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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;

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[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 Case management: Approximately 1,500 clients (Some are also primary care clients) 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. 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) 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) 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 Focus groups Advisory committees	1915(a) and 1915(c) federal waivers and Medicare Section 402 authority	10+ years*
Texas STAR+PLUS	Stakeholder meetings 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 Wisconsin Family Care*
Medicaid 1915(c)	Allows for Medicaid home and community-based services.	MnDHO Texas STAR+PLUS 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 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; • 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.
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; • Development of an individualized plan of care with the member, based on the member's choices about priorities and providers; • Identification of a primary care physician if the member does not have one; • Identification of what services will be managed directly by the consumer (such as personal assistance services); and • 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. Health coordinator is usually an RN or a public health nurse with extensive disability experience. Resource coordinator is usually a social worker. Member services staff are members of the office staff.	Care coordination is provided to all MnDHO members.	*Health coordinator*: • conducts initial assessment and periodic re-assessments; • authorizes most health and social support services; • works with physicians and primary care clinic staff to assure that all services are received and coordinated; • attends most primary care and specialty appointments with members; and • is available 24 hours a day, 7 days a week as first point of triage for members. *Resource coordinator*: • coordinates non-medical supports, including housing, financial assistance, and health education efforts. *Member services staff*: • 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. • Development of a care plan to address the unique needs of each member. • Timely access to providers and services. • 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. • In-service training on medical issues. • Liaison with primary care practices. • Exercise groups. • Diet and nutrition education. • Group activities.
Wiscon-sin 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. • 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.

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 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 <u>review</u> 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: • Overall satisfaction • Plan of care meets the needs of the member • ICS supports members to do for themselves • ICS staff is helpful • ICS staff is respectful • ICS staff communicates changes in service • 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.