
| **Enrollment** | Approximately 600 members. |
| **Formal Coordination with Medicare** | Medicare is billed on a fee-for-service basis for dually-eligible clients. |
| **Care Coordination Model** | Flexible care coordination model with nurses and social workers providing a mix of services, depending on need. |
| **Care Coordination Eligibility** | All members. |

## Minnesota Disability Health Options (MnDHO)

The Minnesota Disability Health Options program (MnDHO) is a state- and federally-sponsored program that contracts with a nonprofit health plan (UCare Minnesota) to provide a voluntary, comprehensive acute and long-term supports managed care plan for adults with physical disabilities. The nonprofit health plan contracts with a care management organization that has significant experience serving people with disabilities (AXIS Healthcare). UCare Minnesota also receives Medicare capitation for dually-eligible enrollees. This is the only program reviewed in this project that is fully integrated with Medicare. Table 3-4 displays the key structural characteristics of MnDHO.

**Table 3-4: Structural Characteristics of Minnesota Disability Health Options**

| | |
|---|---|
| **Location** | Minnesota: Hennepin, Ramsey, Anoka, or Dakota counties |
| **Structure** | Minnesota Department of Human Services contracts with UCare Minnesota, a nonprofit HMO, to provide health services under the UCare Complete health plan. UCare contracts with AXIS Healthcare to conduct care coordination and authorization for members. |
| **Authority** | Operates under the MSHO (Minnesota Senior Health Options) program authorization. CMS approved MnDHO's inclusion under the Medicaid 1915(a) and 1915(c) waivers, and under Medicare Section 402 authority. |
| **Eligibility** | Enrollment is voluntary for Medicaid-eligible adults age 18-64 who have a certified primary physical disability. |
| **Enrollment** | 338 clients as of August, 2004 |
| **Formal Coordination with Medicare** | Fully integrated funding with Medicare; UCare Minnesota receives Medicare capitation. (49% of enrollees are dual-eligible) |
| **Care Coordination Model** | "Health coordinators" are RNs with experience working with disabilities. AXIS Healthcare provides the care coordination function and coordinates all services. |
| **Care Coordination Eligibility** | All enrollees. |

## Texas STAR+PLUS

Texas STAR+PLUS is a state-sponsored program that contracts with two for-profit HMOs to provide acute and long-term care services to Medicaid recipients and dually-eligible enrollees in a mandatory managed care environment. According to STAR+PLUS staff, managed care is "mandatory for SSI and SSI-related aged and disabled adults." The staff noted however that managed care is "voluntary for SSI and SSI-related children and certain severely mentally ill adults." The program serves individuals who reside in Harris County (Houston). Table 3-5 displays the key structural characteristics of STAR+PLUS.

**Table 3-5: Structural Characteristics of Texas STAR+PLUS**

| | |
|---|---|
| **Location** | Texas: Harris County (currently undergoing major expansion to additional counties) |
| **Structure** | The Texas Department of Human Services contracts with two HMOs to provide acute and long-term care services to Medicaid recipients and dual eligibles in a managed care environment. |
| **Authority** | Texas Senate Concurrent Resolution 55 and 1915(b) and 1915(c) federal waivers. |
| **Eligibility** | Mandatory – SSI and SSI-related aged (age 65 and over) and disabled (age 21 and over) adults.<br>Voluntary – SSI and SSI-related children (under age 21) and certain severely mentally ill adults. |
| **Enrollment** | Total Enrollment: 63,716 (as of June 1, 2004)<br>56% are dually-eligible and 44% receive Medicaid benefits only (as of 2002) |
| **Formal Coordination with Medicare** | There is no Medicare waiver for this program. One of the HMOs is a Medicare+Choice provider. |
| **Care Coordination Model** | The model for care coordination is not prescribed by TDHS. The care managers must be either an RN or an LSW. The responsibilities of the care managers are defined by the state. |
| **Care Coordination Eligibility** | All clients receiving long-term care services or who request it receive care coordination services from the HMO. |

## Vermont Medical Home Project

The Vermont Medical Home Project is a grant-funded program to integrate primary care case management services with mental health services for people with diabetes and serious and persistent mental illness. The Vermont Medical Home Project serves adult clients over age eighteen at three state community mental health centers. Table 3-6 displays the key structural characteristics of the Vermont Medical Home Project.

**Table 3-6: Structural Characteristics of the Vermont Medical Home Project**

| | |
|---|---|
| **Location** | Vermont: Howard Center for Human Services, Washington County Mental Heath Services, United Counseling Services of Bennington County |
| **Structure** | Partnership between the state Medicaid program and the Department of Mental Health and operates out of three of the state's community mental health centers |
| **Authority** | Grant-funded |
| **Eligibility** | Enrollment is voluntary for adults age 18 and over who receive services from the community mental health centers |
| **Enrollment** | Total Enrollment: 250 |
| **Formal Coordination with Medicare** | None |
| **Care Coordination Model** | Integration of primary care case management services with mental health services. The case managers are nurses. |
| **Care Coordination Eligibility** | All enrollees |

## Wisconsin Family Care

Wisconsin Family Care is a state-sponsored program that contracts with Aging and Disability Resource Centers (RCs) and Care Management Organizations (CMOs) to provide a voluntary managed long-term care program in five counties. The RCs provide a clearly identifiable single-entry point for information and access to community-based long-term supports. RCs determine functional and financial eligibility for individuals seeking long-term care services. CMOs manage the Family Care benefit and coordinate an array of long-term supports for elders and adults with physical and developmental disabilities. Family Care is the only way to access the fullest array of long-term supports in those five counties; individuals who do not choose Family Care are only eligible for traditional Medicaid state plan services.

**Table 3-7: Structural Characteristics of Wisconsin Family Care**

| | |
|---|---|
| **Location** | Wisconsin: Fond Du Lac, La Crosse, Milwaukee (elders only), Portage, and Richland Counties |
| **Structure** | Wisconsin Department of Health and Family Services contracts with Resource Centers and Care Management Organizations to provide a comprehensive and coordinated long-term care benefit to eligible Medicaid beneficiaries in a managed care environment. |
| **Authority** | 1999 Wisconsin Act 9, and 1915(b) and 1915(c) federal waivers. |
| **Eligibility** | Enrollment is voluntary for older adults and people with physical or developmental disabilities. HCBS services can only be accessed through Family Care. Otherwise eligible people can only access state plan services if they do not choose Family Care. |
| **Enrollment** | Total Enrollment: 8,186 (As of December 31, 2003)<br>Elderly:6,224 (76%) DD:1,075 (13%) Physical Disabilities:862 (11%) Other:25 (3%) |
| **Formal Coordination with Medicare** | None* |
| **Care Coordination Model** | Interdisciplinary case management team: social worker and registered nurse. Primarily based on a social work model with nursing components. |
| **Care Coordination Eligibility** | All enrollees |

* The Wisconsin Partnership Program is a companion program to Family Care and provides fully-integrated Medicaid and Medicare benefits (a modified PACE-type program).

### 3.3.2. Synthesis of Program Reviews

**Planning**

Initiating comprehensive programs to serve people with disabilities can take a significant amount of time and resources. All the programs that were reviewed reported spending many years developing, modifying, and refining the programs that were eventually implemented. At the extreme, Minnesota developed two prior managed care options for people with disabilities that were never fully implemented before creating the MnDHO model, which was fully implemented. Even the private-sector models that were reviewed (DDHA and ICS) reported spending many years and investing significant financial resources to develop the programs that were eventually implemented.

The key components of planning that were common to all programs included the level and methods of consumer involvement during the planning process, the supporting legislation and statutory authority allowing the programs to be created, and the external environment of political pressures and a generalized fear of managed care programs that influenced the overall planning and implementation process.

- **Consumer and other Stakeholder Involvement:** For all but one of the programs that were reviewed, consumer involvement was critical from the inception of planning, throughout implementation, and during program operation. By seeking the active involvement and input from consumers and other stakeholders, the programs were able to ensure that the model that was developed would address the identified problem that the program was trying to solve, and that it would meet the needs of the people it would be serving. In most cases, the programs reported that their models changed significantly over time due to the input and suggestions of stakeholders. Various methods were used to involve consumers and other stakeholders. Table 3-8 displays some of the methods of consumer involvement that were employed by each of the programs.

- **Supporting Legislation:** Four of the six programs that were reviewed had state legislation that mandated or allowed the programs to be created. In some cases, a state agency had decided that it wanted to pursue developing a program for people with disabilities and therefore proposed the legislation. In other cases, there was pressure from an external group (such as in New York with ICS) to pass legislation in order to mandate that the state agency create the program. Additionally, in the case of Wisconsin, the supporting legislation was accompanied by additional financial allocations to start the program. Table 3-8 displays information on the supporting legislation for the programs reviewed.

- **External Environment:** In all the programs that were reviewed, program staff cited a general fear of managed care programs as an obstacle to planning and implementation. Especially in the case of mandatory programs, but also for voluntary programs, advocates and people with disabilities feared that

managed care programs would lead to a reduction in services, rather than an improvement in access and coordination. Many programs indicated that an important role of consumer involvement was to educate consumers and advocates that managed care was a "black box," and that the program could define what managed care would look like. Further, many programs indicated that managed care should be viewed as a payment mechanism, and the care management and coordination as the programmatic benefit to consumers.

**Table 3-8: Consumer Involvement, Supporting Legislation and Statutory Authority, and Length of Time for Planning**

| Program | Method(s) of Consumer Involvement | Supporting Legislation/Statutory Authority | Length of Time for Planning |
|---|---|---|---|
| Developmental Disabilities Health Options | None | None | 3+ years |
| Independence Care System | Consumer committee | None | 7+ years |
| Minnesota Disability Health Options | Pilot project<br>Focus groups<br>Advisory committees | 1915(a) and 1915(c) federal waivers and Medicare Section 402 authority | 10+ years* |
| Texas STAR+PLUS | Stakeholder meetings<br>Local advisory committee | Texas Senate Concurrent Resolution 55, 1915(b) and 1915(c) federal waivers | 1 year |
| Vermont Medical Home Project | 1 ½ day planning session | N/A | 1 year |
| Wisconsin Family Care | Stakeholder meetings | 1999 Wisconsin Act 9 and 1915(b) and 1915(c) federal waivers | 4 years |

*MnDHO was created following several failed attempts at other managed care options for people with disabilities. The total time required to plan for all the various options was well over 10 years. The time from original MnDHO pilot project by AXIS Healthcare to full implementation was 4+ years.

It should also be noted that program staff and national experts indicated that the lessons learned from several programs developed and operating in Massachusetts have been useful as others have planned new programs. For example, ICS met with Dr. Bob Master and others from the Community Medical Alliance (CMA) in Boston during the development of the program. ICS modified the CMA program from a primary-care based model to a long-term supports model, but staff indicated that lessons learned from the CMA were integral in planning for the program.

### Implementation

Program staff indicated that once the planning phase was complete for all the programs, several issues and challenges emerged during the implementation process. In general, initial implementation of the programs was relatively quick; for example, in Texas, over 60,000 individuals were enrolled within the first three months. The issues that were raised included the process of enrolling people in the programs, education and marketing, and infrastructure development.

- **Enrollment:** In the case of Texas, the only mandatory program that was reviewed in this project, enrollment of individuals, as noted above, was very quick (over 60,000 individuals were enrolled in the first three months). In the voluntary programs that were reviewed, enrollment was slower. For example, in Minnesota, at the close of the first year of the program, just over 100 individuals were enrolled. Wisconsin presented a unique case for enrollment. Because Wisconsin's program also created Aging and Disability Resource Centers, which served as a one-stop location for long-term care services, there was an identifiable location in which people could go to or call to determine whether they could enroll in the Family Care program. This helped in transitioning people who were currently receiving traditional long-term care services into the new program, and to assist individuals who were not previously enrolled in publicly-supported long-term care services to enroll in the program. As a result, all five CMOs converted their existing waiver populations into Family Care during 2002, and everyone on waiting lists were enrolled in the program by the end of 2002.

- **Education and Marketing:** Especially for the voluntary programs, education and outreach to potential enrollees was important. As noted above, in the case of Wisconsin, the Aging and Disability Resource Centers created a visible one-stop location for service options. Other programs used such strategies as mailings to current Medicaid beneficiaries receiving services who met the general criteria for the programs and word-of-mouth from other enrollees.

- **Infrastructure Development:** In Texas and Minnesota, the state contracted with large managed care companies who then offered the managed care product. In these cases, the managed care companies generally had the capacity and infrastructure already developed to operate the programs. However, in the case of organizations such as ICS, DDHA, AXIS Healthcare (the care coordination contractor in Minnesota), and the counties in Wisconsin that operate Family Care, significant investments in information technology, including claims systems, were required. Further, in the case of Wisconsin, some of the infrastructure development processes were hindered because of the slow-moving nature of county governments. For example, during tight budgetary times, obtaining approval for the hiring of new staff or to buy new computer hardware was difficult.

**Eligibility**

In order to determine who should be eligible for a comprehensive managed care program for people with disabilities, the states had to consider several issues, including what disability types should be included, what ages should be included, whether individuals would need to meet standard Medicaid rules, whether dually-eligible individuals would be enrolled, and whether the program should be mandatory or voluntary. A summary of eligibility issues for the six programs that were reviewed is provided in Table 3-9.

- **Types of Disabilities to Include:** Two programs that were reviewed, Texas STAR+PLUS and Wisconsin Family Care, include multiple disability types for eligibility. For example, Texas includes anyone who is SSI or SSI-related aged or disabled. Wisconsin includes anyone with a physical disability or a developmental disability. The other four programs have eligibility limited to a single disability type (DDHA: MR/DD; ICS: physical disabilities; MnDHO: physical disabilities; Vermont Medical Home Project: chronic mental illness). One benefit of a program that includes multiple types of disabilities is that the program can achieve economies of scale. In Texas, because it includes various types of disabilities and is mandatory, the program has a large number of enrollees and is more attractive to the managed care companies because the risk is spread among more enrollees. In contrast, the benefit to programs that limit eligibility to a single disability type is that the program can become more specialized. For example, in Vermont the Medical Home Project is designed to address the specific needs of individuals who have chronic mental illness and have, or are at risk of developing, diabetes. Such a program allows the staff to target the program to the specific population and tailor the care management and service delivery to meet the needs of the population. Similarly, in the cases of ICS and MnDHO, by focusing on people with physical disabilities (or developmental disabilities in the case of DDHA), the programs can develop special expertise in serving the population by hiring staff who have significant experience working with the specific population.

- **Age of Enrollees:** Only two programs (DDHA and Texas STAR+PLUS) enroll children in their programs. The other programs limit eligibility to adults. In general, program staff indicated that the needs of children with disabilities generally differed from the needs of adults with disabilities. Therefore, creating a single program for all ages can be difficult (similar to the difficulties associated with creating a single program for multiple disability types). Further, program staff indicated significant resistance (from advocates, consumers, and legislators) to including children in managed care programs, largely because of the general fear of managed care that was identified earlier.

- **Medicaid Eligibility:** In general, all programs require that enrollees meet basic Medicaid eligibility rules. There are two primary exceptions to this. First, DDHA serves individuals who are not Medicaid-eligible (such as individuals with MR/DD who have private insurance). Second, Wisconsin started a portion of their program for individuals who were not Medicaid-eligible. Through this option, individuals who were above the income eligibility rules could “buy-in” to the program if their service plan costs exceeded their monthly income. However, this portion of the program was not eligible for federal matching funds under Medicaid rules. As a result, services for non-Medicaid enrollees were paid for by state allocations and as the state began to experience financial difficulties enrollment in this program was frozen. Staff from Wisconsin

Family Care reported that it was likely that this freeze on non-Medicaid enrollees would continue for the foreseeable future.

- **Individuals Eligible for Medicare:** All programs reviewed include individuals also eligible for Medicare. In general, approximately 50 percent of the program participants in each of the programs are dually eligible. One of the programs, MnDHO, fully integrates Medicare funding for these individuals. In this case, UCare Minnesota (the nonprofit health plan) receives capitation directly from Medicare to serve this population. In Texas, one of the HMO contractors, Evercare, is also a Medicare+Choice contractor. In that case, those individuals who are dually-eligible in Texas STAR+PLUS and choose Evercare have their funding integrated. ICS and DDHA, as private organizations, bill Medicare on a fee-for-service basis for services that are covered by Medicare. Wisconsin Family Care and Vermont Medical Home Project are not integrated with Medicare, although in general the care coordinators will help members coordinate services that are covered by Medicare.

- **Mandatory versus Voluntary Enrollment:** Texas STAR+PLUS is the only mandatory program that was reviewed in this project. The benefit of a mandatory program is the large number of enrollees which creates economies of scale for the program. Mandatory programs are also more attractive to private managed care contractors because financial risk can be spread among more enrollees. However, mandatory programs, because they attempt to enroll large numbers of individuals, can be too "watered down" to meet the specific needs of certain disability groups. For example, Texas STAR+PLUS had to generalize their program in order to make it "one-size fits all," which was at the expense of creating a program designed to meet the needs of a specific population. Additionally, mandatory programs may conflict with other state or federal priorities, such as consumer choice and control. Voluntary programs ensure that consumers have the choice to enroll and disenroll at any point.

**Table 3-9: Summary of Eligibility Information**

| Program Name | Eligibility: Disability Types | Eligibility: Financial | Eligibility: Ages | Eligibility: Dual Eligibles | Eligibility: Mandatory or Voluntary |
|---|---|---|---|---|---|
| **Developmental Disabilities Health Alliance** | Developmental disabilities (including mental retardation) | None – can either be receiving services from an HMO that has contracted with DDHA or be enrolled on F-F-S basis | All | Dual-eligibles are enrolled - Medicare is billed on a fee for service basis. | Voluntary |
| **Independence Care System** | Physical disabilities and chronic conditions | Standard Medicaid eligibility | Adults age 21 and over | Dual-eligibles are enrolled – Medicare is billed on a fee-for-service basis | Voluntary |
| **MnDHO** | Physical disabilities | Standard Medicaid eligibility | Ages 18 – 64 | Dual-eligibles are enrolled – funding is fully integrated | Voluntary |
| **Texas STAR+PLUS** | SSI and SSI-related aged and disabled | Standard Medicaid eligibility | All* | Dual-eligibles are enrolled - One HMO contractor is also a Medicare+Choice contractor. Otherwise, funding is not integrated. | Mandatory* |
| **Vermont Medical Home Project** | Chronic mental illness | Receiving services from a community mental health center | 18+ | Dual-eligibles are enrolled, but the funding is not integrated. | Voluntary |
| **Wisconsin Family Care** | Physical disabilities and developmental disabilities (including MR) | Standard Medicaid eligibility or not eligible for Medicaid with high service costs and cost-sharing | Over age 17 and 9 months** | Dual-eligibles are enrolled, but the funding is not integrated | Voluntary |

*Children and certain individuals with severe mental illness are voluntary in Texas STAR+PLUS.
**Only the adults over age 60 are eligible for Family Care in Milwaukee.

## Authority and Funding

While all of the programs serve Medicaid beneficiaries, each of the programs operates under different statutory authority. Two of the programs, ICS and DDHA, are privately-run and therefore require no statutory authority in order to operate the programs. ICS operates as a Medicaid managed care contractor under New York's larger managed care program. DDHA contracts directly with HMOs, who in turn contract with Medicaid. The Vermont Medical Home Project, while run by the state agency, does not require statutory authority. Rather, it operates as a grant-funded initiative, and thus operates somewhat like a demonstration project. The remaining three programs (MnDHO, Texas STAR+PLUS, and Wisconsin Family Care) all operate under different federal waivers and state-level legislation. Table 3-10 depicts the various federal authorities used by these three programs.

**Table 3-10: Description of Federal Authority Options**

| Authority | Description of Authority | Programs |
|---|---|---|
| Medicaid 1915(a) | Allows for Medicaid voluntary managed care programs. | MnDHO |
| Medicaid 1915(b) | Allows for Medicaid mandatory managed care programs. | Texas STAR+PLUS<br>Wisconsin Family Care* |
| Medicaid 1915(c) | Allows for Medicaid home and community-based services. | MnDHO<br>Texas STAR+PLUS<br>Wisconsin Family Care |
| Medicaid 1115 | Allows for broad research and demonstration programs within the Medicaid program. | None |
| Medicare 402 | Allows for a payment demonstration under Medicare. | MnDHO |

*Wisconsin Family Care operates under a 1915(b) because while the program is voluntary, the only way individuals can access home and community-based waiver services is by joining Family Care. Otherwise, individuals can only access the state plan services. In this way Family Care can be considered "mandatory" if individuals need to access the additional waiver services that are not available through the state plan.

Funding for all programs, except the Vermont Medical Home Project, is through capitation. Through capitation, the state pays a contractor a pre-set fee for providing a selected set of services to enrollees. In general, capitation allows the state to control costs because the contractor receiving the capitation spreads the financial risk for higher-cost individuals across the membership. The set of services included in the capitation payment is different for each program. In general, any services covered by Medicaid and not offered through the capitated program are available to enrollees through the traditional fee-for-service system. For example, Wisconsin Family Care includes most long-term support services in the capitation to the Care Management Organization, but other benefits such as pharmacy, prosthetics, and hospice services are offered on a fee-for-service basis. (The detailed information on each program in Appendix D identifies the fee-for-service versus capitated services provided within each program.)

## Contracting

Each of the programs structures contracting in different ways. In some cases, the state only contracts with one organization (such as an HMO) to offer a managed care product to the population of interest. In other cases, the state may contract with multiple contractors, or the primary contractor may sub-contract with other providers (such as for care management services). In all cases, the state is able to substantively control the features of service delivery and system design through the contracting process. For example, in the current Request for Proposals released by Wisconsin for their Family Care program, all proposals that are submitted must include information on how the contractor will comply with basic requirements in such areas as the provider network, interdisciplinary teams, service authorization, business systems, budgeting, accounting, data management, and quality. Table 3-11 displays various options for contracting that have been employed by the programs.

**Table 3-11: Contracting Structures Used by Programs**

| Contracting Structure | Program |
|---|---|
| State contracts with HMO only; HMO does not sub-contract for care management | Texas STAR+PLUS |
| State contracts with single non-HMO organization | Independence Care System |
| State contracts to HMO; HMO sub-contracts with care management organization | MnDHO<br>DDHA |
| State contracts with another government entity (county) | Wisconsin Family Care |

## Delivery System and Services

Each program has a different set of services that are included in the benefits provided to enrollees. Some programs include primary care and very few long-term supports (DDHA), while other programs include only long-term supports (ICS and Wisconsin Family Care), and other programs fully integrate long-term supports with acute care services (MnDHO and Texas STAR+PLUS).

Additionally, while some programs only include selected services in their capitation payments to the contractors, other services are available to enrollees through the traditional fee-for-service system. Programs report that one benefit of integrating long-term supports with acute and primary care is that such integration reduces the fragmentation that currently exists within the system. Table 3-12 displays what long-term support services and acute care services are included in the benefit package for program enrollees.

**Table 3-12: Services Included in Programs**

| Program | LTC or Acute/ Medical | Services Included |
|---|---|---|
| **DDHA*** | LTC | None |
| | Acute/ Medical Care | Physical and mental health care evaluation and treatment |
| | | Physical examinations and health assessments |
| | | Individualized treatment plans |
| | | Immunizations |
| | | Dietary counseling |
| | | Routine gynecological exams |
| | | Patient and family education |
| | | Health maintenance and promotion |
| | | Referrals to specialists |
| **Independence Care System** | LTC | Home care aide services |
| | | Home health nursing, physical, occupational, and speech therapies |
| | | Nutrition services |
| | | Medical equipment and supplies (including prosthetics and orthotics) |
| | | Non-emergency transportation |
| | | Optometry |
| | | Audiology and hearing aids |
| | | Adult day care |
| | | Social day care |
| | | Respiratory therapy |
| | | Social and environmental supports |
| | | Home delivery of meals |
| | | Personal emergency response systems |
| | | Site-based rehabilitation services |
| | | Nursing home care |
| | Acute/ Medical Care | Prescription and non-prescription drugs (if ordered by a physician) |
| | | Dental care |
| **Minnesota Disability Health Options** | LTC | Therapies (OT, PT, Speech) |
| | | Home and community-based waiver services |
| | | Home care, including PCA |
| | | Assistive technology |
| | | Behavioral health services |
| | | Medical supplies and DME |
| | | Special transportation |
| | | Some common carrier transportation and interpreter services |
| | | 180 days of nursing facility care for new admissions** |
| | Acute/ Medical Care | Inpatient and outpatient hospital |
| | | Physician and clinic services |
| | | Medical specialty services |
| | | Dental services |

*DDHA enters into capitated contracts with HMOs as well as fee-for-service structures. In the fee-for-service contracts, DDHA offers the listed set of services on a fee-for-service basis, rather than through capitation.

**Except for dually-eligible enrollees, for whom the health plan is responsible for all skilled nursing facility stays that meet the Medicare criteria.

**Table 3-12 (continued): Services Available to Program Enrollees**

| Program | LTC or Acute/ Medical | Services Included |
|---|---|---|
| **Texas STAR+PLUS** | LTC (basic benefits) | Home health |
| | | Hearing aid |
| | | Therapies (PT/OT/Speech) |
| | | Behavioral health services (see detail in Appendix for more information on exact services covered) |
| | | Nursing home care up to 120 days** |
| | | Day activity and health services** |
| | | Personal assistance services** |
| | | In-home respiratory care services** |
| | LTC (for individuals on community-based alternatives waiver) | Adaptive aids |
| | | Adult foster care |
| | | Assisted living/residential care services |
| | | Emergency response services |
| | | Medical supplies |
| | | Minor home modifications |
| | | Nursing services |
| | | Occupational therapy |
| | | Personal assistance services |
| | | Physical therapy |
| | | Respite care |
| | | Speech language therapy services |
| | Acute/ Medical Care | Hospital inpatient and outpatient |
| | | Professional services |
| | | Lab and x-ray |
| | | Vision |
| | | Podiatric services |
| | | Rural health services |
| | | Chiropractic |
| | | Ambulatory surgical center services |
| | | Certified nurse midwife services |
| | | Birthing center |
| | | Maternity clinic services |
| | | Transplant services |
| | | Federally qualified health centers |
| | | Adult well check |
| | | Family planning |
| | | Genetics |
| | | EPSDT Medical screens |
| | | EPSDT comprehensive care program |
| | | Triage fees |
| | | Renal dialysis |
| | | Total parenteral hyperalimentation |

**These services offered only when deemed medically necessary by the HMO.

**Table 3-12 (continued): Services Available to Program Enrollees**

| Program | LTC or Acute/ Medical | Services Included |
|---|---|---|
| **Vermont Medical Home Project** | LTC | Behavioral health services |
| | | Diabetes education programs |
| | | Diabetes management |
| | Acute/ Medical Care | Coordination with primary care providers |
| **Wisconsin Family Care** | LTC | Adaptive aids (general and vehicle) |
| | | Adult day care |
| | | Alcohol and other drug abuse day treatment services (all settings) |
| | | Alcohol and other drug abuse services, except those provided by a physician or on an inpatient basis |
| | | Communication aids/interpreter services |
| | | Community support program |
| | | Counseling and therapeutic resources |
| | | Daily living skills training |
| | | Day services/treatment |
| | | Durable medical equipment (except for hearing aids and prosthetics) |
| | | Home health |
| | | Home modifications |
| | | Meals: home delivered and congregate |
| | | Medical supplies |
| | | Mental health day treatment services (in all settings) |
| | | Mental health services, except those provided by a physician or an inpatient setting |
| | | Nursing facility stays (including ICF/MR and Institution for Mental Disease) |
| | | Nursing services |
| | | Occupational, physical, and speech therapies |
| | | Personal care |
| | | Personal emergency response services |
| | | Prevocational services |
| | | Protective payment/guardianship services |
| | | Residential services: residential care apartment complex, community based residential facilities, adult family home |
| | | Respite care |
| | | Specialized medical supplies |
| | | Supported employment |
| | | Supportive home care |
| | | Transportation select Medicaid covered and non-Medicaid covered |
| | Acute/ Medical Care | None |

Appendix D, which provides specific details on each of the programs reviewed, also provides information on the services that are provided to enrollees on a fee-for-service basis. For example, in Wisconsin Family Care, while only long-term support services are included in the capitation to the Care Management Organization, the full menu of state plan services are available to Medicaid enrollees through the traditional fee-for-service program.

The method in which programs address nursing facility care is important for several reasons. First, care in a nursing home is expensive to the state since Medicaid is often the primary payor for nursing home services. Second, by including nursing home services in the capitation payment to the contractor, states are able to place the contractor at some risk for reducing unnecessary institutionalizations. However, there will be individuals who appropriately require nursing facility care. As a result, a proper financing arrangement must be created in order to appropriately reimburse contractors for individuals who require nursing home level of care, while promoting and encouraging the contractor to appropriately manage the care of individuals to reduce nursing home utilization. Table 3-13 provides information on how each of the programs includes nursing home care as part of the capitation arrangement.

**Table 3-13: Coverage of Nursing Facility Stays**

| Program | Nursing facility cost included in capitation? | Coverage |
|---|---|---|
| DDHA | No | N/A |
| ICS | Yes | All nursing facility stays |
| MnDHO | Yes | 180 days of facility care for new admissions |
| Texas STAR+PLUS | Yes | 120 days of facility care |
| Vermont Medical Home Project | No | N/A |
| Wisconsin Family Care | Yes | All nursing facility stays |

## Care Coordination

Care coordination is an important feature of any comprehensive program that serves people with disabilities. Each of the programs reviewed has a care coordination component. The care coordination models within the programs reviewed include specific activities that have been identified as necessary components of care coordination through the literature review. Even though the programs may use different models to ensure the activities are conducted, each program does ensure that these services are provided to the members. Examples of different models include the MnDHO program, in which UCare Minnesota contracts with AXIS Healthcare to provide the care coordination services, while in Texas, each of the HMOs provide the care coordination services. Some programs such as DDHA use nurse practitioners as the care coordinators while in Texas the care coordinator must either be a registered nurse or a licensed social worker. Even though the models of care coordination are different, the underlying emphasis of the programs is the same: reducing the fragmentation of care for people with chronic conditions. Table 3-14 highlights the various components of each of the care coordination models used in the programs that were reviewed.

**Table 3-14: Summary of Care Coordination Models**

| Program | Who Provides the Care Coordination? | Who Receives the Services? | What Services are Provided? |
|---|---|---|---|
| **DDHA** | Nurse practitioners serve as care coordinators in the primary care panel. Consumers not enrolled in the primary care panel have their care coordinated by other professionals such as social workers. | All members receive care coordination whether or not they are enrolled in the primary care panel. | • Problem identification and clarification;<br>• Initial case assessment;<br>• Resource identification and access assistance;<br>• Scheduling and appointment monitoring;<br>• Assistance in interacting with professionals;<br>• Interagency communication and planning;<br>• Treatment compliance assistance;<br>• Case communication;<br>• Documentation assistance;<br>• Crisis stabilization;<br>• Behavioral consultation/implementation assistance;<br>• Individual and family counseling; and<br>• Parent/family training and consultation. |
| **ICS** | A social worker or an RN is assigned as the primary care manager. The care management process is consumer-driven, with the member taking on many of the roles of managing their own health care with the assistance of the care manager. | All members of ICS receive care coordination services. | • Assessment;<br>• Development of an individualized plan of care with the member, based on the member's choices about priorities and providers;<br>• Identification of a primary care physician if the member does not have one;<br>• Identification of what services will be managed directly by the consumer (such as personal assistance services); and<br>• Review of the care plan every four months, and completion of a new care plan annually. |
| **MnDHO** | Three staff positions are assigned to each member: a health coordinator, a resource coordinator, and member services staff.<br>Health coordinator is usually an RN or a public health nurse with extensive disability experience.<br>Resource coordinator is usually a social worker.<br>Member services staff are members of the office staff. | Care coordination is provided to all MnDHO members. | *Health coordinator*:<br>• conducts initial assessment and periodic re-assessments;<br>• authorizes most health and social support services;<br>• works with physicians and primary care clinic staff to assure that all services are received and coordinated;<br>• attends most primary care and specialty appointments with members; and<br>• is available 24 hours a day, 7 days a week as first point of triage for members.<br>*Resource coordinator*:<br>• coordinates non-medical supports, including housing, financial assistance, and health education efforts.<br>*Member services staff*:<br>• assists with administrative details of coordinating services. |

**Table 3-14 (continued): Summary of Care Coordination Models**

| Program | Who Provides the Care Coordination? | Who Receives the Services? | What Services are Provided? |
|---|---|---|---|
| **Texas STAR+ PLUS** | The care coordinator must be either a registered nurse or a licensed social worker. | Care coordination is provided to members receiving long-term care services at the time of enrollment, members whose HMO assessment indicates complex health or support needs, and members who request the service. | • Identification of physical health, mental health, and long term support needs.<br>• Development of a care plan to address the unique needs of each member.<br>• Timely access to providers and services.<br>• Coordination of all plan services with social and other services delivered outside the plan, as necessary and appropriate. |
| **Vermont Medical Home Project** | In one location, the Care Partner is a nurse practitioner, in the remaining two locations the Care Partners are registered nurses. | Care coordination is provided to persons receiving services at one of the three community mental health centers involved in the pilot. | • Consultation at treatment meetings.<br>• In-service training on medical issues.<br>• Liaison with primary care practices.<br>• Exercise groups.<br>• Diet and nutrition education.<br>• Group activities. |
| **Wisconsin Family Care** | Coordination of services is provided by an interdisciplinary team consisting of a social worker and a registered nurse at a minimum. | All members of Wisconsin Family Care receive care coordination services. | • Initial assessment of needs, preferences, and values.<br>• Use of Resource Allocation Decision (RAD) method, which was developed by the state, to identify the member's desired outcomes and the services that will achieve those outcomes in a cost-effective manner.<br>• Arrangement for and authorization of delivery of services.<br>• Monitoring the delivery of services and supports.<br>• Reassessment of the member on an ongoing basis. |

As noted previously, even though there are activities that are common to various care coordination programs, there are other aspects of care coordination that vary depending on the program, including who provides the care coordination and the use of information technology. Currently, DDHA is moving toward a care coordination model that is more flexible in which the needs of the individual dictate who serves as the care manager as opposed to having a stringent criteria for who can serve as a care coordinator. For example, if the member needs more social supports, the care manager would most likely be a social worker whereas if the member needs more clinical supports, the care manager would most likely be a nurse practitioner. ICS is also developing a similar flexible needs-based model.

In the Wisconsin Family Care program, the care coordinators utilize the Resource Allocation Decision Method which is a standardized decision-making process that provides preliminary guidelines about the circumstances in which a Family Care Care Management Organization can decline to provide a service requested by a member. The development of this tool was necessary to clarify that consumer preference is not

the only determinant of the services received. This tool also provides a methodology for the Care Management Organizations to balance member outcomes with costs.

The Wisconsin Family Care Program utilizes a web-based functional screening system to collect information about an individual's functional status, health, and need for assistance from programs that serve the frail elders and people with developmental or physical disabilities. The screen is used to determine if a person is eligible to receive certain mental health services or adult long-term care services. Experienced professionals, usually social workers or registered nurses, are able to access and administer the screen.

Care coordination will always remain an integral part of any program that provides services to people with disabilities. The exact model for care coordination is less important as long as the necessary components (risk screening, assessment, service plan development, service coordination, transition planning, monitoring, and reassessment) are included. According to the literature and interviews with program staff, the care coordination should improve members' health status if the model includes those components.

Additionally, models of care coordination are beginning to be influenced by other developments in service delivery for people for disabilities. Most notably, person-centered planning and self-directed supports are important components of service delivery within the current service structure in Massachusetts, and are gaining momentum across the country. ICS has integrated these concepts into its care coordination model through increasing as much as possible the supports for which the member can direct. Other care coordination models may need to be modified in the future to support self-directed service delivery approaches.

**Evaluation and Outcomes**

The evaluation methodologies used by each of the programs differ significantly. In general, the private organizations have completed internal evaluations, and generally these have only consisted of consumer satisfaction surveys. The larger, state-run programs have completed more rigorous evaluations with multiple domains, usually at the requirement of the Centers for Medicare and Medicaid Services or a legislative mandate. Table 3-15 displays information on the evaluations conducted by each of the programs. Because this project was a review of these programs, no attempt was made to determine the quality of these evaluations. All of the evaluations were completed by different organizations or contractors and utilized different outcome measures and other measures of success. This section reviews the results of these evaluations in the primary domains of satisfaction, access, cost, and utilization.

**Table 3-15: Overview of Program Evaluations**

| Program | Evaluations Completed | Domains/Topics |
|---|---|---|
| DDHA | Consumer satisfaction surveys | Access, quality of care, satisfaction, health status |
| ICS | Consumer satisfaction surveys, performance improvement studies | Overall consumer satisfaction, transportation, home health providers, pressure ulcer risk |
| MnDHO | Evaluation consortium completing series of evaluations – ongoing. | Satisfaction, well-being, cost and utilization |
| Texas STAR+PLUS | Independent evaluation by Public Policy Research Institute at Texas A&M University. Two focused studies completed by the Institute for Child Health Policy. | Access, quality, cost-effectiveness, effect of care coordination |
| VT Medical Home Project | None | N/A |
| Wisconsin Family Care | Evaluation conducted by Lewin Group; Independent assessment conducted by APS Healthcare. | Access, quality, cost effectiveness. |

*Satisfaction*

One of the central goals of the programs that were reviewed is to improve consumer satisfaction with services and the delivery of services. Because many of the members who enter these programs have complex needs and require significant coordination of services, their prior satisfaction with service delivery through the Medicaid program may have been low because coordination services were not readily available.

Overall, it appears that satisfaction with the programs is very high. Table 3-16 displays a summary of the available consumer satisfaction results. Each program displays a different set of measures because of the difference in evaluations and surveys that were completed.

**Table 3-16: Summary of Consumer Satisfaction Findings**

| Program | Summary of Consumer Satisfaction Findings |
|---|---|
| DDHA | 98 percent are pleased with treatment received |
| | 95 percent respond that visits were long enough and staff listened to concerns |
| | 97 percent say that privacy was afforded during health care visits. |
| ICS | The mean score (on a scale of 1 to 5) was above a 4 for the following items:<br>• Overall satisfaction<br>• Plan of care meets the needs of the member<br>• ICS supports members to do for themselves<br>• ICS staff is helpful<br>• ICS staff is respectful<br>• ICS staff communicates changes in service<br>• Would recommend ICS to others |
| MnDHO | 89 percent report higher overall satisfaction rates with their health care than prior to enrolling in MnDHO |
| | 66 percent report higher overall satisfaction with their primary care doctors in the year after enrolling in MnDHO |
| | 80 percent reported that someone helped manage their care only after enrolling in MnDHO |
| | 94 percent reported being involved as much as they want to in their health care decision making |
| Texas STAR+PLUS | 60 percent report good communication from physicians and other health care providers |
| | 80 percent of dual-eligibles and 60 percent of Medicaid-only enrollees say they are involved in decision making about their care. |
| Vermont Medical Home Project | No results available |
| Wisconsin Family Care | 72 percent report overall satisfaction with services |
| | 73 percent report being treated fairly |
| | 89 percent report appropriate privacy |

It is interesting to note a few differences across programs in consumer satisfaction results. For example, in MnDHO, 94 percent of enrollees reported being involved as much as they wanted to be in their health care decision making. In contrast, in Texas STAR+PLUS only 60 percent of Medicaid-only enrollees and 80 percent of dual-eligibles reported that they were involved in decision making about their care. This may reflect the differences between the two programs in that MnDHO is a small, tailored program with more personal contact in their care coordination process, while Texas STAR+PLUS is a large, less personal program that has a less well-defined care coordination process.

Overall, it appears that members enrolled in all of the programs are satisfied with their health care services provided because the programs are actively engaging in the activities of care coordination that were identified in the literature search (identifying medical needs that increase members' risk of adverse health events; addressing needs through education, treatment, and integration; and monitoring patients for progress and early signs of problems). Further, the evaluation completed for MnDHO indicates that enrollees are more satisfied after they enter the program, as compared to the services they were receiving through the traditional Medicaid system prior to entering the program.

*Access*

Programs are expected to improve access to services for people with disabilities. Because individuals are having their care managed, it is expected that the needs assessment process will identify the services needed to appropriately meet the member's needs. Further, the care coordinator should then assist the individual in accessing the needed services.

Table 3-17 displays the summary of selected evaluation results related to access. Overall, it appears that the programs sufficiently provide appropriate access to needed services.

**Table 3-17: Summary of Access Findings**

| Program | Summary of Access Findings |
|---|---|
| DDHA | 98 percent report being able to schedule an appointment with two weeks of calling |
| | 79 percent report the accessibility of waiting rooms/exam rooms as excellent |
| | 93 percent agreed that emergencies are handled efficiently |
| ICS | No results available |
| MnDHO | No results available |
| Texas STAR+PLUS | 80 percent indicate that they always or usually get care quickly |
| | 93 percent of dual-eligibles and 66 percent of Medicaid-only report that it is easy to get a care coordinator to help them |
| | 58 percent indicate that getting the care they need is not a problem |
| | 90 percent of enrollees have a usual source of care, and 80 percent of those also have a personal doctor or nurse |
| | 88 percent of those who needed to see a specialist actually saw the specialist |
| Vermont Medical Home Project | No results available |
| Wisconsin Family Care | Eliminated all wait lists to community long-term support services |
| | Increased number of contracted providers |

The unique case of Wisconsin Family Care should be noted in the area of access. First, because of the simultaneous creation of Aging and Disability Resource Centers, individuals seeking long-term care services have a visible single-entry point for accessing services. Further, one of the central goals of Wisconsin Family Care was to create an entitlement to community long-term care services in the counties in which it operated. This was established in all of the counties by eliminating prior waiting lists for waiver-covered long-term care services. As a result, access to services was immediately increased for all individuals who were eligible and wanted to access needed services.

It is also interesting to note that individuals who are dually-eligible in Texas STAR+PLUS are more likely to report that it is easier to find a care coordinator to help them than individuals who are Medicaid-only. This is similar to a finding in the satisfaction area (noted above) in which dually-eligible individuals were more likely to report that they were involved in the decision making about their health care. It is unclear why there are disparities between the dually-eligible and Medicaid-only populations within Texas STAR+PLUS, although staff from Texas STAR+PLUS

indicated that older enrollees (who are more likely to be dually-eligible) are generally more satisfied because of lower expectations about public programs.

*Cost and Utilization*

Cost and utilization estimates are critical for these programs. In general, states and the Centers for Medicare and Medicaid Services expect that such programs are going to produce cost savings in the long-term which can offset the immediate increases in costs for care management and other service delivery enhancements. This is reflected in the requirements of various waivers that programs either be budget neutral (in federal Medicaid 1115 waivers) or cost-effective (in Medicaid HCBS waivers). Unfortunately, the programs reviewed for this project have not been in existence long enough to have conclusive evidence regarding their cost effectiveness. Further, the cost-effectiveness of the programs reviewed will not indicate the cost-effectiveness of new programs that Massachusetts may implement. Cost-effectiveness can be influenced by a number of factors that will be unique to Massachusetts, including the other related services provided in the state, the state infrastructure of health and human services financing, and the actual design of the program.

Even with these considerations, the analyses of cost-effectiveness that have been completed on these programs can indicate the effect that they have had on costs in the states in which they operate. Wisconsin Family Care and Texas STAR+PLUS have more complete information regarding cost and utilization following the implementation of their programs. For this reason, this section will focus on these two programs. For cost and utilization issues on the other programs, see Appendix D.

The independent assessment completed by APS Healthcare for Wisconsin Family Care included an analysis of costs and utilization and compared the results for the Family Care population to a comparison group of selected Medicaid recipients that were outside of the Family Care counties and matched on a variety of demographic and clinical characteristics. The full results are presented in Appendix D, which has complete information about the program reviews.

In summary, APS Healthcare found that overall costs for the Family Care population were approximately $755 per member per month greater than for the matched comparison group. However, this increase in cost is largely driven by Milwaukee county, which enrolls only elders and has a majority of the Family Care enrollees. In non-Milwaukee counties, the average change following enrollment was $113 *less* per member per month in total long-term care expenditures than the matched comparison group. Additionally, APS Healthcare found that Family Care enrollees were less likely than the comparison group to enter institutions following Family Care implementation. However, APS found, during the analysis, that "this analysis is consistent with the idea that Family Care has the potential to effect cost savings by improving health care and health outcomes. However, it appears that the indirect savings are not sufficient to fully offset the direct increase in costs."

It is important to note that these cost and utilization estimates are based on one year following enrollment in Family Care. Changes in usage over time will not be evident for several years following implementation.

The cost-effectiveness evaluation completed for Texas STAR+PLUS is less detailed than for Wisconsin Family Care. In summary, the initial assessment, based upon data provided to the Public Policy Research Institute at Texas A&M University by TDHS, indicated a savings of $123 million over the two year waiver period. The assessment also indicated that Texas STAR+PLUS reduced overall costs for the state compared to projected costs had the waiver not been in effect over the first two years of the program. Table 3-18 displays the summary of this preliminary information, however, according to STAR+PLUS staff, a subsequent review of the program indicated the savings were not as high as originally thought. The savings were actually about half of the $123 million, or approximately $60 million.

**Table 3-18: Estimated Cost Savings under Texas STAR+PLUS**

| | Year 1 | Year 2 | Total |
|---|---|---|---|
| Estimated costs without waiver (PMPM) | $549.88 | $530.97 | $540.26 |
| Estimated costs with waiver (PMPM) | $448.93 | $448.26 | $448.59 |
| Estimated savings per member per month with waiver | $100.95 | $82.71 | $91.67 |

Adapted from Public Policy Research Institute, Texas A&M University, *Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program*. Table 6.1, page 59.

Like Wisconsin, the findings for Texas STAR+PLUS are based on two years of information. It is too early to determine the long-term cost savings of the programs.

### Replication

All of the programs indicated that there is no reason that these programs could not be replicated in another location. However, there are conditions that can effect whether such programs can effectively be replicated in Massachusetts, such as:

- **State characteristics:** The current characteristics of the state's health and human service delivery system can impact the design of various options. For example, Wisconsin has a strong county-based system, which therefore led the state to develop a county-run program.

- **State plan differences:** Each state's Medicaid program has different state plans. Some states may offer selected optional services that other states do not. As a result, the services included in the benefit package for the programs will depend on the services that are included in the state's Medicaid state plan.

None of these issues indicates that Massachusetts would not be able to replicate one of these programs. However, the more likely situation is that Massachusetts could identify which *features* of the programs are of most interest to serving their members within the current state structure. Those features could then be combined to develop a comprehensive program for serving people with disabilities that would meet the needs of the population in Massachusetts.

## 4. Conclusions and Next Steps

The purpose of this project was to identify promising practices in serving people with disabilities and to collect information about these promising practices. This report has presented the summary of this information. The Appendices to this report are a critical addition that provide much more detailed information about these programs. Further, the Appendices can direct the reader to additional materials which can help illuminate additional questions about the models.

The Executive Office of Health and Human Services, through the Executive Office of Elder Affairs and the Office of Disabilities and Community Services, will be moving forward to determine how to better serve the population with disabilities in MassHealth. The information that has been presented in this report will help to identify the various possibilities for models that could serve this population. However, to further develop the models, Massachusetts must determine several critical features of a new or modified service delivery model. Some of the questions to be answered include:

- Will Massachusetts develop a completely new service delivery model for the population of people with disabilities, or add care coordination as a new/modified function of an existing program?
- Should eligibility for the program include people who have various primary disability diagnoses, or should the program be specific to a single disability type?
- Should Medicare financing be integrated with Medicaid financing?
- Should people who are not eligible for Medicaid be included in the program?
- Should the program only include adults, or should the program also include children?
- Should the program be mandatory or voluntary?
- How should the care management model be structured?
- Should the program be capitated or fee-for-service?
- Should the program be developed by the state agencies or should the state contract with an external organization to develop and operate the model?
- Should the program offer a comprehensive set of benefits, or should it be limited to only acute/primary care or long-term support services?

Depending on how Massachusetts answers these questions, the Commonwealth will be able to rely on the information provided in this report, and in the detailed Appendices included with the report, to determine how other states have approached such issues. Further, more investigation may be required into the models as Massachusetts decides which option to pursue.

## 5. Appendices



*Selected program documents that were collected by the Center for Health Policy & Research are provided in Supplemental Program Documents Binder.*

## Appendix A: Biographies of National Experts Interviewed

**Alexander Blount M.D., University of Massachusetts Medical School, Director of Behavioral Science**
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Dr. Blount is Professor of Clinical Family Medicine at the University of Massachusetts Medical School in Worcester, MA and Director of Behavioral Science in the Department of Family Medicine and Community Health. He teaches physicians the psychosocial skills of primary care practice and directs the post-doctoral Fellowship in Primary Care Psychology. He has over thirty years experience as a therapist, teacher of physicians and therapists, administrator and lecturer in the US and abroad. His previous books include *Integrated Primary Care: The Future of Medical and Mental Health Collaboration* published by W. W. Norton and *Knowledge Acquisition*, written with James Brule', published by McGraw-Hill. Dr. Blount has lectured around the U.S., Canada and Europe on family therapy, systemic approaches to management, solution focused therapy and Integrated Primary Care.

**RoAnne Chaney, Disability Rights Coalition of Michigan**
Contact Information: (517) 333-2477, Ext. 19
roanne@sprynet.com

Ms. Chaney is a Health Policy Coordinator for the Michigan Disability Rights Coalition. She is participating in the development of a public authority model for independent home care workers. Her areas of expertise are with long-term care, community integration, and meaningful consumer involvement.

Ms. Chaney has experience in disability and health care issues in Michigan. Previously, she was a Senior Program Officer with Center for Health Care Strategies where she worked on Medicaid managed care issues. She was the Operations Director for the Michigan Disability Rights Coalition from 1997-2001 where she coordinated Michigan's Assistive Technology systems change project. Ms. Chaney was also the Associate Director of the Ann Arbor Center for Independent Living for ten years where she and a team developed a collaborative interagency process to assist individuals with a variety of significant disabilities leave nursing home settings to live in the community.

**Nikki Highsmith, Center for Health Care Strategies**
Contact Information: (609) 895-8101

Ms. Highsmith has significant experience in Medicaid managed care, both as a state purchaser and a federal budget official. Previously, she was the Deputy Director of the Medicaid Managed Care Program for the state of Massachusetts where she purchased health care on behalf of the state Medicaid agency. Ms. Highsmith was also a senior Medicaid analyst at the Office of Management and Budget, Executive Office of the

President in Washington, D.C., where she was responsible for approving Medicaid managed care waivers and developing the federal Medicaid budget.

**Allen Jensen, George Washington University**
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ihoacj@gwumc.edu

Mr. Jensen is a Senior Research Staff Scientist at the Center for Health Services Research and Policy at The George Washington University School of Public Health and Health Services. Mr. Jensen has research expertise in the areas of the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs and Medicaid, aging, mental health and social services programs. He is currently directing a project funded by the Robert Wood Johnson Foundation related to the implementation of State employment initiatives including State development and implementation of Medicaid Buy In programs for persons with severe mental or physical disabilities. Prior to joining the staff of CHSRP, Mr. Jensen was the principal staff person on the SSI program for the US House of Representatives Committee on Ways and Means for fourteen years and prior to that was the Staff Director for the Human Resources Committee of the National Governors' Association.

**Carol Tobias, Medicaid Working Group**
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Ms. Tobias has directed the Health and Disability Working Group since 1996, including the group's public policy work, program development, training, and technical assistance activities. She has also conducted numerous program evaluations and is currently the Principal Investigator of a national multi-site evaluation of different outreach programs and their effectiveness in engaging and retaining people with HIV in health care.

Ms. Tobias has worked with public policy-makers at the national and state level, managed care organizations, health and social service providers, foundations, and consumer advocacy organizations to promote innovative health care services for people with disabilities and chronic illness. Ms. Tobias has a special expertise in health care delivery systems for people with disabilities, including the financing of care, the use of managed care tools to promote service innovation and flexibility, quality measurement, performance evaluation, and consumer involvement in system design and implementation.

**Kevin Walsh, Ph.D., Developmental Disabilities Health Alliance**
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Dr. Walsh has over 25 years experience in both applied service administration and policy research settings for people with developmental disabilities including the development and direction of all clinical services in a private residential institution. Dr.

Walsh served as a member of the Medicaid Working Group in New Jersey, a joint interdisciplinary working group planning the inclusion of people with disabilities in Medicaid managed care. Additionally, he is a member of three state-level New Jersey Division of Developmental Disabilities standing committees: 1) the Quality Improvement Steering Committee, 2) the Interdisciplinary Research Committee, 2) the DC #34 Behavior Review Committee. Recently, Dr. Walsh served on the NJ/DDD Task Force on Aging and Developmental Disabilities, the Long-Term Care Exploration Working Group, and on the Research and Data Committee of the Waiting List Planning Work Group. Dr. Walsh conducts research and writes on public policy, health care, and clinical issues in developmental disabilities.

## Appendix B: National Experts Interview Template

1) What is it (services, programs, structures) that people with disabilities need?
   *If an expert in a specific field:* What do people with _____ (physical disabilities, CMI, or MR/DD) need?

2) What are the most successful types of practices/strategies that you've seen states develop to serve individuals with disabilities? In what way were these programs successful? Why were these practices successful?

3) Do you think these practices are replicable? Why or why not? Under what conditions?

4) What, in your opinion, are the key issues that must be addressed to successfully serve individuals with disabilities (e.g. success in terms of access, quality, cost-effectiveness, consumer satisfaction)? What are key considerations/methods to address these issues?

5) What do you believe are essential elements of programs that serve individuals with disabilities (e.g. network design, choice, consumer self-direction, care coordination, case management, disease management)? Why? Describe the most important aspects of each element and how you would address them in designing programs to serve individuals with disabilities.

6) What are the key pieces of literature that you are aware of related to serving individuals with disabilities generally? Individuals with CMI, physical disabilities or MR/DD specifically? Are there more recent articles/papers by key authors that have not been published but that you know are in progress?

7) Who are the other key people/experts in the field of developing and managing programs for people with disabilities generally? For developing and managing programs for people with CMI, physical disabilities or MR/DD specifically?

8) What key programs around the country are good examples of serving these populations generally, and for specific types of disabilities? Why would you consider them best practice programs?

9) Can you share the names of people at these programs with whom we should talk?

# Appendix C: Program Review Methodology

## I. Confirmation of Previously Obtained Information

| General Information | Prompts | Source of Information (Interviewee, program literature, etc.) |
|---|---|---|
| | What is the program? | Literature/National Experts |
| | Who does it serve? | Literature/National Experts |
| | How is it structured? | Literature/National Experts |
| | What does it do? | Literature/National Experts |
| | What are the general strengths of the program? | Literature/National Experts |
| | Is it limited to a particular geographic area? | Literature/National Experts |

## II. Program Structure

| Domain and Guiding Interview Question | Prompts for further information | Source of Information (Interviewee, program literature, etc.) |
|---|---|---|
| *Planning*<br><br>**Guiding Question:**<br>Describe how this program came into existence. | - Was this program an evolution of an old program or an entirely new program?<br>- What process did the state use in developing the program?<br>- How long did it take to plan the program?<br>- What evidence was there that the program would be successful?<br>- What data were used to design the program?<br>- What key articles were read during the planning phase?<br>- What led to this particular program design?<br>- Were there other program designs that were considered but rejected? If so, why?<br>- Were consumers involved in the planning process? Were other stakeholders involved? If so, how? If not, why not?<br>- What were the barriers encountered during the planning phase?<br>- Is the program that is in existence now the same as that which was developed during the planning phase? If not, why? What is different?<br>- What was the authority needed for the program; was a waiver needed to implement the program? If so, what waiver? Where there issues in getting approval for the waiver? | Interviewee |

| | | |
|---|---|---|
| *Implementation*<br><br>**Guiding Question:** What were the lessons learned during the implementation of the program? | - What were the things that went well during implementation?<br>- What were the challenging aspects of implementation?<br>- What were the key steps that were required for implementation?<br>- How long did it take for implementation?<br>- Did people currently in the system get moved into the new program? – How did this work?<br>- What were the barriers that were encountered during implementation phase? – Could these barriers have been anticipated? | Interviewee |
| *Eligibility*<br><br>**Guiding Question:** Who is eligible for this program and how do they find out about the program? | - What is the target population of the program?<br>- Does the program serve Medicaid recipients? If yes, what percentage?<br>- Does the program serve Medicare recipients? If yes, what percentage?<br>- Does the program serve dual-eligibles? If yes, what percentage?<br>- Is the program voluntary or mandatory? Why?<br>- How many people are enrolled?<br>- What were the key eligibility decisions that were made for this model?<br>- Was this an expansion for Medicaid? If so, what was the net impact on the state? Are they willing to share their analysis regarding the impact on the state of the expansion?<br>- Do consumers have to meet standard Medicaid eligibility rules, or are there separate criteria?<br>- Does the program target people within certain age groups?<br>- Does the program target people with certain diagnoses?<br>- Are people in nursing homes included in the program? If so, how do you ensure quality for these participants?<br>- How was the program marketed? | Interviewee and program literature |
| *Funding*<br><br>**Guiding Question:** Describe the funding mechanisms and process for the program. | - Is the program a capitated model, FFS model, or both?<br>- If combination, what components are capitated and what components are FFS?<br>- Why was this structure selected?<br>- Was it budget neutral? – When was budget neutrality reached, immediately or over a period of time?<br>- Did the program require additional budget allocation?<br>- What are the strategies to maximize federal and other non-state expenditures in the program? | Interviewee and program literature |

| | | |
|---|---|---|
| *Contracting*<br><br>**Guiding Question:** Did you "make" this program, or did you "buy" this program? Please describe your contracting structure. | - What functions of the program are managed internally? What functions of the program are managed externally?<br>- Is the program managed by an outside contractor? If yes, one or more than one contractor?<br>- What is the contractor's role?<br>- Who is the contractor?<br>- Are there multiple contractors serving different roles?<br>- How was this contractor selected? – Is selective contracting used?<br>- How much is the contractor paid for their services? – Is contractor paid on a capitated basis or FFS basis?<br>- How long has the contractor been under contract?<br>- Have there been other contractors in the past that are not longer a part of the program? If yes, why?<br>- Can you provide us with your PMPM costs?<br>- How do contractors work together?<br>- Are there quality incentives built into the contracts? | Interviewee |

**III. SERVICE DELIVERY COMPONENTS**

| DOMAIN AND GUIDING INTERVIEW QUESTION | PROMPTS FOR FURTHER INFORMATION | SOURCE OF INFORMATION (INTERVIEWEE, PROGRAM LITERATURE, ETC.) |
|---|---|---|
| *Delivery System*<br><br>**Guiding Question:** Describe the basic structure of the delivery of services to members. | - What is the basic structure of the service delivery?<br>- How was this structure selected? | Interviewee and program literature |
| *Services Offered*<br><br>**Guiding Question:** What are the services that are offered by the program? | - Does the program offer long-term supports? What long-term supports are included/excluded?<br>- Does the program offer behavioral health? What behavioral health services are included/excluded?<br>- Does the program offer pharmacy benefits?<br>- Does the program offer acute care?<br>- If it does not cover these benefits, how does the consumer obtain these benefits? | Interviewee and program literature |

| | | |
|---|---|---|
| *Case Management, Care Coordination, and Disease Management*<br><br>**Guiding Question:** Describe the care management process used by the program. | - Does the program offer case management services?<br>- How is case management defined?<br>- Does the program use a particular model of case management/care coordination? What about for people with co-morbidities?<br>- Who are the case managers? How do they interact with members? Are they plan-based or provider-based? What is their case load?<br>- How do you prioritize members for care management services?<br>- Do they offer disease management services?<br>- How is disease management defined?<br>- What diseases does the program manage?<br>- Is there a single point of entry? If not, can individuals access the same information through all entry points (i.e. “no wrong door”)?<br>- Is there a standardized assessment tool for all consumers?<br>- What is the assessment process?<br>- How does the program identify medical, functional, social, and emotional needs that may increase risk for adverse events?<br>- Is the consumer a part of the decision making team regarding treatment?<br>- Is there a team that makes the decisions or does the PCP make the decisions?<br>- What types of patient education occurs<br>- How is the PCP involved in non-medical aspects of care?<br>- Are reassessments conducted on a regular basis? – quarterly, every six months, yearly<br>- How is on-going monitoring of patients achieved? | Interviewee and program literature |

## IV. OUTCOMES/EVALUATION

| DOMAIN AND GUIDING INTERVIEW QUESTION | PROMPTS FOR FURTHER INFORMATION | SOURCE OF INFORMATION (INTERVIEWEE, PROGRAM LITERATURE, ETC.) |
|---|---|---|
| *Evaluation*<br><br>**Guiding Question for entire section:** Please describe your evaluation and quality assurance process for the program. | - How does the program measure consumer satisfaction?<br>- Is the program based on evidence based-model?<br>- What have been the barriers to evaluation?<br>- Has an external evaluation been conducted? | Interviewee and program literature |
| *Quality* | - How does the program measure quality?<br>- What quality measures are used?<br>- How did the program develop the quality measures? | Interviewee and program literature |
| *Consumer Satisfaction* | - How does the program measure consumer satisfaction?<br>- What tools are used? | Interviewee and program literature |
| *Outcomes* | - What were the desired outcomes when the program was designed?<br>- What outcome measures are used?<br>- Have these outcomes been achieved?<br>- How does the program measure the achievement of the outcomes?<br>- If the program is falling short of its outcome goals, why? – Is there anything that can remedy that? | Interviewee and program literature |

## V. CAN THE PROGRAM BE REPLICATED?

| DOMAIN AND GUIDING INTERVIEW QUESTION | PROMPTS FOR FURTHER INFORMATION | SOURCE OF INFORMATION (INTERVIEWEE, PROGRAM LITERATURE, ETC.) |
|---|---|---|
| **Guiding Question:** Do you think this program could be replicated in other states? How? | - Could this program be replicated in another state? If so, what conditions must exist?<br>- Are there structures/conditions that need to be in place for this program to be successful elsewhere?<br>- What are other relevant programs currently occurring in the state? How do they impact this program? | Interviewee |

# Appendix D: Detail of Programs Reviewed

## Appendix D.1: Developmental Disabilities Health Alliance, Inc. Program Overview

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Information utilized in review of the program:

- Telephone interview with Kevin Walsh
- *DDHA Health Care Quality: Report of 2004 Satisfaction Survey*
- Company website: http://www.ddha.com

### Program Structure

*Planning*

DDHA was created in 1997 to address the unmet health care and mental health care needs of people with developmental disabilities in New Jersey. The planning for the program was done primarily by two individuals, Theodore A. Kastner, M.D., MS and Kevin K. Walsh, Ph.D. The idea was to develop physician's offices specializing in developmental disabilities in the community that are easy for people to access and still be specialized for the particular community. The model was developed as a means to move away from the state-sponsored programs and to develop subcontracts with HMOs because state-sponsored programs sometimes have difficulty with growth. Consumers were not included in the planning process of the program.

*Implementation*

DDHA began serving consumers in 2000. The number of persons served has grown not through marketing but rather by word of mouth. In New Jersey, there is limited auto-assignment (one county so far) so those individuals who receive services from DDHA have elected to do so. During implementation, DDHA encountered people who were ideologically against managed care. DDHA staff noted that it is important to understand that managed care is not a bad thing nor is it limiting. Managed care is solely a means of payment.

*Eligibility*

DDHA serves persons with developmental disabilities living in the community. The consumers do not have to be Medicaid eligible to receive services from DDHA. DDHA provides services to those individuals referred by HMOs, as well as individuals on a fee-for-service basis. Enrollment in DDHA is voluntary, the same as choosing a physician in the general population.

*Funding*

DDHA is a subcontractor to various HMOs and receives either a capitated or fee-for-service payment depending upon the contract agreement with the HMO. The HMOs

receive a capitated payment from the State and in turn the HMOs subcontract with DDHA for services. DDHA prefers to receive capitated payments from the HMOs.

*Contracting*

DDHA is a contractor to various HMOs. DDHA provides primary care and/or care management services to their clients.

**Service Delivery Components**

*Delivery System*

In addition to health care and care management, DDHA provides other services locally, regionally, or statewide through contracts with New Jersey State agencies. Such services include comprehensive primary care, coordinated mental health services, family support services, case management, seizure management, managed care, and behavioral consultation.

*Services Offered*

DDHA provides the following primary health care services:

- physical and mental heath care evaluation and treatment;
- physical examinations and health assessments;
- individual treatment plans;
- immunizations;
- dietary counseling;
- routine gynecological examinations;
- patient and family education;
- health maintenance and promotion; and
- referrals to sub-specialists.

*Case Management, Care Coordination*

DDHA performs its work with teams of health care professionals including physicians, nurse practitioners, psychologists, social workers, and administrative support staff. DDHA provides case management services as part of their comprehensive primary health care program. Nurse Practitioners (NPs) serve as the care coordinators for most members enrolled in the primary care panels. Those not enrolled in the primary care panel have their care coordinated by other professionals such as nurses, social workers or other human service professionals. The caseloads are determined by the needs of the consumers (i.e. nurse practitioners seeing higher-acuity patients will have smaller caseloads).

DDHA is currently moving toward a more flexible care management process in which the needs of the individual will dictate who serves as the care manager. For example, if the consumer needs more social supports, the care manager would most likely be a social worker whereas if the consumer needs more clinical supports, the care manager would most likely be an NP. DDHA also has case management software that allows a

case manager to manage the services for a consumer that may be located in a different part of the state.

Services provided by the care managers include:

- problem identification and clarification;
- initial case assessment;
- resource identification and access assistance;
- scheduling and appointment monitoring;
- assistance in interacting with professionals;
- interagency communication and planning;
- treatment compliance assistance;
- case communication;
- documentation assistance;
- crisis stabilization;
- behavioral consultation/implementation assistance;
- individual and family counseling; and
- parent/family training and consultation.

**Outcomes/Evaluation**

There has not been a formal, comprehensive evaluation conducted by or for DDHA. DDHA most recently conducted a consumer satisfaction survey between February and May, 2004 and compiled the results in a June 2004 report, *DDHA Health Care Quality: Report of 2004 Satisfaction Survey*. The areas of focus for the survey were access, quality of care, satisfaction, and health status.

*Access*

The survey covered three areas within the domain of access, scheduling, environment, and special responding (non-visit). The following are some of the results of the survey in these areas:

- 98 percent of respondents indicated that they were able to schedule a clinical appointment within two weeks of calling the office.
- 95 percent of respondents indicated that they agreed or strongly agreed to the statement that phone calls are handled efficiently/effectively.
- 79 percent of respondents rated access to waiting/exam rooms as excellent.
- The average time waited in the waiting room was 6.4 minutes.
- 93 percent of respondents agreed or strongly agreed that emergencies are handled efficiently.

*Quality*

The quality domain of the survey referred to the quality of both the medical professionals and the clerical/secretarial staff.

- 82 percent of respondents indicated that the quality of care on the day of the visit was excellent.
- 90 percent of respondents agreed strongly to the statement that their questions were answered clearly and fully.

- 90 percent of the respondents rated the quality and courtesy of office/secretarial staff as excellent.

*Consumer Satisfaction*

The survey divided satisfaction into two areas, satisfaction with the care received and satisfaction with the facility.

- 98 percent of respondents agreed or strongly agreed that they were pleased with the treatment received from DDHA.
- Over 95 percent of respondents agreed or strongly agreed that visits were long enough and that staff listened to concerns and were respectful to them.
- 97 percent of respondents agreed or strongly agreed that enough privacy was afforded during health care visits at DDHA.

*Health Status*

This domain focused upon the health status of the consumer and does not contain any sub-domains.

- Nearly 80 percent of DDHA patients or their proxies agree or strongly agree that the health of the disabled individual has improved during the last year.
- 92 percent of respondents report participating in day activities outside the home

**Can the Program be Replicated?**

This program has the potential to work in other areas. It would take an organization like DDHA to be willing to provide the primary health care and/or care management for the DD population for the managed care organizations. To make a similar program work in other states, it is thought that the program would have to be regionalized. The regionalization would allow for sites of care to be within the community of the people that they serve. This idea follows the idea behind DDHA, that is, develop clinics in the community that are easy for people to access and have the clinics be specialized for the particular community.

## Appendix D.2: Independence Care System Program Overview

Contact Information: Rick Surpin
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Information utilized in review of the program:

- Telephone interview with Rick Surpin
- Results of internal member satisfaction surveys
- 2003 Focused Clinical Study Final Report
- Independence Care System Case Statement*
- The ICS Story in Five Parts*
- ICS Balanced Scorecard*
- Organization website: http://www.icsny.org

**Provided in Supplemental Documents Binder*

### Program Structure

*Planning*

The idea for ICS came out of the Cooperative Home Care Associates (CHCA) in New York City, which is a worker-owned paraprofessional agency that provides long-term supports to individuals in New York City. CHCA is a nationally-recognized model of the better jobs-better care approach to paraprofessional services. In the early 1990s, amidst changes to Medicare home care rules, and a consolidation of home health agencies, the then president of CHCA (now president of ICS) became interested in creating a model for coordinating the care of people with severe physical disabilities. At the time, the managed care movement was focused mainly on managing costs. Staff from CHCA consulted with Bob Master from the Community Medical Alliance (CMA) to discuss their model of care coordination for this population. CMA was a primary-care based model that sought to balance managing costs with providing appropriate and coordinated care for people with physical disabilities. CHCA staff wanted to develop the same objectives using a long-term care-based model.

After receiving a planning grant from the Center for Health Care Strategies (CHCS), ICS approached the New York Department of Health (NYDOH) to propose a specialized Medicaid managed care organization for people with physical disabilities. NYDOH was not responsive to ICS's proposal, and as a result ICS proposed agency-only legislation in the legislature. This agencies-only legislation was passed in 1997 and became part of general legislation which created a Managed Long-Term Care Demonstration Program and allowed for a capitation for specific services. ICS was thus established as a Medicaid contractor.

Throughout the planning phase for the program, ICS engaged a consumer committee to help with the development of the program. What was finally developed looked considerably different from what was originally envisioned by the creators of the program because of negotiations with the NYDOH after the legislation was passed. For example, originally ICS was interested in enrolling members of all ages, but NYDOH allowed only adults in the program. Additionally, determination of what set of services would be included in the benefit package was controlled by the State. It was decided that physician and hospital services would not be covered in the package, but that the plan was still responsible for coordination of all care.

*Implementation*

Following the legislation passed in 1997, the program began in April 2000. The State originally intended to pursue a Medicare waiver in order to capitate Medicare services for dually-eligible enrollees. However, this was not pursued, and the managed care program that was created was specifically for Medicaid long-term support services.

ICS is regulated through the NYDOH Office of Managed Care, which is important to the program's implementation. The Office of Managed Care has applied traditional managed care insurance rules to ICS. However, because this population presents a unique set of needs and required services, ICS has found it difficult to operate within rate-setting practices, which are designed for larger plans and "average" populations.

Additionally, ICS invested a significant amount of money during the development and implementation of the program to get the program started.

*Eligibility*

ICS serves Medicaid-eligible individuals over age 21 with physical disabilities or chronic illness who live in New York City (Bronx, Manhattan, or Brooklyn) and are determined to be functionally impaired and in need of long-term care services for more than 120 days (eligible for placement in a nursing home). Membership is completely voluntary. The target population primarily consists of younger adults with disabilities, especially spinal cord injuries, multiple sclerosis, cerebral palsy, and muscular dystrophy.

Individuals who are also eligible for Medicare can join ICS. Currently, approximately half of the ICS population is dually eligible and the other half is Medicaid-only. ICS does not receive capitation payments for Medicare-covered services, although they do coordinate this service for members. (See section on care coordination). There are currently approximately 600 individuals enrolled in ICS. ICS expects to enroll an additional 100 individuals each year for the next three years.

Individuals who reside in nursing homes are not eligible for enrollment in ICS. For individuals enrolled in ICS, the ICS benefit package includes nursing home services that may be required. A small number of members at any one time are in a nursing home, usually for 3 to 6 months. (See section on covered services for more information).

*Funding*

ICS receives capitation for Medicaid-covered long-term care services (see section on Services Offered). Other medical services, such as inpatient and outpatient services, physician services, and all Medicare-covered service for those who are dually-eligible, are billed on a fee-for-service basis.

New York does not allow for any type of risk-adjustment payments under the managed care program. Therefore, there are two capitation rates that Medicaid contractors receive: one amount for individuals under age 65, and one amount for individuals over age 65. This capitation rate, according to ICS, does not adequately cover all necessary services for the people who they serve. The actual per-member per-month costs are approximately $5,300 for their population. Additionally, approximately 25 percent of their members require between 12 and 24 hours of personal care assistance. Additional start-up funds were received through grants and medium- and long-term debt from the following sources:

- New York City Investment Fund;
- Ford Foundation;
- Nonprofit Facilities Fund; and
- National Cooperative Bank.

*Contracting*

Medicaid contracts with ICS to operate this program. ICS contracts with a number of organizations to provide the long-term supports. A major contractor is their sister organization, Cooperative Home Care Associates, which provides approximately 25 percent of the services. An additional 25 percent of services are through consumer-directed personal care assistance, in which the employer (the member) hires their own personal care assistants.

**Service Delivery Components**

*Delivery System*

ICS receives capitation payments to provide the covered set of services. ICS coordinates care for all its members, regardless of whether the service is included in the capitated payment. ICS contracts with a number of organizations to provide the covered set of services.

*Services Offered*

The services covered by ICS are:

- Care coordination;
- Home care aide services;
- Home health nursing, physical, occupational, and speech therapies;
- Nutrition services;
- Medical equipment and supplies (including prosthetics and orthotics);
- Transportation (non-emergency);

- Prescription and non-prescription drugs (if ordered by a physician);
- Dental care;
- Optometry;
- Audiology and hearing aids;
- Adult day health care;
- Social day care;
- Respiratory therapy;
- Social and environmental supports;
- Home delivery of meals;
- Personal emergency response systems;
- Site-based rehabilitation services; and
- Nursing home care.

ICS does not receive capitation for other medical services and Medicare-covered services, although ICS will coordinate those services for the member.

*Case Management, Care Coordination*

Case management, referred to by ICS as care management, is an interdisciplinary team approach, including nurses, social workers, physicians, and other specialties. Each member is assigned a primary care manager, who is a nurse or a social worker. The care manager is responsible for:

- Conducting an assessment using a standard assessment tool;
- Developing an individualized plan of care with the member, based on the member's choices about priorities and providers;
- Helping to identify a primary care physician if the member does not have one;
- Working with the consumer to identify what services will be managed directly by the consumer (such as personal assistance services); and
- Reviewing the care plan every four months, and completes a new care plan annually.

The ICS care management process is strongly consumer-driven, with the member taking on many of the roles of managing his/her own health care with the assistance of the care manager. All care management staff are employed by ICS.

Originally, ICS planned to have nurses and social workers who would be interchangeable as care managers. In other words, they originally expected that a member's assigned care manager would not be based on the care manager's professional qualifications. However, over time, ICS has realized that a more effective model is to assign a nurse as primary care manager to members who generally have more medical needs, and a social worker as primary care manager to members who generally have more social service needs.

ICS describes its organization, and the associated care management process, as a "community of people." Sometimes the formal care manager is the one who identifies issues to be resolved and then works to address those issues. However, at other times,

it may be that a consumer advocate or the receptionist is the first person that the member sees, and learns about a problem in the member's life. As a result, the consumer advocate or the receptionist will begin to advocate on behalf of the consumer to assure that their needs are met. In this way, their care management process includes the full range of staff and members and makes it more responsive to an individual's needs.

## Outcomes/Evaluation

### *Evaluation*

There has not been a formal, comprehensive evaluation conducted by or for the ICS program. ICS has conducted consumer satisfaction surveys, has implemented performance improvement studies, and has instituted a consumer complaint process.

### *Quality*

Quality within the ICS program is defined as quality clinical management for members. In this context, quality clinical management involves ensuring: "continuous access to appropriate and specialty care; access to preventive services; optimal functional status by reducing the amount of sickness/complications; reliable home care services; appropriate clinical equipment and rehabilitative services; and appropriate medication management."

ICS has monitored the level of quality clinical management through focused performance improvement studies. The purpose of these focused clinical studies is to determine the level of adherence to accepted clinical practices. One such study, conducted in 2003, was on the assessment for pressure ulcer risk using a standardized screening tool. Data from an interactive database showed that 99 percent of members had a screening using the Braden Scale for Predicting Pressure Ulcer Risk. Between 24 and 46 percent of members were found to be at risk for pressure ulcer development. Such focused clinical studies allow the clinical management of ICS members to develop assessment, monitoring, and intervention approaches.

### *Consumer Satisfaction*

ICS has conducted a number of consumer satisfaction surveys, including surveys on general satisfaction with services provided, satisfaction with the various home care agencies that provide services, and satisfaction with transportation companies. Overall, satisfaction appears to be high. For example, Table D-1 provides mean satisfaction ratings for various items on a 1 to 100 scale.[9]

[9] 1 to 5 likert-scale responses were converted to a 1 to 100 scale where 1=0, 2=25, 3=50, 4=75, and 5=100. In general, any mean score above 75 indicates very high satisfaction.

**Table D-1: ICS Member Satisfaction Rating**

| *Item* | *Mean Score (1 to 100)* |
|---|---|
| Overall Member Satisfaction | 75.8 |
| Plan of care meets your needs | 77.6 |
| You/family involved in determining your needs | 73.8 |
| ICS managers effectively collaborate with you | 71.7 |
| ICS is able to help get what you most value | 74.7 |
| ICS supports you to do for yourself | 76.7 |
| ICS staff is helpful | 78.7 |
| ICS staff is respectful | 82.8 |
| ICS staff communicates changes in service | 75.3 |
| ICS staff responds to concerns in a timely manner | 69.1 |
| Would recommend ICS to others | 80.0 |

Member satisfaction with both the home care agencies and transportation agencies are also very high.

*Outcomes*

In addition to the quality clinical management and consumer satisfaction outcomes presented above, ICS monitors its overall performance through a balanced scorecard approach. With the balanced scorecard, ICS tracks performance in the following domains: financial performance; stakeholder satisfaction; internal processes; and development/innovation. See the Supplemental Documents Binder for the full balanced scorecard.

**Can the Program be Replicated?**

ICS's model was based on a philosophical foundation of what people with disabilities need. It did not evolve out of a state interest in appropriately managing the care of Medicaid members with physical disabilities. Therefore, while it is entirely possible to replicate this model in another location, it requires the development of a nonprofit organization. Unique to ICS was its development out of Cooperative Home Care Associates. Development of such a nonprofit from a state structure is unlikely.

However, replication of select pieces of this model is entirely possible. For example, the care management structure developed by ICS could easily be replicated in another program for serving people with physical disabilities. Further, the model does not appear to be specific to people with physical disabilities. It could most likely be modified slightly to successfully manage the care of people with a wide range of disabilities.

Finally, any replication of this model would be strengthened by appropriate rate setting utilizing risk adjustment procedures. ICS is currently attempting to develop new rates utilizing risk adjustment procedures which combine the Chronic Illness Disability Payment System, developed by Rick Kronick and his colleagues at the University of California, San Diego, for Medicaid beneficiaries with disabilities, and key functional status indicators. Such a system would make this model more financially viable. Without risk adjustment, few organizations would likely be willing to take on the risk associated with this population without significant private investment or a strong dedication to serving the population.

## Appendix D.3: Minnesota Disability Health Options Program Overview

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Information utilized in review of the program:

- Telephone interview with Deb Maruska and Chris Duff
- Award application submitted by MnDHO
- Presentation by Deb Maruska: "Integrated Medicare and Medicaid Chronic Care Populations in Minnesota", October 2003.*
- MnDHO Project Summary, July 2002.
- "Lessons Learned from the Start-up of UCare Complete: A Managed Care Program for Adults with Disabilities: Final Report to the Minnesota Department of Human Services." By Carol Tobias, Health and Disability Working Group, Boston University School of Public Health, November 25, 2002.
- MnDHO Operational Protocol, September 2001.*
- CHCS Resource Paper: "Designing a Program Evaluation for a Multi-Organizational Intervention: The Minnesota Disability Health Options Program." January, 2004.*
- CHCS Resource Paper: "Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities."*
- Various website materials: http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_006272.hcsp

**Provided in Supplemental Documents Binder*

### Program Structure

*Planning*

The Minnesota Medicaid program has attempted to create managed care programs for people with disabilities several times. First, in the mid-1980s, the Minnesota Department of Human Services developed a mandatory managed care plan for people with disabilities in several counties as part of the state's larger Prepaid Medical Assistance Program (PMAP), which also enrolls Medicaid-eligible children, working-age adults, and adults over age 65. The state contracted with Blue Cross/Blue Shield of Minnesota to provide the managed care product to the population. However, Blue Cross/Blue Shield of Minnesota found it difficult to continue to offer the program due to complexities in

serving the population and payment rates were inadequate to compensate the health plan. Blue Cross/Blue Shield dropped the contract for people with disabilities after the first year of the program. Those beneficiaries who were enrolled in the program were returned to a fee-for-service structure.

In the mid-1990s, following the successful implementation of the Minnesota Senior Health Options (MSHO) program, which integrated Medicaid and Medicare funding for adults over age 65, the Minnesota Department of Human Services created the Demonstration Project for People with Disabilities (DPPD), which was also to be a mandatory program for people with disabilities. State legislation provided for counties to be the contractor and take on the risk of a pre-paid Medicaid program for this population. Ultimately, the program was not implemented because counties were unable to commit to the risk of serving this population within the payment parameters set forth in the legislation, and there was also difficulty in setting up the program within the structure of county government because of a lack of infrastructure to operate a managed care program. Additionally, children with disabilities were included in the DPPD model, and advocates were resistant to the inclusion of children with disabilities in a mandatory managed care model.

As a result of the two previous attempts at creating managed care programs for the population, and in recognition of the unmet needs of the population of adults with disabilities, the Sister Kennedy Institute (an inpatient rehabilitation hospital) and the Courage Center (a community-based rehabilitation center) worked to create a new nonprofit organization, AXIS Healthcare (a care management and utilization review organization), and, in collaboration with UCare Minnesota, proposed to the state a voluntary, prepaid managed care program for people with physical disabilities served by Medicaid that would integrate Medicare and Medicaid funding. UCare Minnesota, already a PMAP contractor, was the only HMO that ultimately was interested in participating in such a program. UCare Minnesota is a health plan that specializes in serving the Medicaid and Medicare populations, so they viewed the potential program as a good fit within their existing structure.

AXIS Healthcare was a critical player during the planning and development of the program. AXIS received a grant from the CHCS to design a pilot project to deliver case management. AXIS had nine months to work on developing the model, during which time they built trust with consumers, the state, and other providers for the model. AXIS began the pilot project in 1997. Consumers were involved on a regular basis from the beginning in order to seek input on current challenges within the system and program design options.

There were several key issues that emerged during the planning for MnDHO:

- Obtaining buy-in from potential enrollees, providers, and advocates, and overcoming internal politics at the state Medicaid agency was critical. Strong support was gained from these groups by making the program voluntary.

- Medicare Payment Demonstration Waiver, which allowed the state to receive risk adjustment from Medicare and contract with the state, was difficult to obtain.
- UCare Minnesota had to overcome the challenges of taking on a small number of enrollees, which meant that the risk for a capitated program was spread among fewer members.
- AXIS needed to spend significant private resources to develop the model; AXIS was operating for several years without any members enrolled.

*Implementation*

UCare Minnesota began providing services for the MnDHO program, under the product called UCare Complete, in September 2001. The following steps were required during implementation:

- The Centers for Medicare and Medicaid Services approved the program under the MSHO program authorization (Medicaid 1915(a) and 1915(c) waivers and Medicare Section 402 authority) in May 2001.
- The program received State legislative approval in May 2000.
- A readiness review by a consultant was completed in June 2001.
- The Minnesota Department of Human Services began informational mailings and enrolling individuals in MnDHO in July 2001.

By March 2002 there were just over 50 individuals enrolled in the program. By September 2002, one year after UCare began providing services under the program, there were over 100 individuals enrolled. As of December 2003, there were 259 individuals enrolled in the program. Most recently, as of August 1, 2004, there were 338 individuals enrolled in the program.

The key issue that had to be addressed before and during implementation was trust among all partners. According to program staff from the Minnesota Department of Human Services and AXIS Healthcare, the trust-building process was slow and occurred over a long period of time. Other barriers during implementation included:

- The development of rates because of a small number of people and the potential for adverse selection;
- Establishing a comprehensive provider network (community clinics with disability experience were the easiest to involve); and
- Existing organizations that provide waiver services had to learn a new billing process; they were used to billing the counties for services provided.

*Eligibility*

The target population for MnDHO is adults with physical disabilities who are eligible for Medicaid, including individuals who are also eligible for Medicare. As of August 1, 2004, 45 percent of enrollees were Medicaid-only, while 55 percent were dually eligible for Medicaid and Medicare. The program is voluntary and individuals are eligible to enroll in the program if they meeting the following criteria:

- Medicaid-eligible under standard eligibility rules or dually eligible for Medicaid and Medicare;

- Certified disabled or blind through the Social Security Administration of State Medical Review Team (SMRT: Minnesota Disability Certification Process);
- Diagnosis of a physical disability;
- Aged 18 through 64;
- Reside in Hennepin, Ramsey, Anoke, or Dakota counties; and
- If qualified for Medicaid with a medical spenddown, required to prepay their monthly spenddown obligation to the state.

Additionally, Community Alternatives for Disabled Individuals (CADI) waiver participants who do not have a physical disability are not eligible to enroll. Individuals receiving services under the Community Alternative Care (CAC), Mental Retardation and Related Conditions (MR/RC), or Elderly Waiver (EW) programs cannot continue receiving those services if they enroll in the program.

Individuals who reside in a nursing home are eligible to enroll in the program. According to program staff, about 20 to 25 percent of individuals are in a nursing home when they choose to enroll in the program. After enrolling in the program, the average time to discharge back into the community is approximately 3.5 months. Approximately 10 percent of enrollees at any point in time are in a nursing home.

*Funding*

Funding for the program is provided through the Minnesota Medicaid program (Medical Assistance) and Medicare. UCare Minnesota receives separate capitation payments from Medicaid and Medicare.

- Medicare Part A and B Rates: For MnDHO enrollees eligible for both Medicare Parts A and B in the year 2003, payments to UCare were based on 100 percent of the traditional demographic ratebook except that an adjuster factor of 2.39 was applied to the base rates for community-based dually-eligible beneficiaries determined to be Nursing Home Certifiable by State criteria. Beginning in January 2004, a portion of the Medicare capitation is determined using the risk-adjusted model required under section 1853 of the Social Security Act. During calendar year 2004, Medicare payments equal the sum of 90 percent of the traditional demographic ratebook and 10 percent of the new risk-adjusted ratebook including the CMS community frailty adjuster which will be applied by CMS.
- Medicaid Rates: Rates are based on the Medicaid fee-for-service experience of eligible people with physical disabilities. Historical rates were originally trended to September 2001 using the Minnesota Department of Human Services' Medicaid program increases. The base rates are then grouped into twenty-one "experience" rate cell categories, based on residence, Medicare coverage, nursing facility residents, conversions (previously served in a nursing home), nursing home certifiable, community/not nursing home certifiable. The State issues a single monthly payment to UCare Minnesota under which all necessary services must be provided to all enrolled members. Medicaid payments range from $189 to $26,887 per member per month depending on the individual's risk classification.

For more information on the payment and financial structure, see the document "Minnesota Disability Health Options: Operational Protocol," [10] which is provided in Supplemental Documents Binder. See section *Services Offered* for the list of services included in the capitation rates and other services available to enrollees under a fee-for-service structure. The program was designed to be budget neutral, and according to state staff was budget neutral from the very inception of the program.

*Contracting*

The Minnesota Department of Human Services, through its Health Care Administration office, manages the day-to-day state oversight of the MnDHO program. All programmatic and service delivery activities are the responsibility of UCare Minnesota. UCare Minnesota, in turn, subcontracts with AXIS Healthcare to provide service authorization and care coordination services to all MnDHO members.

UCare Minnesota was selected as the sole contractor for MnDHO following a Request for Proposals. UCare Minnesota was the only entity that responded to the RFP. AXIS Healthcare was selected as the subcontractor because of their established pilot project serving this population, and because of their experience in serving people with disabilities through the two parent entities: the Sister Kennedy Institute and the Courage Center.

**Service Delivery Components**

*Delivery System*

All services under the MnDHO program are provided through UCare Minnesota's network of providers. AXIS Healthcare provides the service authorization and coordination of care for MnDHO members.

*Services Offered*

Table D-2 shows the services offered under the MnDHO capitation, as well as the services offered to enrollees under the traditional fee-for-service Medicaid system. Additionally, all Medicare-covered services are provided to individuals who are dually-eligible, including inpatient and outpatient hospital, physician and clinic services, specialty care, therapies, Medicare-covered home care, and Medicare-covered skilled nursing facilities.

[10] September 2001, available online: http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/DHS_id_017523.pdf

**Table D-2: Benefits Included and Excluded from MnDHO**

| *Included in the MnDHO Benefit Package (Capitated to UCare MN)* | *Excluded from the Benefit Package (Available fee-for-service)* |
|---|---|
| Inpatient and outpatient hospital<br>Physician and clinic services<br>Medical specialty services<br>Therapies (PT, OT, ST)<br>Home and community-based waiver services<br>Home care, including PCA<br>Assistive technology<br>Dental services<br>Behavioral health services<br>Vision care<br>Medical supplies and DME<br>Special transportation<br>Some common carrier transportation and interpreter services<br>180 days of nursing facility care for new admissions<br>Alternative services authorized by the health plan<br>Care planning and care coordination | Nursing facility costs for current residents and services beyond 180 days for new admissions*<br>Pharmacy services (being added in 2005)<br>Child Welfare Targeted Case Management<br>Mental Health Case Management<br>Developmental Disability (DD) Case Management |

* Except for dually-eligible enrollees, for whom the health plan is responsible for all skilled nursing facility stays that meet the Medicare criteria.

*Case Management, Care Coordination*

Case management, referred to as care coordination in MnDHO, is a key feature of this program. As described above, all care coordination services are subcontracted to AXIS Healthcare by UCare Minnesota. All members, once they choose to enroll in MnDHO, are assigned a health coordinator, a resource coordinator, and a member services coordinator. The health coordinator is the primary person responsible for overall care coordination for the member. Table D-3 shows the primary responsibilities of each position within this care coordination model.

**Table D-3: Responsibilities for Coordination Positions in MnDHO**

| | ***Health Coordinator*** | ***Resource Coordinator*** | ***Member Services Coordinator*** |
|---|---|---|---|
| **Professional Orientation** | Nursing (RN or public health nurse) | Social work | Administrative |
| **Caseload** | Approximately 35 | Approximately 70 | Approximately 70 |
| **Responsibilities** | Conducts initial assessment and periodic re-assessments<br><br>Authorizes most health and social support services<br><br>Works with physicians and primary care clinic staff to assure that all services are received and coordinated<br><br>Attends most primary care and specialty appointments with members<br><br>Available 24 hours a day, 7 days a week as first point of triage for members. | Coordinates non-medical supports, including housing, financial assistance, and health education activities | Assists with administrative details of coordinating services<br><br>Often is a central point of contact for members |

MnDHO's care coordination model is designed to be flexible and responsive to the member's needs. Following enrollment in the program, the health coordinator meets with the member and conducts a comprehensive assessment to learn about their health conditions, family situations, current services that are being received, unmet social service and medical needs, and life goals. An individualized care plan is developed in collaboration with the member, including a mutually-agreed upon schedule of regular contacts and check-ins with the health coordinator (re-assessment must occur at least annually, although more frequently if a member's health condition changes). In an award application, MnDHO staff wrote: "As a result [of the assessment and close monitoring process], health coordinators develop a close familiarity with members' medical problems and providers that allows them to recognize patterns in members' health problems and set up services to help minimize them. When crises occur, familiarity with the individual helps them react quickly and effectively."

The care coordination process in MnDHO is needs-driven. The MnDHO Operation Protocol (September 2001) includes that the service delivery system must include "non-traditional, ancillary, and needs-driven supports." The protocol goes on to describe in detail the types of non-traditional supports that may be provided: "In order to enhance the effectiveness and efficiency of health care services and to enhance the enrollee's

self-sufficiency and control over his/her care, the health plan may provide highly-individualized informal or non-traditional supports when appropriate and coordinate supports with formal health services. An example of such an informal support might be to pay for an enrollee's home telephone if it is a more effective or efficient means of managing medications or monitoring symptoms."

There do not appear to be any specific disease management programs within MnDHO. While the program is designed for people with physical disabilities, individuals often present many different conditions, including mental health conditions, that require management. The health coordinator is responsible for managing services that will meet the individual's overall needs, which will include these other conditions. It should be noted, however, that if the individual is eligible for services under Rule 185 case management (DD case management), Rule 79 case management (mental health), or child welfare targeted case management, those services are provided on a fee-for-services basis but are still coordinated by the health coordinator to ensure appropriate linkages between MnDHO and these other services.

## Outcomes/Evaluation

### *Evaluation*

A number of groups were interested in using the MnDHO project as the focus of evaluation and research activities. To reduce the burden on members from responding to too many questionnaires and surveys, an Evaluation Consortium was developed to conduct the evaluation of MnDHO. The Evaluation Consortium includes AXIS Healthcare, Minnesota Department of Human Services, National Rehabilitation Hospital Center for Health and Disability Research, UCare Minnesota, University of Minnesota, and CMS. The evaluation plan was designed around three primary program goals: improved consumer satisfaction, increased well-being of members, and meeting cost and utilization goals. See the Supplemental Documents Binder for the full evaluation plan.

### *Consumer Satisfaction and Well-Being*

According to a longitudinal survey of enrollees conducted by the National Rehabilitation Hospital Center for Health and Disability Research:

- 89 percent reported higher overall satisfaction rates with their health care in the year after they enrolled in the MnDHO program, as compared to the year before.
- 66 percent of respondents reported higher overall satisfaction with their primary care doctors in the year after they enrolled in the program.
- 80 percent of respondents reported that someone helped them manage health care services only after they enrolled in the MnDHO program.
- Only 11 percent stated that someone had talked to them about their health needs and created a plan for treatment and services during the year prior to MnDHO enrollment.
- In terms of self-direction, 94 percent of respondents reported being involved as much as they wanted in health care decision making.

These findings, and the more complete results of the survey, demonstrate that there was a lack of care coordination services in the traditional fee-for-service Medicaid program. MnDHO appears to have improved satisfaction for those members who choose to enroll in the program.

*Cost and Utilization*

Because MnDHO is a relatively new program, information regarding cost and utilization goals is still incomplete. However, according to MnDHO staff, preliminary findings indicate that the program is meeting its cost and utilization goals. Emergency room visits, nursing home admissions, and length of hospital stays appear to be decreasing. Additionally, staff note that it is becoming clear that members are receiving "more services for the same cost that would have been spent on them under regular Medicaid." The payments for the program were structured so that payments cannot exceed more than what the projected costs were under regular Medicaid, based on historical information on service utilization.

AXIS Healthcare staff and Minnesota Department of Human Services staff also note that the program has shown success in helping people transition from nursing homes. For example, approximately 20-25 percent of members who choose to enroll are in nursing homes when they enroll. On average, these individuals are transitioned to the community within 3.5 months. As a result, only 10 percent of their membership at any point in time is in a nursing home. Financial incentives further encourage the health plan and health coordinators to help divert nursing home admissions.

**Can the Program be Replicated?**

The structure and operation of this program is such that there is no apparent reason why the program could not be replicated in another location. There are issues that would have to be considered, however, including the authority required for operating such a program, relationships of involved groups, and state structure.

First, MnDHO operates under Medicaid 1915(a) and 1915(c) federal waivers. The approval of these waivers was made under the existing authorization for the Minnesota Senior Health Options program (MSHO). Additionally, CMS allowed the Minnesota Department of Human Service to add people with disabilities enrolled in MnDHO under the state's existing Section 402 Medicare payment demonstration waiver for MSHO. Obviously Minnesota's implementation of the program was unique because of its existing waivers. In a state without an existing waiver structure, implementation would be different, although not impossible.

Second, staff from the Minnesota Department of Human Services and AXIS Healthcare repeatedly discuss the importance of relationships for this program. All involved organizations, including the state, AXIS, and UCare Minnesota, have strong relationships that have strengthened over time, which staff credit as absolutely critical for program success. At the inception of the program, these relationships were unique because AXIS had already been working with UCare Minnesota to design this model and then approached the state with their idea. This set the stage for a strong

partnership between the two non-state entities. UCare Minnesota, as an existing Medicaid managed care contractor, also already had a relationship with the Minnesota Department of Human Services.

Third, as with any state program development, the structure of the state's health and human services infrastructure is important. How existing structures (such as Minnesota's strong county government system) work together is important to determine whether there were structures in place in Minnesota that facilitated or impeded development of the MnDHO program. Further, philosophy around the development of programs for people with disabilities is important. MnDHO was established with philosophy first, especially as it relates to care coordination, self-direction, and independent living, and cost savings and efficiency second.

## Appendix D.4: Texas STAR+PLUS Program Overview

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Information utilized in review of the program:

- Telephone interview with Pamela Coleman
- Public Policy Research Institute, Texas A&M University: *Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program**
- *Renewal 1915(b) Medicaid Managed Care Waiver: STAR+PLUS Medicaid Managed Care Program.**
- *STAR+PLUS Enrollees' Satisfaction with Their Health Care*. Report by the Institute for Child Health Policy. September 2003.
- *The Impact of Care Coordination of the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Enrollees.* Report by the Institute for Child Health Policy. November 2003.
- Program website: http://www.hhsc.state.tx.us/starplus/starplus.htm

**Provided in Supplemental Documents Binder*

### Program Structure

*Planning*

The Texas STAR+PLUS program is a Texas Medicaid pilot project mandated by Senate Concurrent Resolution 55 in 1995. The Senate Concurrent Resolution 55 required the Texas Health and Human Services Commission to pilot a cost-neutral model for the integrated delivery of acute and long-term care services for aged and disabled Medicaid recipients. Following the Resolution, a team was formed and charged with looking at various models that provide acute and long-term care services for aged and disabled Medicaid recipients. The team looked at the existing programs in Wisconsin (Family Care) and Minnesota (MSHO) and ultimately decided that the program would have to be mandatory for it to work in Texas. One of the reasons for this decision was that it was not clear as to whether or not CMS would approve another program like that in Minnesota.

The planning for the program took approximately one year. The primary objective during the planning period was to get all of the players "on board" with the idea of the managed care program. A local advisory committee comprised of HMOs, providers, consumers, advocates, state staff, and other interested parties began meeting in 1997 to provide input on the preparation for and implementation of Medicaid managed care in the Houston area. The committee met monthly through the first year of implementation and now meets quarterly. Regular stakeholder meetings were held during the pre-

implementation phase of the program. These meetings created an ongoing opportunity for consumers and advocacy organizations to ask questions about and provide input on Medicaid managed care. The biggest concern regarding Medicaid managed care that was encountered was the fear of "gatekeepers", that is, having to go through a primary care physician to be allowed to see necessary specialists. Advocates for long-term care support services feared that the services clients were currently receiving would be denied or reduced. Because these were known concerns, it was important to educate the stakeholders and explain that managed care is a means to get more services with the same amount of money. Because of the committee and the stakeholder meetings, individuals in the community, as well as advocates were heavily involved in the development of the program.

Based upon discussions with community members and advocacy groups, it was decided that certain groups would be carved out of the program. These groups include members currently receiving services through a Medicaid 1915(c) waiver other than the nursing facility waiver program called the Community Based Alternative (CBA) waiver, persons with chronic mental illness, and residents in ICF/MRs. Nursing facility residents were originally included in the program, but were carved out as of September, 2000. One of the primary reasons for carving people out of the program was to ensure that the program was being tailored to the right population and that they were not trying to create a one-size-fits-all program.

*Implementation*

The Texas Health and Human Services Commission applied for and received a 1915(b) waiver and a 1915(c) waiver to implement the STAR+PLUS program. The STAR+PLUS program began mailing enrollment packets and enrolling voluntary individuals in November 1997. Services for those individuals who enrolled in the program voluntarily began in January 1998. Those clients who were not enrolled by mid-March 1998 were assigned to a health plan and a primary care physician as of April 1, 1998, the date STAR+PLUS became mandatory for eligible individuals. Within 3 months, all 60,000 members were enrolled in the program.

STAR+PLUS was able to take advantage of the fact that another mandatory Medicaid managed care program was in the process of being rolled out in the Houston area. STAR+PLUS opted to start in the Houston area so that it could utilize the same MCOs that had already agreed to take on a mandatory managed care program.

STAR+PLUS utilizes an enrollment broker to perform outreach, conduct enrollment events, and assist clients with enrollment in person and over the phone. Examples of outreach activities include informing clients about the program via publicized events; partnering with community based organizations to disseminate information about the program; and distributing brochures, flyers, and posters in the consumers' communities. Newly-eligible consumers receive enrollment kits that contain information about the program and each HMO that is affiliated with the program. The kit also provides instructions regarding enrollment and how to enroll either via phone, mail, or at an enrollment event. Staff from the enrollment broker will do home visits if necessary to

assist the consumers in understanding their options and the enrollment process. The enrollment broker contracts with community-based organizations and consumer advocacy groups to provide a critical link between the enrollment broker and the aged and disability community.

*Eligibility*

To be eligible for STAR+PLUS, an individual must be elderly, or have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid due to low income. STAR+PLUS is a mandatory program for most eligible consumers, the following provides more detail as to which groups are considered mandatory and which groups are considered voluntary under STAR+PLUS.

Mandatory participation: HMO

All SSI, SSI-related, and Medical Assistance Only (MAO) consumers who do not fall within the subsequent groups must choose an HMO. The HMO will provide acute and long-term care services for these consumers. If the individual is also on Medicare, the HMO will only provide long-term care services. Mandatory participants include:

- SSI-eligible consumers age 21 and over;
- MAO consumers who qualify for the CBA waiver; and
- Consumers who are Medicaid-eligible because they are in a Social Security exclusion program.

Mandatory participation: HMO or PCCM

Children and certain Department of Mental Health and Mental Retardation (MHMR) consumers must choose either an HMO or PCCM. However, the PCCM choice is only available to non-Medicare consumers. Mandatory participants with this choice are:

- SSI clients under age 21.

Voluntary participation: HMO

The following individuals are not required to participate in STAR+PLUS. If they do elect to participate, they must choose an HMO.

- Dually eligible clients under age 21.

Excluded from the program

Individuals that meet the following criteria are not eligible to participate in STAR+PLUS:

- STAR+PLUS HMO members who have been in a nursing facility for more than 120 days;
- individuals already residing in a nursing facility at the time they become otherwise eligible for STAR+PLUS;
- consumers of any Medicaid 1915(c) waiver besides CBA;
- residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
- consumers not eligible for full Medicaid benefits (Frail Elderly program, QMB, SLMB, QDWI, undocumented aliens);
- individuals not eligible for Medicaid; and
- children in state foster care.

STAR+PLUS does serve dually eligible consumers, in fact about half of the approximately 60,000 STAR+PLUS eligibles are dually eligible. Although the program serves dual eligibles, Medicare and Medicaid funding is not integrated for these individuals. Dually eligible consumers select an HMO through STAR+PLUS, but do not select a primary care physician. The reasoning for this is that dual eligibles receive their acute care through their Medicare providers and not through STAR+PLUS, STAR+PLUS only provides Medicaid long-term care services to dual eligibles.

*Funding*

Funding for STAR+PLUS is provided through the Texas Medicaid program. The HMOs are capitated for STAR+PLUS on a per-member per-month basis by client risk group. The first few years of the program the rates were based on historical fee-for-service expenditures. Last year, rates were based on the actual experience of the health plans. The savings for the program has been about 6.5 percent annually over traditional Medicaid, which for Harris County is almost $30 million per year. The HMOs also participate in an experience rebate process that is based on the percent of profit against the revenues. This is detailed in Table D-4.

**Table D-4: Graduated Rebate Method**

| Graduated Rebate Method | | |
|---|---|---|
| Rebate as a Percent of Revenues | HMO Share | State Share |
| 0% - 3% | 100% | 0% |
| Over 3% - 7% | 75% | 25% |
| Over 7% - 10% | 50% | 50% |
| Over 10% - 15% | 25% | 75% |
| Over 15% | 0% | 100% |

Capitated rates for Medicaid only consumers are higher than those for dually eligible consumers. This difference reflects the liability of the HMOs for acute care for the Medicaid only population. STAR+PLUS capitation rates are discounted 5 percent from projected fee-for-service acute and community care costs.

**Table D-5: Capitation Rates**

| Risk Group | Medicaid Only | # of Eligibles * | Dual Eligible | # of Eligibles |
|---|---|---|---|---|
| Community Consumers | $676.83 | 23,282 | $152.54 | 6,496 |
| CBA Waiver Consumers | $3,526.67 | 461 | $1,503.36 | 1,205 |
| Nursing Facility Consumers | $676.83 | 6 | $152.54 | 38 |

* All as of April 1, 2004

* As of 9/00 Nursing Facility consumers were removed from STAR+PLUS. Providers are responsible for the first four months a member is in a nursing home. They are reimbursed at the community rate.

Community Consumers – a blended rate, based on historical costs and projected utilization and expenditure data, for consumers who are neither institutionalized nor

enrolled in the Community Based Alternatives waiver at implementation. HMOs are liable for 120 days of nursing facility care for clients in this risk group. This rate covers clients who currently receive acute care services through Medicare as well as those who receive Medicaid long-term services at home or in a community setting. For clients receiving only acute care, the capitation functions as a long-term care insurance.
CBA waiver consumers – a rate for consumers receiving services through the Community Based Alternatives waiver.
Nursing Facility consumers – a rate for consumers who need nursing facility care. HMOs are liable for 120 days of nursing facility care. The rate payable is the same as the Community rate.
The program was designed to be budget neutral so the savings have been an added benefit.

*Contracting*

The Texas Health and Human Services Commission contracts with two for-profit HMOs to provide acute and long-term care services to Medicaid only recipients and dual eligibles in a managed care environment. The HMOs, Amerigroup and Evercare, were selected via a competitive procurement process. Amerigroup is an HMO with experience in serving Medicaid recipients. Evercare is an HMO with experience in serving both Medicaid recipients, and dual eligibles.

**Service Delivery Components**

*Delivery System*

STAR+PLUS consumers select an HMO and a primary care provider. A consumer can change health plans at any time while enrolled in STAR+PLUS. All Medicaid acute and long-term care services are obtained through the HMO and its network of providers. Consumers may access providers within the network for behavioral health and family planning without a referral.

*Services Offered*

At a minimum, the participating HMO must provide a benefit package to consumers that includes fee-for-service services currently covered under the Medicaid program. The HMO may elect to offer additional benefits within the capitation rate received from Texas Department of Humans Services (TDHS). Table D-6 provides the list of benefits included in capitated premiums.

**Table D-6: Benefits Included and Excluded from STAR+PLUS**

| Included in the STAR+PLUS Benefit Package | Excluded from the Benefit Package – However HMO is responsible for appropriate referrals to these services |
|---|---|
| Hospital - Inpatient Services - All Care<br>Hospital - All Outpatient Services<br>Professional Services<br>Professional - Lab and x-ray Services<br>Professional - Podiatric Services<br>Professional - Vision Services<br>Ambulance Services<br>Home Health Services<br>Rural Health Services<br>Hearing Aid Services<br>Chiropractic<br>Ambulatory Surgical Center Services (ASC)<br>Certified Nurse Midwife Services (CNM)<br>Birthing Center<br>Maternity Clinic Services<br>Transplant Services<br>Federally Qualified Health Centers (FQHC)<br>Adult Well Check<br>Family Planning<br>Genetics<br>EPSDT Medical Screens<br>EPSDT Comprehensive Care Program (CCP)<br>Triage Fees<br>Renal Dialysis<br>Total Parenteral Hyperalimentation (TPN)<br>Physical Therapy<br>Occupational Therapy<br>Speech/language therapy | EPSDT Dental (including Orthodontia)<br>Early Childhood Intervention (ECI)<br>MHMR Targeted Case Management<br>Mental Retardation Diagnostic Assessment (MRDA)<br>Mental Health Rehabilitation<br>Pregnant Women and Infants Case Management (PWI)<br>Texas School Health and Related Services (SHARS)<br>Texas Commission for the Blind (TCB)<br>Tuberculosis (TB) Clinic Services<br>Vendor Drugs |

**Table D-7: Behavioral Health Benefits**

| Basic Behavioral Health Benefits for Members under age 21 | Basic Behavioral Health Benefits for Members age 21 and over |
|---|---|
| Early Screening, Diagnosis and Treatment of Behavioral Disorders<br>Psychiatric Hospital / Facility (freestanding)*<br>Hospital -Inpatient Services - Mental Health and Chemical Dependency Treatment<br>Licensed Master Social Workers- Advanced Clinical Practitioners (LMSW - ACPs")<br>Licensed Professional Counselors ("LPCs")<br>Psychology<br>Psychiatry<br>Chemical Dependency Treatment | Screening for Behavioral health disorders<br>Chemical Dependency Treatment*<br>Psychiatry** |

** NOTE: Treatment in a freestanding psychiatric facility for members age 21 to 65 is not a benefit of the Medicaid program but may be proposed as a value-added activity. Inclusion of this service will not increase the capitated payment to the HMO nor will other payment be made for this service.
** NOTE: outpatient mental health visits for members age 21 and over are limited to 30 visits per calendar year unless more visits are deemed medically necessary and prior authorized by the HMO.

In addition to the services listed in Table D-6 above, the following are additional STAR+PLUS covered services for those consumers on the CBA waiver. These services are to be provided when they are determined to be medically necessary.

**Table D-8: Benefits Covered for Consumers on CBA Waiver**

| Covered Services for Consumers on the CBA waiver |
|---|
| Adaptive Aids |
| Adult Foster Homes Services |
| Assisted Living/Residential Care Services |
| Emergency Response Services |
| Medical Supplies |
| Minor Home Modifications |
| Nursing Services |
| Occupational Therapy |
| Personal Assistance Services |
| Physical Therapy |
| Respite Care |
| Speech Language Therapy Services |

In addition to the covered services listed above in Table D-6, the following services shall be provided to STAR+PLUS members when necessary.

**Table D-9: Covered Services When Necessary**

| Covered Services for STAR+PLUS Members When Necessary |
|---|
| Day Activity and Health Services |
| In Home Respiratory Care Services |
| Nursing Facility Care |
| Personal Assistance Services |

Detailed descriptions of the aforementioned services can be obtained from the Texas Health and Human Services Commission's website.[11]

*Case Management, Care Coordination*

Care coordination is a specialized care management service designed to ensure that all members receive necessary care and that both in-network and out-of-network care is integrated as much as possible. The care coordinator must be either an RN or an LSW. The care coordinators must be available to the consumer when needed. The contract between the state and the HMO defines the responsibilities of the care coordinators but does not define the model to be used. There is no set ratio of consumers to care managers. Of the two HMOs currently providing services, one uses telephonic care coordination and the other provides care coordination through home visits.

[11] Services included under HMO capitation payment, behavioral health services, and services not covered can be found at: http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxc.htm
Covered services for CBA consumers can be found at:
http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxll.htm
Covered services for STAR+PLUS members when determined necessary can be found at:
http://www.hhsc.state.tx.us/starplus/star_plus_101/appdxpp.htm

As defined by the Texas STAR+PLUS program, care coordination includes:

- identifying physical health, mental health, and long term support needs;
- developing a care plan to address the unique needs of each member;
- ensuring timely access to providers and services; and
- coordination of all plan services with social and other services delivered outside the plan, as necessary and appropriate.

The care coordinator is also responsible for monitoring the members in care coordination, periodically reviewing the member's needs and care plan, and reassessing members when their needs change. The process of care coordination begins at the time of enrollment. The HMO provides a care coordinator to each member who requests one, who is receiving long-term care services at the time of enrollment, or whose HMO assessment indicates complex health or support needs. The care coordinator works with the member, the member's family, and the member's primary care physician and other service providers to develop a seamless plan of care that addresses primary, acute, and long-term care service needs. If the member is eligible for Medicare, the care coordinator becomes familiar and communicates with the member's Medicare providers and services in order to integrate the care received through the two programs. Care coordinators have the authority to authorize and refer members for all long-term care services and some acute care services. In addition to working with the member, the family, and all Medicaid and Medicare providers, the care coordinator also works with community organizations such as government agencies, social service agencies, and civic and religious organizations that provide needed non-Medicaid services.

**Outcomes/Evaluation**

*Evaluation*

An independent assessment was conducted by the Public Policy Research Institute (PPRI) of Texas A&M University that looked at access, quality, and cost-effectiveness of the STAR+PLUS program. There are two additional studies completed on the program, the first is an overall satisfaction study, and the second is on the impact of care coordination on the provision of services. In all three studies, the overall assessments found that STAR+PLUS is generally ensuring members have access to care and an adequate level of quality in the services provided to its members. Based upon the data provided to PPRI by TDHS, the implementation of STAR+PLUS in Harris County indicated a savings of approximately $123 million to the State during the waiver period (February 2000 – January 2002). However, according to the state this figure was found to be in error and is actually approximately half this amount.

*Access*

According to the assessment conducted by PPRI:

- Close to 80 percent of STAR+PLUS respondents indicated they always or usually get care quickly.

- 58 percent of STAR+PLUS respondents indicated that getting the care they need is not a problem, while thirty-three percent indicated it is only a small problem.
- Over 93 percent of dual eligibles indicated that they find it easy to get a care coordinator to help them.
- About two-thirds of Medicaid-only consumers indicated they find it easy to get a care coordinator to help them.

Further, according to the study on satisfaction completed by the Institute for Child Health Policy:

- 90 percent of enrollees have a usual source of care; 80 percent of those also have a personal doctor or nurse;
- 48 percent of respondents used their usual source of care at least once in the previous six months, with almost 25 percent seeing their care provider between 1 and 4 times in that period; and
- 88 percent of those who needed to see a specialist in the six months preceding the study actually saw the specialist.
-

*Quality*

According to the assessment conducted by PPRI:

- Over 60 percent of STAR+PLUS respondents reported that physicians and other health care providers “always” communicate well with them.
- Over 60 percent of STAR+PLUS respondents rated their personal doctor as a nine or ten on a zero to ten likert scale where ten is best possible and zero is worst possible.
- A majority of STAR+PLUS respondents rated their health plan highly with an average score of 7.9 on a ten-point likert scale.
- Most STAR+PLUS respondents rated their overall health care very highly with an average rating of 8.3 on a ten-point likert scale.
- Almost 80 percent of dual eligibles and 60 percent of Medicaid-only members say they are involved in decision making about their care.

According to a study on the impact of care coordination on the provision of health care completed by the Institute for Child Health Policy, which focused on individuals receiving Day Activity and Health Services or Personal Assistance Services:

- Care coordination for STAR+PLUS enrollees has reduced inpatient stays and emergency department use as compared to a control group of individuals enrolled in the standard STAR managed care program; and
- Total health care expenditures for STAR+PLUS enrollees were less than expenditures for the control group enrolled in the STAR managed care program.

*Cost Effectiveness*

According to data provide to PPRI by TDHS, the implementation of the STAR+PLUS program indicated a savings of approximately $123 million to the State during the

waiver period. Again, according to the state this number is not completely accurate, and the savings were approximately half of this level. The estimated results are savings for the State that produced nearly a seventeen percent reduction in State expenditures had the waiver not been in effect in Harris County.

**Can the Program be Replicated?**

For this program to be replicated elsewhere, there are some elements that need to be in place, such as the necessary authority to implement and operate the program, buy-in from the stakeholders, and oversight provisions.

The Texas STAR+PLUS program was mandated by the Texas Senate Concurrent Resolution 55 operates under Medicaid 1915(b) and 1915(c) federal waivers. It was necessary for the planning team to work with community members, advocates, and other stakeholders to alleviate the fears of managed care and to obtain the buy-in from the community for the program. The planning team needed to show the community members, advocates, and other stakeholders that managed care is a means to obtain more services for the same amount of money and that they would not have to be concerned with “gate keepers” preventing them from obtaining needed services.

In addition to the authorities and buy-in, the State must be able to draft explicit contracts between the State and the HMOs to ensure that the services are provided to the consumers and that there are provisions in place to provide those services. The State must also be in a position to oversee the contracts to ensure that the contract requirements are being met.

Finally, it should be noted that Texas is currently planning to expand the STAR+PLUS program to additional urban areas of the state in September, 2005.

## Appendix D.5: Vermont Medical Home Project Program Overview

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Information utilized in review of the program:

- Telephone interview with Liz Reardon
- Internal project documents provided by the program
- Center for Health Care Strategies Website: http://www.chcs.org/grants_info3963/grants_info_show.htm?doc_id=206517
- *Understanding MassHealth Members with Disabilities*, Report of the Massachusetts Medicaid Policy Institute

### Program Structure

*Planning*

The origin of the project was an analysis of claims data that showed that approximately twenty percent of mental health consumers were diabetic, and over half of the remaining eighty percent were at risk for diabetes, primarily because of weight gain associated with the newer atypical antipsychotics. The program received a one-year planning grant from the Center for Health Care Strategies to develop the model and implementation plan. In April, 2002 a 1 ½ day planning session was held that brought consumers, recovery experts, diabetes educators, and clinicians together to pool the wisdom and experience of the participants and to solicit suggestions and guidelines for the program. Consumers were actively involved with the planning of the program.

*Implementation*

It was not necessary to convince people that this type of program was needed. Consumers are worried about their physical conditions, as well as their mental health. The grant has funded the co-location of Care Partners within three community mental health sites within Vermont. In one location the Care Partner is a nurse practitioner, in the other two sites, the Care Partners are registered nurses. It is hoped that this program will become a part of the medical care system.

*Eligibility*

The target population for this project is consumers with diabetes and serious and persistent mental illness. The program serves individuals aged eighteen and over who receive services at one of the three community mental health centers that are serving as pilot sites for the grant. One-third of the consumers enrolled in the program are Medicaid consumers and one-third of the consumers are dually-eligible. The program is voluntary and there are currently 250 consumers enrolled. A majority of the consumers are women between the ages of 30-45.

*Funding*

This is a grant funded project made possible through a grant from the Centers for Health Care Strategies and the Robert Wood Johnson Foundation. It is a two-year grant that was awarded in January 2003. The Vermont Medicaid program is currently making changes to its State Plan to make nutrition counseling billable for individuals at risk for diabetes. This funding source will assist in keeping the Care Partner program sustainable in the future. The potential for sustainability for the case management would be through a fee-for-service model. There is a fear that it could get swallowed if it is included in capitated mental health payments.

*Contracting*

The Office of Vermont Health Access works with providers at three Community Mental Health Centers to operate the program.

**Service Delivery Components**

*Delivery System*

Services are provided by the Care Partners through the community mental health centers.

*Services Offered*

The aim of the project is to provide effective medical and psychosocial interventions/supports by integrating diabetes prevention/management components in consumer-driven recovery programs, offering tailored diabetes education programs, and connecting with consumer's primary care physician to screen for diabetes.

*Case Management, Care Coordination*

The objective of this program is to develop care coordination programs for patients with chronic illnesses and patients with mental health disabilities. The Nurse Care Partners (the name given to the care managers) have integrated their activities with the Mental Health case managers at the local Community Mental Health Centers. The Care Partners provide consultation at treatment meetings, provide in-service training on medical issues, and act as liaisons with primary care practices. The Care Partners organize services for the consumers including exercise groups, diet and nutrition education, and group activities.

**Outcomes/Evaluation**

*Evaluation*

Since this a new program, at the current time no official evaluation has been conducted. The following are the goals of the program:

- Improve access to a usual source of care and appropriate specialty care;
- Increase the use of effective preventive care services;
- Prevent unnecessary hospitalizations and institutionalizations; and
- Increase consumer self-management and wellness.

HEDIS measures may be used to evaluate the program.

**Can the Program be Replicated?**
According to grant staff, this program can be replicated elsewhere. Although this model is for consumers who have serious persistent mental illness and diabetes, the care management that is provided to address the diabetes is something that can be transferred to other populations. The programs that are conducted at the community mental health centers, such as the nutrition program and the mall walkers program, are programs that could easily be run out of other community locations like the Aging Services Access Points and the Independent Living Centers.

## Appendix D.6: Wisconsin Family Care Program Overview

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Information utilized in review of the program:

- Telephone interview with Monica Deignan
- "Request for Proposals: To Contract as a Care Management Organization in the Current Family Care Service Areas": RFP #0442-DDES-SM RPA#FHD0029, April 2004. Wisconsin Department of Health and Family Services.*
- "Family Care Independent Assessment: An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2002." APS Healthcare, Inc.*
- "Wisconsin Department of Health and Family Services: Family Care Capitation Rates, CY 2004." Milliman USA, December 12, 2003.*
- "Wisconsin Family Care Implementation Process Evaluation Report." Prepared for the Wisconsin Legislative Audit Bureau by The Lewin Group, November 1, 2000.
- "Wisconsin Family Care Final Evaluation Report." Prepared for the Wisconsin Legislative Audit Bureau by The Lewin Group, June 30, 2003.*
- "Overview of Family Care Resource Allocation Decision Method."*
- Program website: http://www.dhfs.state.wi.us/LTCare/Generalinfo/CMOs.htm

**Provided in Supplemental Documents Binder*

### Program Structure

*Planning*

Planning for the Wisconsin Family Care program began in 1995. While consumers identified many problems with the long-term care system in Wisconsin during the planning process, some of the original problems that Wisconsin was trying to address were the fragmented process of accessing services and a lack of a single-entry point for services. Additionally, consumers identified that there was a fragmented service delivery system for people who are also eligible for Medicare. The first program that was created by Wisconsin was to address the latter issue. A pilot was established for the Wisconsin Partnership Program, which is fully integrated with Medicare to provide access to a full range of benefits for people who are dually-eligible.

Following the pilot of the Wisconsin Partnership Program, a proposal was developed to include acute and primary care with long-term care supports in a managed-care arrangement. This was a broad proposal for long-term care redesign. This plan was met with opposition because of the generalized fear of managed care, especially within the developmental disabilities community. Others also opposed the plan because of the integration of acute/primary care with long-term support services. As additional input was sought from consumers and advocates, the plan was modified to only include a set

of long-term care supports and to ensure that the managed care concept was appropriate for the population.

A packet of legislation was passed in the 1999-2001 biennial budget which created local long-term care councils to advise the state, and to create two organizational concepts: Care Management Organizations (CMOs) and Aging and Disability Resource Centers (RCs). These two organizational components were developed separately, but considered together comprise the Family Care program.

The Care Management Organizations were designed to administer the long-term care benefits that are provided in the Family Care program. Wisconsin received a time-limited sole-source agreement with CMS to use counties as the contractors for the CMOs.

The Aging and Disability Resource Centers were designed to be the single-entry point for accessing Family Care and other long-term supportive services. Wisconsin contracted with counties to operate the RCs. RCs also exist in some counties which do not operate the Family Care program and do not have CMOs. In this case, the RCs serve as a single-entry point for accessing the traditional long-term care service system and information and referral.

*Implementation*

The first step in the broad redesign of the long-term care system in Wisconsin was the selection of eight counties and one tribe to pilot the Aging and Disability Resource Center in September, 1997 (the tribe withdrew as a pilot in 1999). The biennial budget in 1997 authorized the establishment of these RC pilots. While the RC pilots began operation in January, 1998, Governor Thompson proposed the Family Care program in his State of the State address the same month.

In May, 1998, the Wisconsin Department of Health and Family Services issued a request for consideration to counties and tribes to become CMOs. Eighteen counties or county consortiums applied. In October, 1998, four counties were chosen as CMO pilots, while four additional counties were selected as alternate sites. Legislatively, the Family Care program was then established through the biennial budget act in October, 1999.

Operations began at the CMOs between February, 2000 and January, 2001. By January 2001 CMOs were operational in Fond du Lac, La Crosse, Portage, Milwaukee, and Richland counties.

Family Care originally operated under existing Medicaid home- and community-based waivers. Wisconsin received approval from CMS in June, 2001 for new waivers for Family Care. As a result in January, 2002, Family Care began operating under new 1915(b) and (c) waivers.

Although county governments in Wisconsin have responsibility for providing a wide array of health and human service programs, and also have significant strengths in operating values-based long-term care services, they do not have experience in operating managed care programs. As a result, there were many lessons that were learned during the implementation of the Family Care program.

First, counties had difficulty quickly hiring staff to prepare to launch the program. Because some counties were experiencing significant budget difficulties, there were some staff hiring freezes that also affected the CMOs. Because hiring was centralized at the county-level, hiring freezes at the county slowed down the process of hiring staff quickly as enrollment in the CMOs increased.

Second, there was significant need for improved infrastructure for the counties that were operating CMOs. Infrastructure needs included new accounting systems for a capitated system (including transitioning the finances for the CMOs to an enterprise account), improved information systems that could accommodate the standard assessment tool results and transmit those results to the state, and development of claims systems.

It should be noted that while counties were initially selected to operate the CMOs, Wisconsin has recently released an RFP for the current CMO counties which is open to all qualified contractors. Wisconsin will then select the most qualified and competent providers to operate Family Care, possibly including organizations other than county governments.

*Eligibility*

Because RCs serve as a single-entry point for long-term care services, all individuals can access those information and referral activities. The RCs will determine whether individuals are eligible for the Family Care program if they meet the following criteria:

- Over age 65 (over age 60 in Milwaukee), or an adult with a physical disability or a developmental disability.
- Meets the comprehensive functional level or the intermediate functional level (see Table D-10).
- Meets Medical Assistance (MA – Medicaid) financial criteria.

**Table D-10: Functional Eligibility Criteria for Wisconsin Family Care**

| Comprehensive Functional Level | Intermediate Functional Level |
|---|---|
| Unable to safely perform any of the following:<br>• 3 or more activities of daily living (ADLs)<br>• 2 or more ADLs and 1 or more instrumental activities of daily living (IADLs)<br>• 5 or more IADLs<br>• One ore more ADLs and 3 or more IADLs and has a cognitive impairment<br>• 4 or more IADLs and has a cognitive impairment | Unable to safely perform any of the following:<br>• One or more ADL(s)<br>• One ore more of the following critical IADLs:<br>o Management of medications and treatment<br>o Meal preparation and nutrition<br>o Money management<br>And at least one of the following applies:<br>• In need of Adult Protective Services<br>• Qualify for Medical Assistance<br>• Grandfathered from an existing LTC program |

Source: The Lewin Group, "Wisconsin Family Care Final Evaluation Report." June 30, 2003.

Additionally, when the CMOs were created, an eligibility category was created for people who are not Medicaid-eligible (non-MA). For people who were non-MA, they were eligible for Family Care if their service plan costs exceeded their gross monthly income plus 1/12$^{th}$ of countable assets. Cost-shares and deductibles were required for these individuals. Services for these individuals were financed through state allocations and were not matched by the federal government. As a result of budget shortfalls in Wisconsin, a freeze on enrollment of those not eligible for Medicaid (with some exceptions) was placed on enrollment for non-MA individuals at the end of 2001. The freeze was lifted in August of 2002, but was reinstituted in mid-2003. The freeze remains in effect and program staff indicate that this freeze will probably remain in place for the foreseeable future.

Because both the RCs, which establish eligibility for the program, and the CMOs, which operate the program, CMS required that Wisconsin establish independent "Enrollment Consultants" at each RC to provide counseling and information to all individuals who may be eligible for Family Care. These enrollment consultants ensure that individuals have the fullest amount of information regarding their options and the programs available to them.

*Funding*

In the Family Care program, Wisconsin contracts with county governments to operate the CMOs. The methodology used to set the capitation rates for Family Care is complex. This section provides a summary of the capitation methodology; for more complete detail on the methods used, see the document "Family Care Capitation Rates, CY 2004", which was produced by Milliman USA for the Wisconsin Department of Health and Family Services and is provided in Supplemental Documents Binder.

For Calendar Year 2004 prospective capitation rates, the methodology for setting the rates included the use of two primary factors: original CY 2001 capitation rates trended forward (25 percent weight), and functional status of Family Care's October 2003 enrollees (75 percent weight). The functional status of enrollees is determined utilizing the following factors:

- SNF level of care for the elderly;
- Type of developmental disability for the disabled, if any;
- ADLs and their level of help;
- Number of IADLs;
- Interaction terms among various ADLs;
- Behavioral indicators; and
- Medication management.

Additionally, because counties have different service fees and other cost differences, the county of service also is included in the equation to develop the capitation rates. The functional data were collected from the Long-Term Care Functional Screen, which is used by the CMOs. This data is provided to the state on a regular basis through electronic means.

The 2004 capitation rates (per member per month) are provided in Table D-11.

**Table D-11: 2004 Family Care Rates**

| County | Final 2004 Composite Net Rates |
|---|---|
| Fond du Lac | $1,881.07 |
| La Crosse | $1,764.17 |
| Milwaukee | $1,810.61 |
| Portage | $2,255.32 |
| Richland | $1,970.98 |

*Contracting*

The Wisconsin Department of Health and Family Services currently contracts with counties to operate the CMOs and RCs. Originally, Wisconsin had a sole-source agreement with CMS to only contract with counties to operate Family Care. Wisconsin recently released a Request for Proposals to continue to operate the CMOs in the current Family Care counties. In the current RFP, additional entities are allowed to submit proposals to operate the CMOs. The RFP indicates that the proposal can come from one of the following:

- A Wisconsin county or counties;
- A Family Care District, as defined in s. 46.2895, Wis. Stats.; or
- Another entity – proposals from another entity must be either:
  - In partnership with a county of Family Care District; or
  - Independent of, but with a memorandum of understanding with, a county or Family care District.

For more information, see the current RFP "Request for Proposals: To Contract as a Care Management Organization in the Current Family Care Service Areas," April 2004 (RFP #0442-DDES-SM), which is provided in Supplemental Documents Binder.

## Service Delivery Components

*Delivery System*

The CMOs are responsible for providing long-term care services to their members. Interdisciplinary teams individually plan and authorize delivery of services for each Family Care member. CMOs are required to have a substantial provider network in order to meet the needs of each member. The CMO must have formal contractual arrangements with providers to provide each of the included services in the Family Care benefit (see the below section for services included).

*Services Offered*

The Family Care benefit includes some services from the standard Medicaid state plan, Community Options Program (COP) services, and Home and Community-Based Waiver services. The benefit package includes the following services:

- Adaptive aids (general and vehicle)
- Adult day care
- Alcohol and other drug abuse day treatment services (all settings)

- Alcohol and other drug abuse services, except those provided by a physician or on an inpatient basis
- Communication aids/interpreter services
- Community support program
- Counseling and therapeutic resources
- Daily living skills training
- Day services/treatment
- Durable medical equipment (except for hearing aids and prosthetics)
- Home health
- Home modifications
- Meals: home delivered and congregate
- Medical supplies
- Mental health day treatment services (in all settings)
- Mental health services, except those provided by a physician or an inpatient setting
- Nursing facility stays (including ICF/MR and Institution for Mental Disease)
- Nursing services
- Occupational, physical, and speech therapies
- Personal care
- Personal emergency response services
- Prevocational services
- Protective payment/guardianship services
- Residential services: residential care apartment complex, community based residential facilities, adult family home
- Respite care
- Specialized medical supplies
- Supported employment
- Supportive home care
- Transportation select Medicaid covered and non-Medicaid covered

Other Medicaid-covered services, for individuals eligible for Medicaid, are available on a fee-for-service basis. For more information on the benefits available, and the Medicaid benefits not included in the package, see http://www.dhfs.state.wi.us/LTCare/Generalinfo/Benpackage.htm

*Case Management, Care Coordination, and Disease Management*

The case management process in Wisconsin Family Care is based on an interdisciplinary team approach. The team consists, at a minimum, of a social worker and a registered nurse. Additional professionals are included in the team on an as-needed basis. All individuals enrolled in Family Care receive care coordination services.

The interdisciplinary team engages in the following activities:

- Initial assessment of needs, preferences, and values.

- Use of Resource Allocation Decision (RAD) method, which was developed by the state, to identify the member's desired outcomes and the services that will achieve those outcomes in a cost-effective manner.
- Arrangement for and authorization of delivery of services.
- Monitoring the delivery of services and supports.
- Reassessment of the member on an ongoing basis

More detail about the RAD method is provided in the document "Overview of Family Care Resource Allocation Decision Method" by the Wisconsin Department of Health and Family Services.

**Outcomes/Evaluation**

*Evaluation*

There have been two primary evaluations of the Wisconsin Family Care program. First, the Lewin Group conducted an independent assessment of the program at the request of the Wisconsin legislature. Second, APS Healthcare conducted an independent assessment of access, quality, and cost effectiveness for 2002 to meet the requirements of the CMS 1915(b) waiver. State staff indicated that they believed the APS Healthcare assessment was a more accurate reflection of the program, as it was conducted further into the implementation of the Family Care Program. The Lewin Group analysis, according to the state, was conducted too early in the implementation process to provide information useful in assessing program outcomes. This section of the report considers both assessments.

*Quality*

The APS Healthcare assessment found the following positive aspects of quality in the Family Care program:

- Strong member-centered orientation;
- Strengths in care management;
- Resolution of issues related to quality monitoring;
- Members report high levels of self-determination and choices, and health and safety outcomes.

The Lewin Group assessment also found high levels of satisfaction in choice and self-determination, community integration, and health and safety outcomes.

The APS Healthcare report did note, however, that grievance and appeal data did not "fully reflect the total amount of complaints that have been made." APS Healthcare noted that plans are currently in place to improve the monitoring and resolution of complaints and grievances. Further, some of the CMOs have had difficulty in record keeping and data utilization, which was also noted earlier in the difficulties of infrastructure development.

*Expenditures and Utilization*

APS Healthcare completed extensive preliminary evaluations of the expenditures and utilization for program enrollees. The findings are preliminary, in that the program has

not been in existence long enough to fully determine the effect of the program on expenditures. Table D-12 shows the preliminary findings regarding cost and utilization.

**Table D-12: Wisconsin Family Care Average Level of Expenditures and Utilization 7 to 12 Months After Enrollment (per member per month)**

| Service Label | Family Care – adjusted | Comparison Group – adjusted | Difference |
|---|---|---|---|
| Monthly Total LTC Expenditures | $2,246 | $1,491 | $755 |
| Monthly State Center for Developmentally Disabled Expenditure | -$50** | $137 | -$186 |
| Monthly Home Health Expenditure | $61 | $0 | -$60 |
| Monthly Intermediate Care Facility Expenditure | -$46** | $153 | -$199 |
| Monthly Nursing Home Expenditure | $145 | $163 | -$18 |
| Monthly Personal Care Expenditure | $183 | $127 | $56 |
| Monthly Residential Care Facility Expenditure | $409 | $130 | $279 |
| Monthly Supportive Home Care Expenditure | $512 | $178 | $335 |
| Monthly Emergency Room Expenditure | $1 | $1 | $0 |
| Monthly Hosp. Inpatient Expenditure | $21 | $87 | -$67 |
| Monthly Hosp. Outpatient Expenditure | $35 | $24 | $11 |
| Monthly Physician Office Expenditure | $17 | $18 | -$2 |
| Monthly Prescription Drug Expenditure | $376 | $241 | $135 |
| Monthly State Center for Developmentally Disable Days | -0.13** | 0.34 | -0.46 |
| Monthly Home Health Visits | 0.97 | 0.01 | 0.97 |
| Monthly Intermediate Care Facility Days | -0.23** | 0.96 | -1.19 |
| Monthly Nursing Home Days | 1.66 | 1.81 | -0.15 |
| Monthly Personal Care Days | 11.83 | 8.19 | 3.64 |
| Monthly Residential Care Facility Days | 2.66 | 1.65 | 1.01 |
| Monthly Supportive Home Care Days | 5.45 | 1.62 | 3.83 |
| Monthly Emergency Room Visits | 0.03 | 0.01 | 0.01 |
| Monthly Hospital Inpatient Admissions | 0.04 | 0.03 | 0.01 |
| Monthly Hosp. Inpatient Days | 0.17 | 0.22 | -0.04 |
| Monthly Hosp. Outpatient Visits | 0.22 | 0.19 | 0.03 |
| Monthly Physician Office Visits | 0.46 | 0.41 | 0.05 |
| Monthly Prescription Drug Claims Paid | 6.80 | 4.47 | 2.33 |

Adapted from: APS Healthcare, Inc. *Family Care Independence Assessment: An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2002.* Table 21, page 86.

**Adjusted valued were determined by APS Healthcare using regression equations, which can result in negative values. Negative values should be interpreted as meaning "close to zero."

As shown in the table, total long-term care monthly expenditures for the Family Care population was approximately $755 per-member per-month greater than for the comparison group. However, this finding must be qualified. Family Care members in Milwaukee (where only elders are enrolled) had a significantly higher increase in long-term care spending than members in other counties. In fact, members in other counties had significantly ***lower*** expenditures than the comparison groups ($113 less per-member per-month). Because this project is focused on people with disabilities, the findings for the non-Milwaukee counties are most relevant. APS Healthcare reached this conclusion following a more detailed analysis of changes in utilization for Family Care members following enrollment as compared to the comparison group. In other words, APS Healthcare followed members and the matched comparison group for one full year following enrollment to identify how spending and utilization changed.

An additional "path analysis," completed by APS Healthcare, looked specifically at the pathway individuals in Family Care follow, as compared to those outside Family Care. The analysis found the following: "Note that each of the indirect effects of Family Care is *negative*, which indicates a tendency to reduce spending through these three pathways: reducing institutionalization, reducing illness burden, and reducing functional status impairment." While they found those initial cost savings, they went on to note: "However, it appears that the indirect savings are not fully sufficient to fully offset the direct increase in costs." Therefore, more time will be needed to determine whether the cost savings can long-term offset the direct cost increases for the Family Care program.

For more detail about the cost effectiveness analyses and other outcomes, please see "Family Care Independent Assessment: An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2002" by APS Healthcare, which is provided in Supplemental Documents Binder.

**Can the Program be Replicated?**

Program staff from Wisconsin Family Care indicated that this program should be able to be replicated in another location. However, there are significant differences between Massachusetts and Wisconsin, primarily the presence of a strong county system in Wisconsin. Wisconsin originally relied on this strong county system to operate the CMOs. Further, Wisconsin was uniquely positioned and politically ready to restructure their long-term care system, which led to Family Care.

Other features of Family Care could have relevance, including the use of the Resource Allocation Decision Method for planning and authorizing services. Such a process could be utilized in a number of ways to assist in the care management of people with disabilities.