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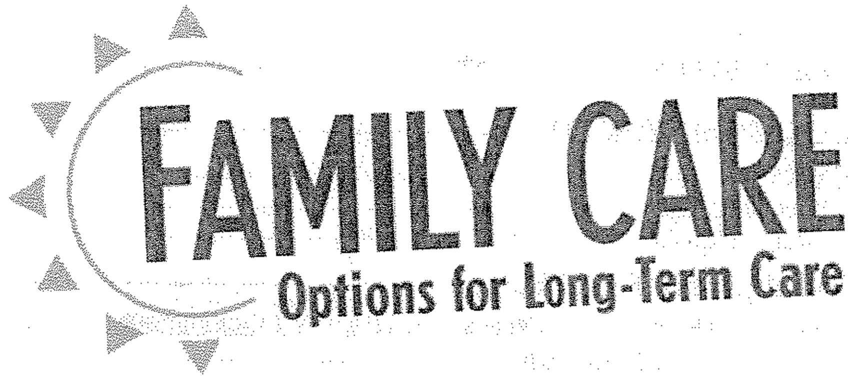

Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2002

Presented by
APS Healthcare, Inc.

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I. Executive Summary

APS Healthcare (APS) prepared this report. The Centers for Medicare and Medicaid (CMS) requires an Independent Assessment of access, quality and cost-effectiveness of all 1915(b) waivers. A waiver was granted by CMS to Wisconsin to operate Family Care for the time period of January 1, 2002, through December 31, 2003. This report provides for the Independent Assessment of the Wisconsin Family Care managed care 1915(b) waiver program.

Family Care is Wisconsin's effort in providing comprehensive long-term care services through a managed care delivery system for the aged and physically and developmentally disabled population. As with any new initiative, evaluation may be limited or constrained by start-up issues, such as general Medicaid recipient and provider confusion, difficulties reporting accurate and reliable data, and lag time in reporting.

With these issues and caveats in mind, APS analyzed data collected directly by the Wisconsin Department of Health and Family Services (DHFS), the Family Care programs External Quality Review Organization (EQRO), the Family Care Care Management Organizations (CMOs), as well as information gathered independently by APS.

The following findings emerged from these efforts. This information details where aspects and activities of the Family Care program are successfully contributing to access, quality and cost-effectiveness, as well as areas that are in need of improvement. Specific items are grouped within each of the objectives this Independent Assessment intends to address:

A. *Access to Care*

1. Screening
   - **The Wisconsin Long-Term Care Functional Screen (LTCFS) is an accurate and reliable instrument for assessing Family Care program eligibility.** The LTCFS is a validated instrument utilized to determine eligibility and assess level of care needs for potential members.

2. Entry into the Program
   - **The use of independent, third-party "Enrollment Consultants" to ensure potential members and/or their representatives fully understand aspects of the Family Care program and eligibility for other long-term services is valuable.** The function of the Enrollment Consultants proves to be one of significant added value in ensuring that potential Family Care members and/or their representatives have complete understanding of the intricacies of the program, as well as being keenly aware of any other long-term care services that individual might be eligible for.

3. Elimination of Waiting Lists
   - **A major accomplishment of the Family Care program was elimination of wait lists in the CMO counties by the end of CY 2002.** Waiting lists in the CMO counties were eliminated while the wait lists in the non-CMO counties

continued to increase during this same time. By eliminating the wait lists, individuals in need of services begin receiving them soon after application for Family Care, as opposed to waiting what could be months or years in non-Family Care counties.

4. Access Monitoring

- **Family Care Access Monitoring Activities need to be strengthened**. DHFS and the EQRO need to enhance the level of access-monitoring activities. DHFS has not been routinely monitoring the 30-day enrollment requirement. It has been recommended that DHFS develop routine reports to monitor access to Family Care on a county-by-county basis.

- **Family Care CMOs appear to meet requirements for 1) Health Services Availability, Accessibility, and Adequacy, 2) Access Performance Standards.** While APS did not find any indication that these requirements and standards were not met, limited availability of documentation in this area (e.g. the access to care standard was not evaluated by the EQRO during the period of the Independent Assessment) made it difficult to fully assess these requirements. However, the EQRO evaluated service availability and other access issues through care plan reviews and found that the CMOs were sufficiently meeting program requirements.

5. Services Within the Program

- **Family Care may have increased the number of providers participating in the Medicaid program.** Determining the exact number of providers participating in the Family Care program across the five pilot counties is difficult due to various record keeping efforts. However, information gathered through site visits and meetings with the CMO directors and DHFS revealed that overall, providers are joining the network, are being retained, and meeting both the traditional and more unique service needs of Family Care members.

6. Patterns of Service - (Although these items are issues of Access, this information is detailed in the Cost-Effectiveness section of the report)

- **Family Care reliance on emergency room utilization did not significantly change over time.** Analysis of Medicaid claims data indicated no significant change in the frequency of use for emergency rooms. A pre- and post-analysis of emergency room visits per member per eligible months indicated no significant reductions in visits.

- **Family Care seems to have decreased the frequency of visits to physicians.** Although not conclusive, Family Care members appear to be visiting doctors at their office significantly less often than prior to their enrollment in the program. A pre- and post-analysis of physician office visits per member per eligible months indicated a significant reduction of visits. Although less likely to see a physician, those who did, tended to be in the program longer and it is likely Family Care's interdisciplinary team care plan approach, which includes a nurse, is contributing

to this improvement. The impact of Milwaukee county is clearly identified through analyses designed to assess county specific influence.

- **Family Care hospital lengths of stay decreased.** Analyses of Medicaid claims data indicate that while there is no change in hospital admissions pre- and post-enrollment, hospital lengths of stay significantly decrease following enrollment in the Family Care program.

7. Exit From the Program
   - **DHFS must continue developing strategies to better track and understand reasons for Family Care disenrollments.** Recognizing the need for better data on the reasons why people decide to disenroll from the Family Care program, DHFS worked with Resource Centers to develop new guidelines for recording and reporting disenrollments. In April 2003, Resource Centers implemented a new process to record a single, primary reason for disenrollment. Generally speaking, examining disenrollment data for calander years 2000 through 2002 accounting for all reasons for disenrollment, including death, rates for the Family Care program appeared high (over 14 percent in 2001 and 2002). However, when disenrollments due to death are excluded rates were nearly cut in half and appear reasonable for the populations served by Family Care as noted in previous research. It is suggested that DHFS utilize historical disenrollment data to identify and address disenrollment trends ("red flags") that deviate from normal patterns. Further, it is recommended, in accordance with reviewed literature on disenrollments, that DHFS conduct routine surveys for individuals who both voluntarily disenroll and who lose eligibility from Family Care, to better assess patterns that may be occurring for various subgroups within the program.

B. *Quality of Services*

1. Overall Quality Strengths of the Family Care Program
   - **All five CMOs demonstrate strong "member centered" orientation.** Site visits by DHFS, the EQRO and APS all reveal that each CMO possesses a strong orientation toward member centeredness, which means Family Care members are given the opportunity to take an active role in decision-making regarding the long-term care and health services they need to live as independently as possible.

   - **Family Care's CMOs demonstrated strengths in care management.** The EQRO's on-site review of the Family Care CMOs found that care managers were creative and flexible in terms of working for the most appropriate level of services for members.

2. Quality Monitoring
   - **Four of the five CMOs were able to resolve all outstanding issues within three reviews of their Member Centered Assessment and Plan Reviews (MCAP).** While one CMO did not rectify outstanding issues within their care

plans, DHFS, the EQRO and CMO are cooperatively working to resolve these concerns and put aspects into the process to ensure these issues do not return.

- **Family Care Grievance and Appeal data does not fully reflect the total amount of complaints that have been made.** Thus far, DHFS has begun to analyze grievances and appeals, but only for those that have been filed with the Regional DHFS offices. Plans are in place to utilize other sources of information, such as CMO log books and complaints that have been filed with the Wisconsin Department of Administration's Office of Fair Hearings. DHFS plans to integrate other sources of grievance and appeals data to construct more detailed analyses.

- **Family Care CMOs have great levels of flexibility and autonomy in terms of meeting quality requirements, as demonstrated by enhanced creativity in serving members, but this has been coupled with problems related to record keeping and data utilization.** DHFS has designed a program that has fostered innovation by CMOs in serving their membership by allowing them the ability to be effective and creative. However, a lack of specificity by DHFS on reporting requirements and data record keeping has resulted in CMOs operating differently in record maintaining efforts. Two such examples include information that needs to be transmitted to the Family Care Enrollment Consultant and record keeping related to contractually required performance measures.

3. Member Outcomes

- **Family Care members consistently report high levels of "Self-determination and Choice," and "Health and Safety" outcomes and supports.** Through the use of the Member Outcome Interview surveys, Family Care members are consistently reporting the presence of outcomes and supports in these two areas. While Family Care members have reported lower levels of "Community Integration" outcomes and supports, it is not unreasonable to expect a bit of a "lag time" given that a fundamental principle of the Family Care program is to provide ways to reintegrate institutionalized individuals back into the community.

- **The more time an individual spent in Family Care resulted in a greater presence of indicators of outcomes and supports being present**. Intuitively, this makes sense in that CMOs and members' care managers would have more time to work with the member to ensure that their individual outcomes and supports were being met, where possible.

4. Members Health and Functioning

- **Family Care has the potential to reduce costs by improving health care and health outcomes.** Through a path analysis, it was learned that Family Care members saw significant reductions in institutional settings (increased community integration) and significant reductions in functional status impairment[1].

[1] Path analysis is an extension of the regression model, used to test the fit of the correlation matrix against two or more causal models which are being compared by the researcher. The model is usually depicted in a circle-and-arrow figure in which single arrows indicate causation. A regression is done for each variable in the model as a dependent on others which the model indicates

C. Cost-Effectiveness

1. Payment Methodology
   - **The Family Care rate setting and capitated payment system methodology is sound.** The Family Care capitation and rate setting process has been continually improving since inception to more accurately reflect the population covered and the services provided under the program. Using encounter data and LTCFS data to risk adjust the rates according to the needs of the members has resulted in improvement.

2. Individual Costs
   - **Total Long-Term Care costs for Family Care members in the four non-Milwaukee CMO counties (Fond du Lac, La Crosse, Portage, and Richland) increased less than for the statewide Comparison Group from pre- to post-enrollment.** Costs for the statewide Comparison Group increased $238, on average, in non-Family Care counties. Total long-term costs for non-Milwaukee Family Care members increased $113 per member per month (PMPM) less, on average. The slower growth in costs is not apparent when the Family Care study group is examined as a whole, which includes the Milwaukee County CMO members, only when these counties are studied separately from the Milwaukee CMO cohort.

   - **In the change from pre- to post-enrollment periods, Family Care members experienced increases in spending and utilization rates for Home Health Care visits.** Increases were significant for both the collective Family Care study group ($35 PMPM) and for the collective non-Milwaukee CMO counties ($32 PMPM) relative to the statewide Comparison Group. The Milwaukee County CMO had no significant change for this cost or utilization.

   - **Costs for Inpatient Hospital and Physician Office Visits went down for Family Care members, but increased for the Comparison Group during the study period.** Post-enrollment actual spending for these services was less for Family Care members than the Comparison Group. Family Care members' post-enrollment Inpatient Hospital costs and Physician Visits costs were $21 PMPM and $17 PMPM, respectively. For the Comparison Group, Inpatient Hospital and Physician Visit costs were $87 PMPM and $18 PMPM, respectively.

   - **Prescription Drug costs increased more for Family Care members then the Comparison Group over the study period. However, for those Family Care members in the non-Milwaukee County CMOs Prescription Drug costs decreased during the study period.** When looking at all five CMOs

are causes. The regression weights predicted by the model are compared with the observed correlation matrix for the variables, and a goodness-of-fit statistic is calculated. The best-fitting of two or more models is selected by the researcher as the best model for advancement of theory.
Path analysis requires the usual assumptions of regression. It is particularly sensitive to model specification because failure to include relevant causal variables or inclusion of extraneous variables often substantially affects the path coefficients, which are used to assess the relative importance of various direct and indirect causal paths to the dependent variable.

Prescription Drug costs increased $34 PMPM more than the Comparison Group. In the four non-Milwaukee CMOs, the cost of prescription drugs decreased $31 PMPM relative to the Comparison Group.

- **Geographic differences account for a substantial amount of the changes over time observed in spending and utilization rates by Family Care members.** The Family Care program operates in five diverse counties across the state of Wisconsin. Above and beyond the impacts of the Family Care program itself, services accessed, utilized, and spent for, vary dramatically between these counties. Differences among them contribute a great deal to the variation in spending and utilization rates. Specifically, the Milwaukee CMO illustrated very different findings from other CMO counties that tended to show more consistency when compared to one another.

3. Source of Cost Savings

- **Family Care members in the four non-Milwaukee CMO counties saw significant decreases for Personal Care and Residential Care services.** In contrast to the Comparison Group, the four non-Milwaukee Family Care CMOs experienced a collective decrease of $175 PMPM for Personal Care services and $98 PMPM for Residential Care services while the Milwaukee County CMO individuals saw a significant increase of $90 PMPM in Residential Care and no significant change for Personal Care costs.

- **In the change from pre- to post-enrollment periods, Family Care members saw post-enrollment cost and utilization reductions in ICF-MR days.** Through the use of CMO encounter data and Human Services Reporting System (HSRS) data, APS determined that costs ($62 PMPM) and utilization rates (0.28 days PMPM) significantly declined for this service from the pre- to post-enrollment periods relative to the Comparison Group.

- **As previously mentioned, Family Care has the potential to effect cost savings through improved member health care and health related outcomes.** Family Care members saw significant reductions in institutional settings (increased community integration) in addition to significant reductions in functional status impairment.

II. Requirements of Independent Assessment

The 1999 Wisconsin Act 9 authorized the Department of Health and Family Services (DHFS) to operate the Family Care program. DHFS is able to offer long-term care services utilizing a capitated payment system after applying for both 1915(b) and a 1915(c) waivers and receiving approval for the waivers from the Center for Medicare and Medicaid Services (CMS). The two 1915(b) waivers (one for individuals age 60 and over in Milwaukee County and one for adults in the other four pilot counties), which allow DHFS to limit the provision of long-term care services in those counties to individuals who enroll in a Care Management Organization (CMO) using a "central broker" (Resource Center). The two 1915(c) waivers (one for individuals with developmental disabilities and one for individuals with physical disabilities) allows DHFS to provide home and community based services, in lieu of institutional placement, for individuals with long-term care needs that would qualify for Medicaid funding in a nursing home. Through these waivers, the Department is able to pay a pre-paid capitation amount to the CMOs who are then responsible for providing the services in the Family Care benefit that are needed by the member. The five Family Care CMOs are Fond du Lac, La Crosse, Milwaukee, Portage and Richland Counties.

CMS requires that an Independent Assessment of the Family Care program be conducted and the findings be submitted as part of the Department's waiver renewal request. In September 2002, DHFS contracted with Innovative Resource Group d/b/a APS Healthcare, Inc (APS) to fulfill this requirement. APS has been working with DHFS, as well as Metastar, the Family Care External Quality Review Organization (EQRO), to gather data for the Independent Assessment. The goal of the Independent Assessment is to describe the impact the Family Care program has had on long-term care services in Wisconsin in terms of access to services, quality of services and cost effectiveness. This Independent Assessment report will accompany the Department's application for renewal of the Family Care waivers due to CMS September 30, 2003.

In Fond du Lac, Portage, La Crosse and Milwaukee counties, CMO implementation of Family Care was completed during CY 2000. Richland began operations of its CMO in January 2001. Therefore, while CMOs began operating as early as February 2000, the program was not receiving federal funding under the federal waivers until January 1, 2002[2]. The pilot counties received start-up funding from various sources to plan, develop, and implement the Resource Centers (RCs) and Care Management Organizations (CMOs). The waivers, effective for two years, began January 1, 2002. The 1915 (c) waiver was also approved June 1, 2001 for three years. Therefore, the primary focus of the Independent Assessment is for CY 2002. The Independent Assessment separately addresses Family Care in Milwaukee County and in the rest of the program in order to meet federal requirements for each of the Family Care waivers. Some of the questions addressed in the Independent Assessment include:

1) Access – Can people get access to the services they want and/or need?

[2] See Lewin Group Family Care Implementation Process Evaluation Reports I, II and III (November 2000, 2001, and December 2002) for specific start-up funding tables.

a) Screening: Is information about the availability of long-term care options, including Family Care and options counseling, effectively reaching those who need to know about their options?
b) Entry into the Program: How has Family Care affected access to Medicaid-funded long-term care services, for those who are eligible? In particular, how does Family Care enrollment differ from traditional waiver enrollment – target group, diagnoses, residence, age, and other characteristics?
c) Access Monitoring: How do DHFS and the EQRO monitor program access?
d) Services within the Program: Once in the program, can individuals get the services that they want and need?
e) Patterns of service: How do packages of services delivered to Family Care members differ from those delivered to individuals participating in fee-for-service long-term care, including the traditional waivers?
f) Exit from the Program: What are the reasons that individuals disenroll from Family Care?

2) Quality – Are the services effective? Is the program achieving its goals?
   a) Member Outcomes: Do Family Care Members achieve their personal outcomes and do they get support for those outcomes?
   b) Members' health and functioning: Are Family Care members maintaining their level of functioning and staying as healthy as possible?
   c) Quality Monitoring: How do DHFS and the EQRO monitor program quality?
   d) Preventive Health Conditions: How does Family Care compare to other long-term care programs, such as Partnership on the utilization of heath services for preventable conditions?

3) Cost Effectiveness –Is Family Care cost effective?
   a) Payment Methodology: Are the Family Care rate-setting assumptions and methodology reasonable?
   b) Individuals' costs: Does Family Care restrain Medicaid costs for those individuals who participate in the program?
   c) Source of Cost Savings: What changes in utilization have contributed to any identified cost savings?

III. Family Care Program Overview

Family Care is a long-term care pilot program operating in selected Wisconsin counties under four federal Medicaid waivers described in Section II. The program is intended to re-design the state's long-term support systems in the pilot counties in order to: provide individuals better choices about their living arrangements and services they receive; improve access to services; improve quality of care including an emphasis on both health and social outcomes; and establish a system that will be cost-effective into the future. Another program goal is to reduce the complexity of the system in order to improve access to services. To achieve this goal, Family Care was developed as a combined, coordinated system of long-term supports, rather than a system made up of discrete, separate elements.

Under Family Care, individuals are entitled to both community-based supports and institutional care, so that they may find the balance that best meets their needs over time. Stakeholder involvement in the design of Family Care was critical to making sure it could meet the needs of the target population. Therefore, input and involvement in program design was sought from individuals who would likely utilize the system: persons with physical disabilities, persons with developmental disabilities, and the frail elderly, as well as representatives for these individuals. It was also determined early on that the program's success would rely, in part, on the "buy-in" of providers serving individuals in the five CMOs. Therefore, the goals and values of the program have been incorporated into the policies and procedures created for participating providers[3].

At the local level, two different entities are responsible for implementing Family Care. First, Aging and Disability Resource Centers (Resource Centers) serve as the primary point of entry for accessing long-term care services in nine counties. The Resource Centers are designed to provide information and advice, as well as access, to the full range of resources available within the community for people in need, such as older persons and persons with disabilities. The information Resource Centers provide is essential to allowing individuals to make informed choices about the options that exist for long-term support services. They also provide the key function of performing functional and financial screening that is required to determine eligibility for certain services, such as the Family Care program.

The second entity that is at the core of the Family Care program is the Care Management Organization, or CMO. CMOs serve the purpose of managing the Family Care benefit at the county level (current operating CMOs include Fond du Lac, La Crosse, Milwaukee, Portage and Richland counties). State and Federal funding from a variety of sources are combined into a single capitated payment to the CMO. The CMO is then responsible for providing all needed long-term care services covered by the Family Care benefit (see **Attachment 1** for a list of items covered under the Family Care benefit). A variety of Medicaid services are included in and excluded from the Family Care Benefit Package. In general, long-term care (LTC) services (i.e., Home Health Care, Personal Care and Supportive Home Care services) are included in the Family Care benefit package. Primary and acute care services, including physician and hospital

[3] The Lewin Group. Implementation Process Evaluation Reports I, II, and III. November 2000, 2001, and December 2002.

services, are not included in the Family Care benefit package and remain available as a Medicaid fee-for-service benefit.

The CMO then contracts with service providers to form its Provider Network for services included in the benefit package. Provision of a self-directed care option allows a member to arrange, manage and monitor services in the Family Care benefit package directly or with the assistance of another person chosen by the member. The intent of this unique approach is to enable CMOs, and more globally, the Family Care program, to address the specific needs of its members through consumer direction in a cost-effective manner. Primary and acute health care services, such as physician services, hospitals services and prescription drugs are available on a fee-for-service basis to Family Care members who are also Medicaid eligible (approximately 97 percent)[4]. Family Care participants then work with the CMO to choose from the whole range of long-term care options, including both the type of care and the setting in which it is received (individual's home, community residence, institution) and to coordinate other health care services. This arrangement allows long-term supports to be focused upon the needs of the member, rather than being limited by traditional service systems. The program is more flexible than previous waivers and allows individual needs and preferences to become a primary consideration in the delivery of care.

There is also an independent organization that ensures that potential Family Care members fully understand the implications of participating in a managed care program and provides these individuals with information about all available options for which they are eligible, Family Care or otherwise. Individuals serving in this capacity are called Enrollment Consultants. DHFS has contracted with the Southeastern Area Agency on Aging (SWAAA) to carry out this service (see Section V. E. for specific details on Enrollment Consultants).

At the present time, Resource Centers and CMOs are operational in five counties (Fond du Lac, La Crosse, Milwaukee, Portage, and Richland), covering approximately 29 percent of all those individuals statewide who would be eligible for the Family Care benefit[5]. All three target group populations (older persons, persons with developmental disabilities, and persons with physical disabilities) are served in four of the five counties. The fifth, Milwaukee County, is currently only serving older persons. As of August 1, 2003 there were 7,474 individuals cumulatively enrolled in Family Care from all five counties[6]. Over fifty percent of Wisconsin's Family Care members reside in Milwaukee County.

Four additional counties (Jackson, Kenosha, Marathon and Trempealeau) operate Resource Centers, but do not have CMOs. They serve to communicate full information about available community resources, and thus serve the same purpose as the other Resource Centers, except that they do not offer Family Care eligibility testing or enrollment. The following table provides information on start dates for Family Care Resource Centers and CMOs.

[4] DHFS. Quarterly Family Care Activity Report. For the Quarter ending December 31, 2002.
[5] Medstat. Promising Practices in Long Term Care Systems Reform: Wisconsin Family Care. March 3, 2002.
[6] Total CMO enrollment data posted on http://www.dhfs.state.wi.us/LTCare/Generalinfo/EnrollmentData.htm.

Table 1 Family Care Resource Center and CMO Dates of Initial Operation		
County	***Resource Center***	***CMO***
Fond du Lac	1999	February 2000
La Crosse	2000	April 2000
Milwaukee	2000	July 2000
Portage	2000	April 2000
Richland	2000	January 2001

Source: Wisconsin Department of Health and Family Services (DHFS)

A. *Eligibility Criteria*

CMOs serve people in three primary target groups who have a long-term care condition expected to last for more than 90 days. The three Family Care target groups are:

1. Frail Older Adults (65 years or older; age 60 or older in Milwaukee County);
2. Adults with Physical Disabilities (17 years, 9 months or older);
3. Adults with Developmental Disabilities (17 years, 9 months or older).

In order to be eligible for Family Care an individual must meet the following conditions: have long-term care service needs, be an older adult or an adult with a disability; live in a Family Care pilot county; and meet financial and functional program eligibility requirements. Anyone who qualifies for Medicaid meets the financial eligibility criteria for Family Care. Individuals who are not financially eligible for Medicaid may still qualify for Family Care based on their cost of care needs.

In order to be functionally eligible for Family Care, an individual must meet the following condition(s).

At the comprehensive level, the person has a long-term or irreversible condition that requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screen:

1. The person cannot safely or appropriately perform:
   - 3 or more activities of daily living(ADLs)
   - Two or more ADLs and one or more instrumental activities of daily living(IADLs).
   - Five or more IADLs.
   - One or more ADL and 3 or more IADLs and has cognitive impairment.
   - Four or more IADLs and has cognitive impairment.
2. The individual:
   - Requires frequent medical or social intervention to safely maintain an acceptable health or developmental status; or requires frequent changes in service due to intermittent or unpredictable changes in his or her condition; or requires a range of medical or social interventions due to a multiplicity of conditions; and
   - Has a developmental disability that requires specialized services; or has impaired cognition exhibited by memory deficits or disorientation to person, place or time; or has impaired decision-making ability exhibited by wandering, physical abuse of self or others, self neglect or resistance to needed care.

At the intermediate level, the person has a long term or irreversible condition and is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others, as is evidenced by a finding from application of the functional screen that the person needs assistance to safely or appropriately perform either of the following:

1. One or more ADL, or
2. One or more of the following critical IADLs : management of medications and treatments, meal preparation and nutrition, or money management.

Or to be grandfathered in for Family Care functional eligibility, the person:

1. Has a long–term or irreversible condition.
2. Is in need of services included in the Family Care benefit.
3. On the date that the family care benefit became available in the county of the person's residence:
   - Was a resident in a nursing home, or
   - Had been receiving for at least 60 days, under a written plan of care, long-term care services under any of the following:
     i. Any Medicaid home and community-based waiver program.
     ii. The State-funded Community Options Program.
     iii. The State-funded Alzheimer's Family Caregiver Support Program.
     iv. Services provided through State- and county-funded Community Aids.
     v. Services provided through county funding.
4. Be financially eligible for Family Care by:
   - Being financially eligible for Medicaid, or
   - Having case plan costs that exceed her/his gross monthly income plus one–twelfth of his/her countable assets, less deductions and allowances permitted by rule by DHFS.

Most, but not all, individuals who are eligible for Family Care will be eligible for Medicaid. Federal Medicaid matching funds are not claimed for Family Care services provided to individuals who are Family Care-eligible but not Medicaid-eligible. Services for those individuals are funded entirely with state general purpose revenue. Some individuals receiving Family Care benefits may be required to pay a cost share to the CMO depending on their current income level.

The following table provides detailed information on the functional and financial eligibility criteria for Family Care and Medicaid eligibility.

<table>
<tr><th colspan="5">Table 2 Functional and Financial Eligibility Criteria for Family Care and Medicaid</th></tr>
<tr><td rowspan="2">Target Population</td><td>Frail Older Adults</td><td colspan="2">Adults with Physical Disabilities</td><td colspan="1">Adults with Developmental Disabilities</td></tr>
<tr><td>Age 65+ except Milwaukee age 60+</td><td colspan="2">Age 17 years and 9 months and older</td><td>Age 17 years and 9 months and older</td></tr>
<tr><th colspan="5">Resource Center (RC) Services</th></tr>
<tr><td>Eligibility</td><td colspan="4">Individual of all income and functional need can access information
and referral services and options counseling</td></tr>
<tr><th colspan="5">Care Management Organizations (CMO) Benefits</th></tr>
<tr><td rowspan="2">Functional Eligibility</td><td>Comprehensive Functional Level</td><td colspan="3">Intermediate Functional Level</td></tr>
<tr><td>Unable to safely perform any of the following:
• 3 or more ADLs
• 2 or more ADLs & 1 or more IADLs
• 5 or more IADLs
• One or more ADL(s) and 3 or more IADLs and has a cognitive impairment
• 4 or more IADLs and has a cognitive impairment</td><td colspan="3">Unable to safely perform any of the following:
• One or more ADL(s)
• One of more of the following critical IADLs:
➢ Management of medications and treatment
➢ Meal preparation and nutrition
➢ Money management
And at least one of the following applies:
• In need of Adult Protective Services
• Qualify for Medical Assistance
• Grandfathered from an existing LTC program</td></tr>
<tr><td rowspan="3">Financial Criteria</td><td colspan="3">Medical Assistance (Title XIX – Medicaid)</td><td>Non-Medical Assistance</td></tr>
<tr><td>HCBS Waiver/Nursing Facility</td><td colspan="2">Medically Needy</td><td></td></tr>
<tr><td>Income: 300% of Supplemental Security Income (SSI) limit
Individual: $1,656/mo or $19,872/yr
Couple: $2,487/mo or $29,844/yr
Resources:
Individual: $2,000
Couple: Spousal impoverishment provisions of $2,000 + ½ combined countable assets greater than $100,000 where spouse may retain a minimum of $50,000 and maximum of $90,600</td><td colspan="2">Income: Gross monthly income – medical expenses < 591.67/mo.
Resources:
Individual: $2,000
Couple: $3,000

Cost-share/deductible required</td><td>Service plan costs< gross monthly income + 1/12 countable resources

Cost – share/deductible required</td></tr>
</table>

Note: Countable resources include bank accounts, stocks, bonds, and the face value of life insurance policies greater than $1,500. The value of the individual's owned primary place of residence, one automobile, burial plots, home furnishings, and personal jewelry are not included.
Source: The Lewin Group. Wisconsin Family Care Final Evaluation Report.

An important role played by CMOs is to assist Family Care members in coordinating their health care to determine and achieve the best possible health for their members. While CMOs do not provide direct health care services, per se, their role in coordinating primary and acute health care services is critical in optimizing social and health-related outcomes for Family Care members.

B. *Eligibility Determination Process*

There are three steps in determining an individual's eligibility for the Family Care benefit. Interested individuals are assisted with each step by Resource Center staff.

A trained staff person from the Resource Center will meet with an individual and complete the Long-Term Care Functional Screen to assess the individual's level of need for services and functional eligibility for the Family Care benefit. Once the individual's particular needs for long-

term care are determined, the Resource Center will provide advice about the options available to him or her including Family Care (where applicable), other publicly funded LTC programs or services and private pay services available in the community. If the person is interested in Family Care or another Medicaid program, the Resource Center will help the individual contact the county's Economic Support Unit (ES) to continue the eligibility determination process for those programs. The county ES unit makes the final eligibility determination for Family Care and Medicaid. Additionally, the ES unit in CMO counties administer the tracking and resolution of applications for Family Care and Medicaid.

Once functional and financial eligibility is determined, the Resource Center notifies an Enrollment Consultant who is required to contact the person, either by phone or in person. The Enrollment Consultant ensures the person understands what it means to enroll in the Family Care program, become a member of the CMO, and that he or she understands all the options for long-term care available to him or her. If after this consultation, the person decides on pursuing Family Care membership, the Resource Center completes the enrollment process and notifies the CMO of the enrollment date.

C. *Quality Assurance – Quality Improvement*

The Department's measurement of CMO performance is focused on the health and social outcomes of its members. These measures help determine if the Family Care program is achieving its goal of improved quality of care and services. In consultation with a variety of stakeholders, DHFS established the following Member Personal Outcomes for measuring Family Care quality:

Self-Determination and Choice Outcomes

- People are treated fairly.
- People have privacy.
- People have personal dignity and respect.
- People choose their services.
- People choose their daily routine.
- People achieve their employment objectives.
- People are satisfied with services.

Community Integration Outcomes

- People choose where and with whom they live.
- People participate in the life of the community.
- People remain connected to informal support networks.

Health and Safety Outcomes

- People are free from abuse and neglect.
- People have the best possible health.
- People are safe.
- People experience continuity and security.

These outcomes are measured through member and case manager in-person interviews using a tool developed by The Council on Quality and Leadership ("The Council"), a nationally-

recognized quality assurance organization. Interviewers are trained by The Council. Three rounds of interviews have been completed to date. The third round of 491 member outcome interviews was completed in May 2003, and a fourth round began in July 2003.

In addition to the member outcome interviews, the Family Care quality management system includes certain activities monitored by the EQRO: annual Performance Measures calculated by CMOs and validated by the EQRO, annual Performance Improvement Projects (PIPs) conducted by the CMOs and reviewed by the EQRO, and ongoing EQRO reviews of selected member care plans and other defined quality standards. The EQRO ensures that the quality information provided by CMOs is accurate and reliable, and the EQRO provides constructive feedback to the CMOs for ongoing improvement of their quality monitoring systems.

Performance measures are tied to program participant outcomes and focus on self-determination and program participant rights, community integration and social roles, and health and safety. CY 2002 quality indicators included measuring the turnover of care management staff and immunization rates for influenza and pneumonia. These indicators provide information as to how the CMO is doing in achieving specific member outcomes such as continuity of care and best possible health.

The CMO contract requires the pilot counties to conduct at least one PIP annually. The focus of the PIP must be on at least one program participant outcome: self-determination/choice; community integration; or health and safety. CMOs must then develop specific, quantifiable outcome indicators to measure the progress of their performance in the context of this project. Further, they are required to demonstrate improvement by the end of the following year. The program participant outcome that they choose must be a relevant concern for the CMO. They are required to have a data collection and analysis plan, and implement an improvement plan. In 2002, each CMO worked on two separate projects, so altogether ten performance improvement projects were underway. Examples of PIPs conducted by the CMOs include improving management of congestive heart failure, increasing access to preventive health services, and ensuring appropriateness of residential placements.

The Department also monitors a series of population health indicators for Family Care members. These measures include 17 clinical, functional and preventive health measures. The data for generating these indicators come from administrative data routinely collected by the Department, such as Medicaid claims data, LTCFS data and CMO encounter data.

Member-Centered Care Plan reviews of a five percent sample of new and ongoing waiver participants are conducted by the EQRO annually. This review also includes participants identified at higher risk for health, safety and welfare problems. Care plan reviewers follow a written protocol and use a standardized data collection form. The reviews focus on the extent to which waiver participant needs are met, service plan timelines are met, services are coordinated, and assessment/planning are conducted consistent with a member-centered approach. At the conclusion of a review, case-specific and summary reports are provided to the CMO in writing. In 2002, 436 care plans were reviewed, including plans of 101 new members, 185 continuing members and 150 members identified as high-risk.

The CMOs are also contractually required to demonstrate to the Department that they have the structures and processes in place that are required by state legislation, administrative rules and managed care organization (MCO) contracts. On-site reviews are conducted by DHFS staff prior to an initial contract with a CMO and as a condition of annual contract renewal.

Each CMO receives an annual site review from the Department, which focuses on the CMO's quality assurance/quality improvement program. Included in the review is the adequacy of the CMO's provider network, its monitoring of provider performance, and its safety/risk policies and procedures. In 2002, five quality site visits took place and CMOs have been implementing the Department's recommendations for improvement (More detailed information on these site visits is provided in **Section VIII. A. 1.**).

Finally, as part of its ongoing quality assurance and improvement activities, Department program staff and consultants engaged by the CMOs provide technical assistance to both the CMOs and the Resource Centers on an as-needed basis. Technical assistance addresses problem areas and performance improvement.

IV. Family Care Member Characteristics

In order to understand the impact of Family Care on the delivery of long-term care services in terms of access, quality and cost effectiveness, it is helpful to have an understanding of the characteristics of individuals who demonstrate an interest in program enrollment and those who subsequently enroll in the program. Data on individuals who were screened for Family Care eligibility during calendar year 2002 in the five CMO counties, data on individuals enrolled in Family Care as of July 1, 2002 and data on individuals who met the criteria for inclusion in the IA cost effectiveness analysis ("the Independent Assessment population") are presented below[7]. Therefore, not all of these tables are descriptive of all individuals enrolled in Family Care during CY 2002.

A. Initial Long-Term Care Functional Screens Completed by Target Group

Individuals who are actively seeking long-term care and exploring their options receive functional screens from Family Care Resource Centers. Not all individuals who are screened are found to meet Family Care financial and functional eligibility criteria. Table 3 provides information on those individuals who were screened in the five CMO counties during CY 2002 by Target Group and CMO.

Table 3 Initial Long-Term Care Functional Screens Completed by Target Group CY 2002

CMO Counties	Elderly		Developmental Disabilities		Physical Disabilities		Totals	
	CMO Members	CMO Percent	CMO Members	CMO Percent	CMO Members	CMO Percent	CMO Members	CMO Percent
Fond du Lac	455	55.1	259	31.4	112	13.6	826	100.0
La Crosse	476	42.7	312	28.0	327	29.3	1,115	100.0
Milwaukee	4,193	98.5	13	0.3	49	1.2	4,255	100.0
Portage	315	54.8	151	26.3	109	19.0	575	100.0
Richland	125	46.0	78	28.7	69	25.4	272	100.0
All CMO Column Totals	5,564	79.0	813	11.5	666	9.5	7,043	100.0

Note: Actual CY 2002 data were used for this analysis. This table is not based on the sample of Family Care Members used throughout this Independent Analysis. Further, it should be noted that the Milwaukee pilot CMO serves the elderly, hence the large elderly proportion.
Source: APS analysis of Long-Term Care Functional Screen (LTCFS) data.

Screened in each county

[7] Medicaid eligibility data was queried to find July 1, 2002 eligible Family Care members who were selected for the Family Care Independent Assessment analysis sample population (n=6,332).

B. Total CMO Enrollment by Target Group

Implementation of Family Care occurred at different points in time across the five CMO counties:

CMO	Implementation Date
Fond du Lac	February 2000
La Crosse	April 2000
Portage	April 2000
Milwaukee	July 2000
Richland	January 2001

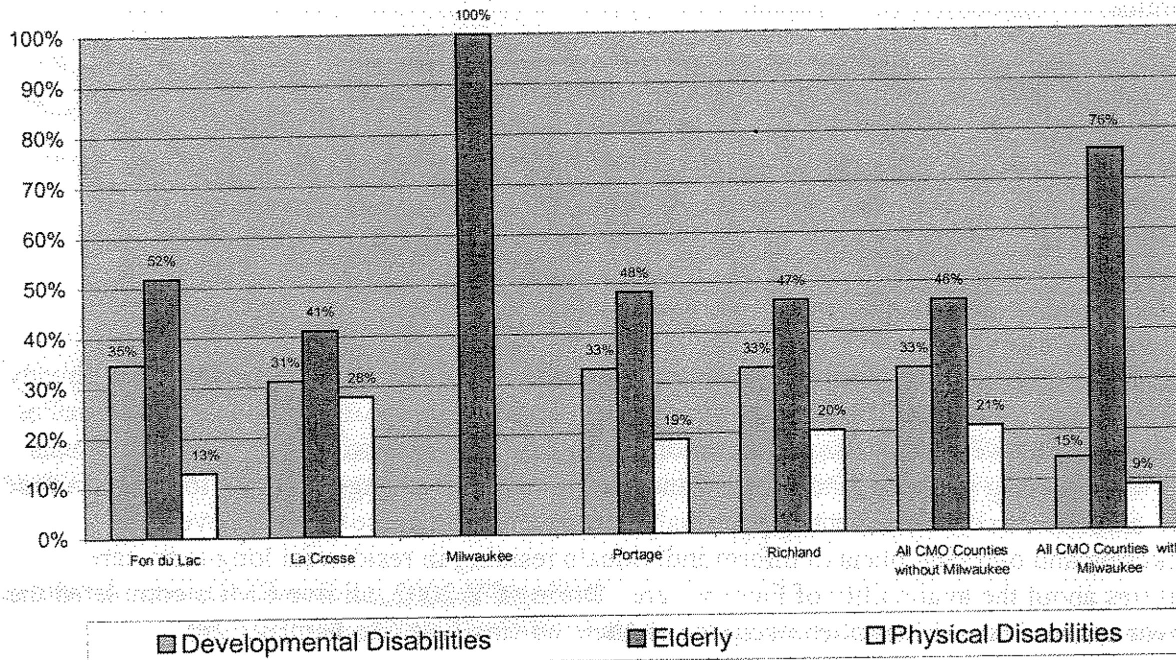
Source: Wisconsin Department of Health and Family Services (DHFS)

Initially, the Resource Centers screened, and the CMOs enrolled, individuals who were already participating in a long-term care waiver program. The next group of individuals to be enrolled were those who were on waiting lists for long-term care waiver services. Finally, individuals who were seeking publicly funded home and community based long-term care for the first time were enrolled. In order to identify potential members, the Resource Centers developed marketing and outreach plans to inform individuals residing in residential long-term care facilities about the availability of Family Care. During CY 2002, all five CMOs completed their waiver conversions and enrolled everyone on their waiting lists into Family Care.

The enrollment approach affected the target group composition of the Family Care membership. Initially, it appeared very similar to the waiver programs that Family Care replaced in those counties. However, the makeup changed as "new" individuals who were seeking community-based long-term care options enrolled. Initially, the majority of the individuals enrolled in Family Care outside of Milwaukee County were individuals with developmental disabilities. The proportion of elderly members has significantly increased over time as the Milwaukee CMO became operational (July 2000). Additionally, contributing factors such as outreach to nursing home residents and the increasing proportion of members from the Milwaukee CMO, the largest of the CMOs, will also be underlying factors. For example, in CY 2002, the elderly represented nearly half of the population. The figure below provides a snapshot of CMO enrollment as of July 1, 2002, by target group.[8]

[8] These figures include all members whose eligibility for the Family Care benefit had been determined and recorded as of August 8, 2003.

Figure 1: Total CMO Enrollment by Target Group – July 1, 2002



Note: Actual CY 2002 data were used for this analysis. This figure is not based on the sample of Family Care Members used throughout this Independent Analysis. Further, it should be noted that the Milwaukee pilot CMO serves the elderly, hence the large elderly proportion.
Source: APS analysis of Medicaid eligibility data.

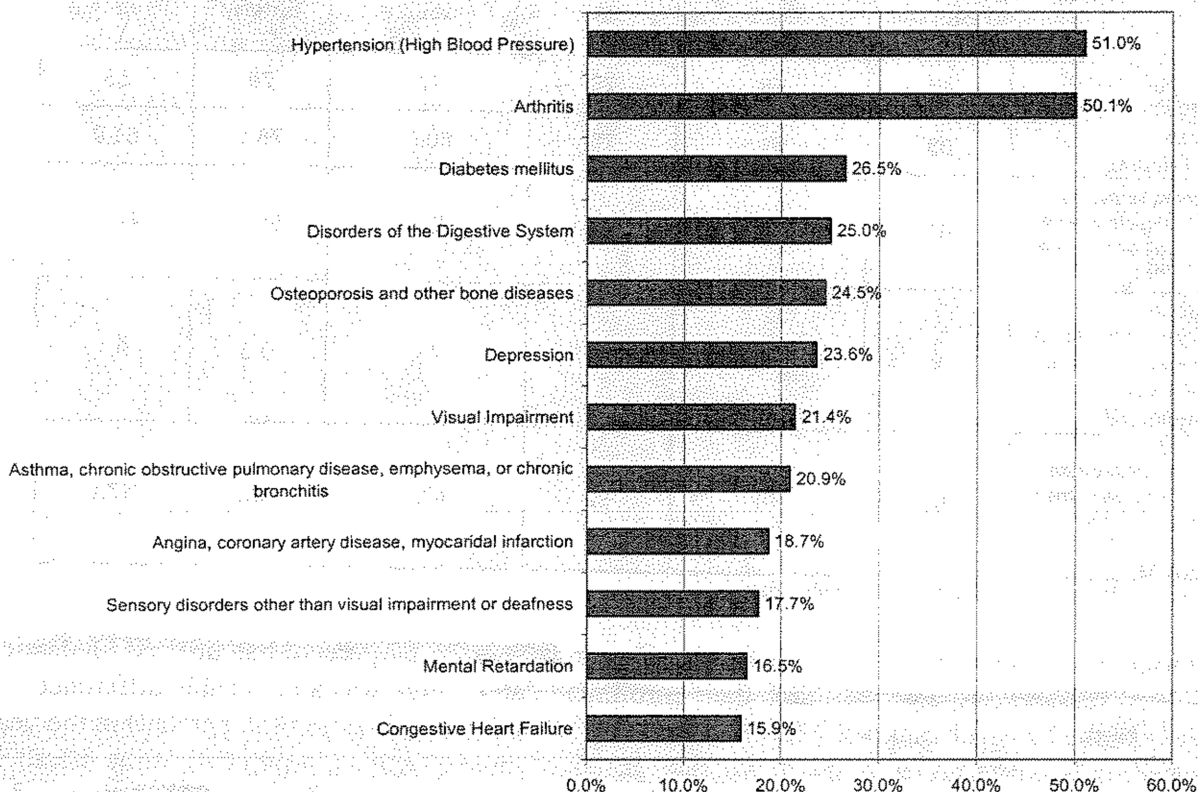
C. *Most Commonly Occurring Diagnoses*

Figure 2 represents the 12 most commonly reported diagnoses among Family Care individuals who are in the Independent Assessment cost-effectiveness analysis and were enrolled as a Family Care member on July 1, 2002[9]. These individuals are able to report, where applicable, multiple diagnoses. DHFS conducted a similar examination of members who were enrolled in Family Care on December 31, 2000.[10] While the three most frequently noted diagnoses are the same at both points in time, there are slight changes that reflect differences between the enrollment patterns that have taken place over this period of time. For example, Visual Impairment was reported by 21.4 percent of the Family Care Independent Assessment population in July 2002 (ranked sixth) and this diagnosis was not reported among the top 15 diagnoses in December 2000. Mental retardation ranks as the fourth most frequent diagnosis in the December 2000 analysis with 21.1 percent of eligible members citing this condition, but moves down to eleventh in July 2002 with 16.5 percent of the Family Care members indicating this diagnosis.

[9] All analyzed data from this point forward is for the Family Care IA and Comparison Group sample populations. While dementia is prevalent among Family Care members, it does not emerge in this list due to the more than 1 categorizations of dementia within the Long-term Care Functional Screen.
[10] Department of Health and Family Services, Office of Strategic Finance, Center for Delivery Systems Development. Family Care: A Pilot Program for Redesigned Long-Term Care. May 2002 Progress Update. Table 3.

In all likelihood, many of these changes can be attributed to the increasing elderly population in the Family Care program.

Figure 2: 12 Most Frequently Reported Diagnoses for Family Care Members Eligible July 2002



Note: Diagnoses are based on percentages for the Family Care Independent Assessment Population (N=3780) who were eligible July 1, 2002. Each individual's most recent LTC Functional Screen was utilized.
Source: APS analysis of Medicaid claims data.

D. Demographics

The majority of Family Care members, as of July 2002, were women. Just over two-thirds (70.2 percent) of the participants were women with a mean age of 74 years. At that time, male participants had a mean age of 64 years, while the overall population had a mean age of 71 years. Collectively, the four non-Milwaukee CMO counties had 64.3 percent of their membership from women while the Milwaukee CMO is made up of 74.9 percent women, reflecting the fact that women, on average, live longer than men and the Milwaukee CMO membership is limited to the elderly (See Table 4 below).

Table 4 Family Care Independent Assessment Population Characteristics						
	Family Care Geographic Compositions			Target Group		
	All CMO Counties	Non-Milwaukee CMO Counties	Milwaukee CMO	Developmental Disabilities	Frail Elderly	Physical Disabilities
Average Age at Enrollment (years)	67	58	76	47	79	53
Gender (% Female)	68	61	76	50.6	76.1	61.9
Percent Waiver or COP eligible in Year Prior to Family Care Enrollment	67	56	78	63.1	66.8	64.4
Percent Institutionalized in the 6 months prior to Family Care Enrollment[11]	9	9	10	7.4	9.3	9.1
Percent Medicaid/Medicare Dual Eligible in the 6 months prior to Family Care Enrollment	83	74	92	47.7	72.2	47.1

Source: APS analysis of Medicaid eligibility data.

Among those who were eligible for Family Care in July 2002, 67 percent had utilized Medicaid covered services in the year prior to their enrollment date. There was a noticeable difference between the non-Milwaukee CMOs, who had lower Medicaid utilization (56 percent) in the year preceding Family Care enrollment, where as just over three quarters (78 percent) of the members in Milwaukee had prior Medicaid utilization during this same period. Further, Milwaukee had a much higher percentage of its members who were dually eligible for Medicaid and Medicare in the six months prior to their enrollment (92 percent) compared to 74 percent in the non-Milwaukee CMO counties. This only stands to reason given that the Milwaukee CMO's primary target group is individuals over the age of 60, the majority of whom are eligible for Medicare coverage.

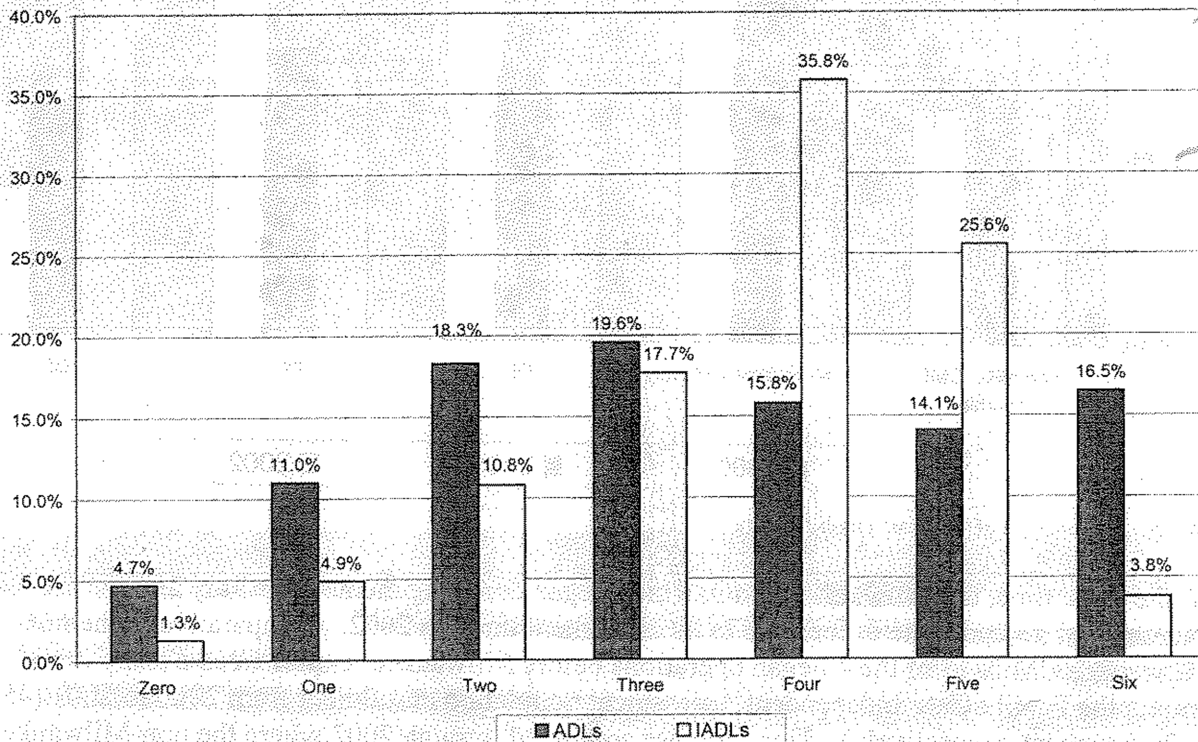
Family Care eligibility designations to the two levels of care (comprehensive or intermediate) were similar for elderly and developmentally disabled members, but those members with physically disabilities had a larger percentage of individuals with an intermediate level of care[12]. Among the members with developmentally disabilities, 97.2 percent had comprehensive eligibility. Among the frail elderly members, 6.9 percent were determined to have intermediate

[11] For Purposes of the Family Care Independent Assessment Evaluation, residing in an institution is a collapsed figure for Nursing Home or ICF-MR facility or State DD Center. This figure is representative of having any institutionalization in the six months prior to Family Care enrollment. For the study sample, this time frame ranged from August 1999 through July 2002.

[12] Family Care functionally eligible levels — the **comprehensive level** is for persons who have long-term or irreversible conditions that are terminal or expected to last at least 90 days and require ongoing care or assistance or the **intermediate level** for persons with those conditions who are at risk of losing independence or functional capacity. Determinations are made through the Long-Term Care Functional Screen during the eligibility determination process.

eligibility and 93.1 percent with comprehensive. Of the members with physical disabilities, 82.3 percent had comprehensive eligibility and 17.7 percent intermediate eligibility. Further, as Figure 4 illustrates, two-thirds of the Family Independent Assessment population (66 percent) report needing assistance with three or more ADL activities. Over three-fourths of the population (82.9 percent) report requiring aid with three or more IADLs.

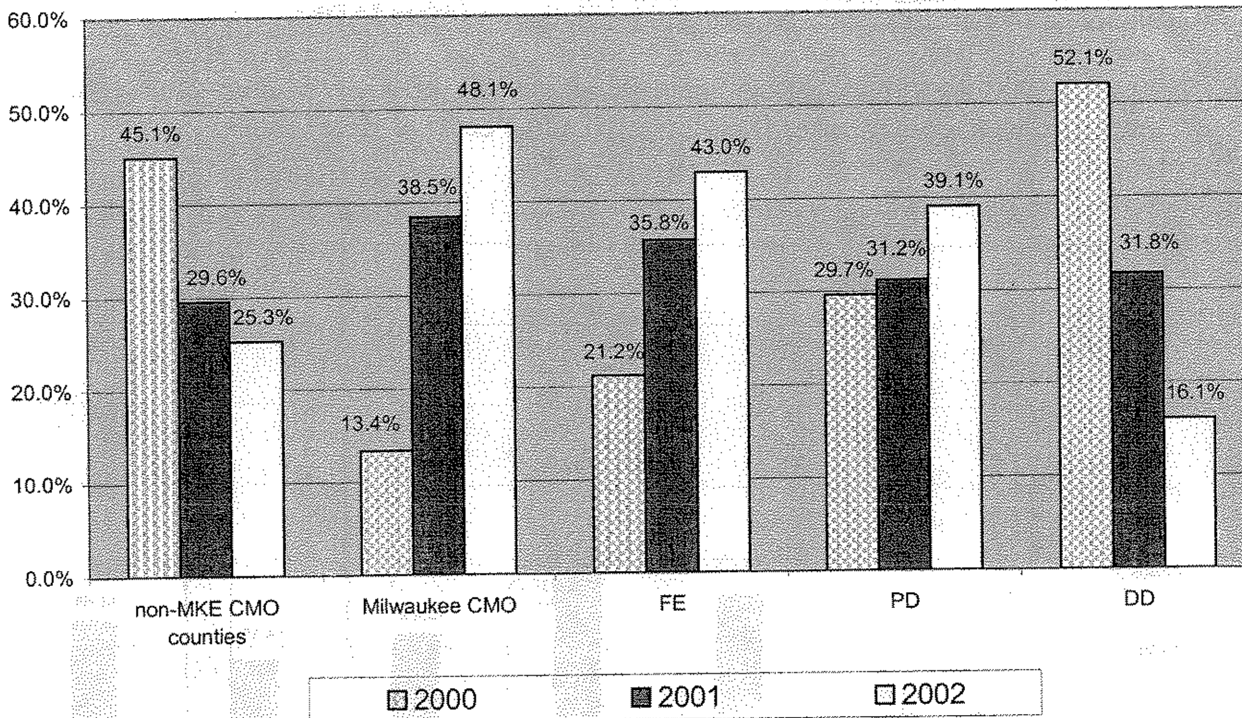
Figure 3: Percent of Family Care Population Reporting Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Level of Help Counts



Source: APS analysis of Long-Term Care Functional Screen (LTCFS) data.

Finally, observing the enrollment cohorts by year for 2000 through 2002 among target groups, and between the non-Milwaukee and Milwaukee CMOs provides information as to the changes in demand of various services that have taken place during this time. Members with physical disabilities enrollment rose slightly between 2000 and 2001 (29.7 and 31.2 percent, respectively), with a more substantial gain coming in 2002 (39.1 percent). While elderly members saw a steady state of enrollment growth during this three-year period (21.2, 35.7 and 43.0 percents), the enrollment cohorts for Developmentally Disabled members from the Family Care Independent Assessment population experienced rather sharp declines over this same timeframe (52.1, 31.8, and 16.1 percent).

Figure 4: Enrollment Cohort Patterns – CY2000-2002



Source: APS analysis of Medicaid eligibility data.

At the same time, the Milwaukee CMO, which began enrolling members in July 2000, encountered a steady rate of increase in its enrollment through 2002. Comparatively, the non-Milwaukee CMOs (3 of the 4 began operations before Milwaukee) experienced a sharp drop among the Family Care Independent Assessment population enrollment from 2000 to 2001 (45.1 to 29.6 percent, respectively). This decrease continued through 2002 where the non-Milwaukee CMOs reported 25.3 percent.

V. Access to Care

Improving access to services is an important goal of the Family Care program and the program is designed to improve access in a number of different ways. First, the Resource Centers are intended to offer individuals better and more accessible information on available long-term care services. Access to services could also be improved through Family Care because of the expanded benefit package and the designation of an inter-disciplinary team to coordinate service in the Family Care benefit, and primary and acute health care services covered by Medicaid on a fee-for-service benefit. Family Care accomplished one of its primary goals with the elimination of the waiting lists in all CMO counties by the end of CY 2002.

The Independent Assessment review of access to care focuses on the following:

- Family Care Access Component Contract Requirements
- EQRO Site Reviews
- Access Monitoring Activities
- Prevention/Early Intervention Services
- Provider Network Capacity
- Long-Term Care Functional Screen
- Enrollment Consultants
- Disenrollment
- Utilization of Long-Term Care and Other Health Services (presented in the Cost Effectiveness section of the report)

A. Family Care contract requirements (Access to Care)

Whether or not Family Care can meet its goal of improving access to services is dependent, in large part, on the CMOs who arrange and pay for long-term care services and coordinate other health services for it members on behalf of the State and on the Resource Centers who are the point of entry for the program. Consequently, there are a number of contractual requirements related to access to care for both the Resource Centers and the CMOs.

Under contract, the Resource Centers are required to have a Family Care access plan, which assures that individuals eligible for Family Care are able to access all benefits available under Family Care. The Resource Centers provide consumers with a screening process, and the major contract requirements relating to access include:

- The LTC Functional Screen, for eligibility, determines if a person qualifies for the comprehensive functional level or the intermediate functional level.
- Financial Options Counseling, used to make a preliminary determination of financial eligibility for Family Care.
- LTC options counseling, which, prior to enrollment, assists consumers in the decision-making process by offering information and counseling regarding their choices. Options counseling is also required of the Resource Center before individuals disenroll from the CMO.
- If an individual is determined to be functionally eligible, but is still awaiting the financial eligibility determination for the Family Care benefit, the Resource Center is required to refer these individuals to the appropriate provider if urgent services are needed. In these

cases, the Resource Center is also responsible for letting the individual know that they will be responsible for any costs for these services if they are determined to be financially ineligible for Family Care.

Some contractual requirements are also made of the CMOs in terms of access. The major access-related requirements are:

- Enrollment must be kept open to all individuals who meet the eligibility requirements.
- The CMO is required to provide, or arrange for the provision of, the services an eligible member qualifies for.
- The CMO is required to coordinate Family Care services with other services the individual receives that are outside the benefit package.
- Coverage is required to be available 24 hours a day, seven days a week.
- A CMO employee is designated as the member advocate.
- Interpreter services must be provided by the CMO when needed.

There are also CMO requirements in terms of access that are related to service providers. The major requirements are:

- The CMO is required to allow free choice of providers for services in the LTC benefit package that relate to intimate personal needs or when a provider frequently comes into the member's home. The CMO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the CMO's subcontract for subcontractors of the same service. These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service.
- The CMO is required to maintain contractual agreements with a network of providers who must meet State requirements.
- The CMO can pay the family members of its clients under certain conditions.
- Both CMO staff and service providers should maintain environments in which cultural competence is promoted.

B. *State Monitoring Activities of CMO Access Standards*

DHFS also has its own methodology for measuring access to services for CMO members. In order to evaluate whether or not the CMO's provider network is adequate to provide required care to the members, Wisconsin utilizes a range of methods, both before and during the time the contract is in effect.

Before the start of the contract, the CMO is required to perform a needs assessment for its provider network. Also, the CMO has to provide the following, for every service in the benefit package, both before the start of the contract and before it can be renewed:

- For each service, the number of providers under contract.
- What kind or kinds of provider will supply each kind of service.
- Where are the providers physically located, and are they situated inside the CMO's service area.
- Does the provider serve all of the target groups, or only particular groups.
- Does the provider have strengths in cultural and linguistic competencies.

- For residential service providers, how many individuals can they serve, do they have private rooms, and what are their hours of operation.
- Is the provider accepting new members.

This information is provided to DHFS as part of the certification process, and in this manner, the Department can ensure that the full range of covered services will be available to members through the CMO's service provider network, with adequate capacity. This can be fulfilled either by CMO employees, or by providers under subcontract to the CMO. Additional sections of the certification review include a site visit with CMO staff in charge of contracting with providers, and a review of any other materials provided to DHFS by the CMO.

DHFS shares its findings from the review with the CMO, including informing the CMO if any additional documentation is required in order to proceed with signing the contract with the Department. If necessary, the Department requires participation by CMO staff in training and technical assistance sessions. Also, the Department may have specific performance measures for the period of the contract that are tied to the CMO's provider network. These would be part of the contract through an amendment. Progress in these areas is reviewed by the Department during the time of the contract.

DHFS also conducts site visits annually to evaluate the functioning of the CMO. This site visit reviews the geographic coverage provided by the CMO's service provider network, as well as the timeliness of services provided to members. If the CMO uses any providers outside its geographic service area, justification as to why this is necessary and what benefit it provides is required. Overall, the review is a thorough on-site examination of the CMO's policies, procedures and processes, and includes staff interviews.

Additionally, the Department utilizes regular CMO monitoring reports to share the status of access and capacity elements of the program. Annual performance reviews are used to determine if any provider network issues are present. If there are any concerns, the CMO has opportunities to discuss these with the Department and correct them. If the concerns are not remedied in an appropriate or timely manner, DHFS can take steps to address this according to policy.

C. *Access Monitoring Activities*

Successful access to the Family Care benefit requires coordinated efforts by the local Resource Center, the county's Economic Support Unit (ESU), and the regional Enrollment Consultant. However, the final eligibility determination process that precedes enrollment is the responsibility of the ESU. Enrollment in Family Care can take no longer than 30 days, barring delays sought by the consumer, from the time a consumer first expresses a desire to join Family Care to the date when enrollment is confirmed.

During the first two years of Family Care operations, considerable work was needed to design and implement systems to coordinate enrollment activities among the local agencies. These efforts were described in detail in the Lewin implementation reports[13].

[13] The Lewin Group. Wisconsin Family Care Implementation Evaluation Process Update Reports I (November 2000), II (August 2001), III (December 2002).

EQRO activities in 2002 did not include a formal review of program access, but conversations with state-level staff have highlighted a major challenge to monitoring program access and compliance with the 30 day enrollment requirement. Family Care state-level staff have desktop access to an extensive array of Family Care data, such as member level service data and LTCFS data. However, these staff do not have direct access to the Client Assistance for Re-Employment and Economic Support (CARES) system, the data system used by the ESU to determine eligibility and finalize Family Care enrollment. CARES is the only source of information for determining the length of the enrollment process at an individual or aggregate level.

While DHFS did not routinely monitor the 30 day enrollment process in 2002 using data from CARES, staff were made aware of access problems through other mechanisms such as member complaints and grievances. DHFS has indicated that many of the early problems with enrollment processing were resolved by 2003, with the exception of Milwaukee County.

In Milwaukee County, communication and coordination issues between the Resource Center, the Economic Support Unit, and the CMO continued to result in enrollment-processing times that routinely exceeded 30 days. A review of 130 new Milwaukee Family Care enrollments that took place from January 2003 through April 2003 found that 37 percent exceeded 30 days in processing. With concerted technical assistance from Department staff, this proportion fell to 18 percent by June 30, which is an improvement but still out of compliance with expectations and requirements. Milwaukee County submitted a plan for improvements in the Family Care enrollment process to the Department in mid-August 2003, and the Department will require additional specific plans for implementation and monitoring in the near future.

It is recommended that DHFS develop routine CARES reports to monitor access to Family Care at a county level. These reports could be generated monthly to identify the minimum, maximum and average time it takes for an individual to be enrolled in Family Care by county. The report should also identify the number of cases pending for enrollment that have been open for more than 30 days so that DHFS can track these cases and provide technical assistance as needed to maximize compliance.

D. Prevention/Early Intervention Services by Target Group

Family Care places an emphasis on prevention and early intervention services. This is evidenced by the fact that CMOs are contractually required to provide prevention and wellness services to all of their members.

1. Visits to Primary Care Physicians

Visits to a primary care physician are often used as an indicator of program quality. It is thought that these visits can increase opportunities for prevention and early intervention health care services in order to reduce more acute and potentially more costly services down the road.

Among the Family Care Independent Assessment population, 66 percent had at least one visit to a primary care physician during 2002. For those members who had one or more visits, the average number of visits was 5.91. The most discernable difference between those Family Care members who had a visit to a primary care physician and those who did not was the length of

time the individual had been a Family Care member. Those who had at least one visit, were a Family Care member for an average of 24.5 months versus 18.7 months for those who did not visit a primary care physician during the year. It is likely that the interdisciplinary care team approach utilized by the Family Care program is responsible for the outcome that individuals who have been in Family Care longer are more likely to have had a primary care visit.

Further significance testing between these two groups revealed significant differences in Family Care eligibility levels, and reported ADL and IADL counts[14]. There were no apparent differences that could be distinguished when looking at characteristics between CMOs. In summary, those who did not have a visit to a primary care physician in 2002 tended to be enrolled in Family Care approximately 6 months less time, were about 5 years older, and had slightly higher ADL and IADL counts with a larger percentage meeting comprehensive eligibility requirements.

Table 5 Characteristics of Members With and Without Primary Care Visits - 2002

Individual Characteristic	At Least 1 Primary Care Physician Visit in 2002	No Primary Care Physician Visit in 2002	Significant Difference
Mean Age	69.4	74.5	
Gender (Percent Female)	70.0	68.0	
Mean ADL Level of Help Count	3.35	3.54	*
Mean IADL Level of Help Count	3.72	3.85	*
Mean Months of Family Care Eligibility	24.5	18.7	**
Percent with Comprehensive Eligibility	90.3	94.6	**

Note: Significance levels = ***<0.01**<0.05; *<0.10. Figures are based on those individuals in the Family Care Independent Assessment Population who were eligible for the Family Care benefit in CY 2002.
Source: APS analysis of Medicaid claims data.

2. CMO Considerations/Situations – Summary of Prevention Literature Review

In order to provide the CMOs with guidance for considerations related to prevention and early intervention strategies, the EQRO conducted a literature review to aid CMOs in their contemplation of what prevention and early intervention projects to undertake[15]. It was determined that the CMOs needed to develop strategies that took into account identified best practice and clinical practice guidelines, focused on disease prevention and were well coordinated. It will also be important to ensure that CMO prevention activities can be implemented in such a way that they stay true to the person-centered care plan model.

Research into prevention activities by the EQRO indicates three primary categories of prevention: primary, secondary, and tertiary. Any comprehensive prevention program should include activities covering all three of these categories. Further, the unique needs of the three target populations should also be included as considerations when developing the prevention program. The following items are issues CMOs will need to consider in developing their selection of prevention and early intervention services as identified by the EQRO.

[14] Variables tested for significant differences included the following: Target Group; Age; Gender; Family Care Eligibility Level; and, ADL and IADL counts.
[15] Angie Morgan/Metastar. Report on Best Practice Prevention Activities for Family Care Members. April 28, 2003.

Primary prevention activities are those that are intended to prevent the occurrence of disease and promote health. Thus, this category includes screenings, medical tests and interventions, and lifestyle/behavioral education. For the CMOs, this translates into providing education to members, and ensuring access to primary prevention medical services. According to the EQRO's findings, for the elderly, this means the prevention and wellness programs ought to include, but not be limited to: exercise (prevents functional disability); nutrition education; and age-appropriate disease screening (e.g., cardiovascular disease, dementia). The EQRO report includes specific screening tests and recommended frequencies.

For adults with physical disabilities, there is a limited amount of research regarding primary prevention. In general, it is recommended to follow guidelines for adults in general. For example, this would include blood pressure and cholesterol screening, and smoking cessation counseling, among others.

The situation is considerably different for individuals with developmental disabilities, including mental retardation and Down's Syndrome. Study findings[16] show that there is an increased amount of such health problems as vision impairment, oral health disease, and mental health conditions, like depression in this population. Some of this may be due to lower use of the health care system; therefore, any prevention program will need to include methods of learning about and removing barriers to health care access for these individuals. As with adults with physical disabilities, it is recommended that adults with developmental disabilities should also follow the same guidelines for primary prevention as adults are advised to generally. However, the exception to note is that there are specific guidelines recommended for individuals with Down's Syndrome. These should be noted and utilized in developing prevention programs.

Secondary prevention activities are often referred to as disease management. This aspect of care comes into play when a diagnosis has already been made. The guiding principle in secondary prevention is that diseases or conditions should be identified as early as possible to maximize success in treating or managing the condition and preventing further worsening of the condition or occurrence of sequelae. Therefore, in order to prevent a worsening of the condition, including any resulting disability, activities should include screenings and medical tests, as well as appropriate lifestyle and behavioral education geared toward the specific diagnosis. An example of secondary prevention is diabetes education and insulin treatments to prevent neuropathies and foot deformities. Good disease management programs will take into account the severity and risk factors of each individual in relation to their condition in order to follow the most effective course of action.

Research suggests that CMOs ought to identify disease prevalence among their populations as a first step. They will then need to implement means for identifying and monitoring individuals with those diseases, and then be able to stratify those individuals identified according to their level of severity and attendant risk factors. This will allow for creation of optimal secondary prevention programs.

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[16] Horowitz SM, Kerker BD, Owens PL, Zigler E. The Health Status and Needs of Individuals with Mental Retardation. Department of Epidemiology and Public Health, Yale University School of Medicine. Department of Psychology, Yale University. September 15, 2000. Revised December 18, 2000.

Tertiary prevention is focused upon promoting as much independent function as possible while preventing worsening of the condition or disease. This would include, for example, amputating the damaged leg of a person with diabetes-related complications. The key guideline for tertiary prevention activities among all persons is that it should occur with maximum sensitivity to the individual, and timeliness to minimize to the extent possible the need for interventions. Education for the individual is also extremely important for good outcomes. CMOs should emphasize good access to medical assessment and treatment for members affected by advanced illnesses. In order to maximize the individualized, person-centered approach desired, CMOs should also have strong ties for collaboration with primary and specialty health care providers in order to best tailor management programs for affected persons.

A more thorough description of these recommendations can be found in the EQRO Annual Report. It is anticipated that this literature review will inform future EQRO assessments of CMOs in this area.

E. Long-term Care Functional Screen

The Long-Term Care Functional Screen (LTCFS) serves a dual purpose for the Family Care Program. It is one component of the pre-admission counseling provided by Resource Centers, and it is also used to assess functional eligibility for Family Care participants on an on-going basis. Because Family Care incorporates many different services, funding streams, and populations, DHFS developed a tool that would apply to a range of individual situations and living environments.

This comprehensive screen gathers the following information:

- Demographic characteristics
- Living arrangements
- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)
- Medical diagnoses
- Health-related needs
- Cognitive abilities
- Behavior/lifestyle/risk factors

The length of time required to complete the screen depends on each individual's status at the time of administration. Although the instrument's principal purpose is to assess the functional needs of the individual and to determine eligibility for Family Care, additional information is gathered, which can later be used by CMO staff to assist in determining service needs.

To assure that the screen is completed properly and will produce valid results, those who administer it are required to have a bachelor's degree in health, social services, or a related area. Specific training for the screen, which provides an opportunity to complete trial screens, is also provided. Additionally, a certification exam is required before access to the Functional Screen is granted.

Functional Screen results are very important to CMOs because a portion of the CMO's capitation payment is based upon the functional level of its members as determined by the LTCFS. Even

gradations within levels of care (comprehensive or intermediate) can affect the amount of capitation payments[17].

In calendar year 2002, 7,043 individuals were assessed using the LTCFS. Among those individuals, 79.0 percent were deemed to be frail elderly members, 11.5 percent were determined to be members with developmental disabilities and 9.5 percent were physically disabled members. (Section IV. A.) of this report provides more detailed information of LTCFS results.

F. *Enrollment Consultants*

Under the Family Care waivers, CMS requires that Family Care applicants receive information about the variety of service options available to them. This information is to be made available by an unbiased enrollment consultant who is charged with protecting the interests of the applicant. CMS has determined that the enrollment consultant cannot be someone who works for the county that operates the CMO.

Beginning in January 2002 (April 2002 for Milwaukee), counties incorporated an independent Enrollment Consultant into the enrollment process for the Family Care benefit. Presently, DHFS contracts for this service in the five Family Care pilot counties with the Southeastern Wisconsin Area Agency on Aging (SEWAAA). The agency employs three full-time equivalent staff to carry out the enrollment consultant function. One full-time staff person covers La Crosse, Portage, and Richland counties. The other two full-time positions are shared among three individuals and serve Milwaukee and Fond du Lac counties.

The Enrollment Consultant enters the process after receiving a referral notification from either the Resource Center or Economic Support Unit after eligibility has been determined for an individual. Then, contact is made with the consumer within three days, on average. The individual chooses whether a meeting with the Enrollment Consultant will occur face-to-face or via telephone conversation, and works with the Enrollment Consultant to determine a convenient time for the meeting. The enrollment consultation generally consists of a single meeting unless the individual requests an additional telephone or face-to-face meeting.

Through their work as the Enrollment Consultant, SEWAAA is contracted to ensure that members are provided with accurate and unbiased information that has been tailored to the potential member's specific circumstances. Further, the Enrollment Consultant is expected to determine how much understanding the potential member has of the Family Care program as well as address any questions about this program or others programs for which he/she might be eligible. Specifically, information the Enrollment Consultant provides the potential member includes the following:

- Outlining aspects of different programs and services, including quality, costs, outcomes, estate recovery, residential services, available resources, and compatibility with the individual's preferred lifestyle.

[17] Family Care functionally eligible levels — the **comprehensive level** is for persons who have long-term or irreversible conditions that are terminal or expected to last at least 90 days and require ongoing care or assistance or the **intermediate level** for persons with those conditions who are at risk of losing independence or functional capacity. Determinations are made through the Long-Term Care Functional Screen during the eligibility determination process.

- Identifying the spectrum of services available should the individual decide not to enroll in the Family Care program, including community services, nursing home, case management, home care and other residential services.
- Detailing consumer rights and responsibilities, including the complaint and grievance and fair hearing procedures.
- Specifying the entirety of publicly funded long-term care program options, including Family Care services and, Medicaid state plan services (as well as the Wisconsin Partnership Program and PACE in Milwaukee county).

For those counties where there is more than one managed long-term care program from which to choose (at the present time, only Milwaukee county), the Enrollment Consultant shares detailed information with the individual that compares and contrasts the various choices, outlining what services each program offers and what services it does not. Further, any confines or restrictions on obtaining certain services and all relevant information about the quality of services in the various programs are specified by the Enrollment Consultant.

Upon the completion of the enrollment consultation, the Enrollment Consultant determines whether or not the individual wants to enroll in a Family Care CMO or a similar managed care organization or program. Should the individual decide not to enroll in the Family Care program, the Enrollment Consultant informs the Resource Center of this decision as soon as possible via a written notice, telephone call, or E-mail message, unless an otherwise specified mode of contact exists within the Family Care Access Plan. Otherwise, the consumer would move on to the CMO for enrollment. At the present time, only Portage and Richland county CMOs are notified when a person decides to enroll. The Richland CMO receives an Enrollment Consultant form through Winzip electronic file transfer and Portage receives one by fax, once again using their own enrollment form that the Enrollment Consultant signs and dates. The CMOs are not notified by Enrollment Consultants in the other pilot counties (La Crosse, Fond du Lac and Milwaukee). Who is contacted when a person does or does not enroll was determined by the Resource Center and CMO during meetings they had with the Enrollment Consultants when the Enrollment Consultant Program began. In sum, the process is different, to some degree, with each county.

1. Value of the Enrollment Consultants

The function the Enrollment Consultants provide is a valuable one. While their purpose is one of quality assurance, guaranteeing that all individuals clearly understand and are presented all relevant information and choices, the Enrollment Consultants provide value added services beyond preventing conflicts of interest. Additionally, the value of this far exceeds the approximate two hours and related cost invested in the Enrollment Consultant.

Prior to the implementation of the Enrollment Consultants, the CMOs had expressed concerns about the introduction of an additional person with whom consumers would interact, which could potentially make the enrollment process overly complex. However, during site visits with the CMO counties and with the Enrollment Consultants, it seems that this concern has not manifested itself. Rather, the Enrollment Consultants seem to provide consumers and their

family members with a face on the system that might not otherwise be present in helping them clearly understand what options they have to choose from.

While they are not serving as an advocate, Enrollment Consultants operate more as an intermediary to ensure clarity for the individual and/or their family. For example, Enrollment Consultants are frequently contacted after initial meetings to address follow-up questions from consumers. In other less frequent instances where consumers died after meeting with the Enrollment Consultant, family members made a point to contact the Enrollment Consultant to alert him/her of this situation. Clearly, this action would indicate that a connection had developed between these parties. Also, where consumers had misunderstandings about their eligibility for certain programs and services, the Enrollment Consultants were able to ensure full understanding of what benefits they were eligible for and those that they were not.

2. Areas for Improvement and Recommendations

Overall, the inclusion of the enrollment consultant within the system is a valuable asset. In addition to ensuring that consumers and their family members are provided with clear and comprehensive information on all eligible managed care programs and services, the Enrollment Consultants also fulfill a void that would otherwise be present. Although the process seems to be stable for the most part, there are certain aspects that DHFS might address for improvement, particularly in the context of considering statewide expansion of the Family Care program.

At the present time, there is no specified or standardized reporting method and format between the Resource Center and Enrollment Consultant. As a result, the Enrollment Consultants receive varying levels of detail and quality of information from each of the pilot counties. For example, the Enrollment Consultants receive information in the form of fax, password encrypted and regular E-mail documentation, and other forms of communication. The lack of continuity of this reporting process can potentially cause the Enrollment Consultants to spend unnecessary time deciphering hand written materials, checking for name misspellings, Medicaid eligibility, incorrect dates of birth or social security numbers. Currently, only Fond du Lac and Richland counties use the detailed, electronic reporting format based on the PACE and Wisconsin Partnership programs, which was provided by DHFS to the CMOs as an example. Investing time up front to accurately complete and detail consumer information will benefit the program by ensuring that participants in all five CMO counties moves through the Enrollment Consultant process at a pace where quality is not compromised.

Finally, Richland County is the only pilot that has regular meetings (twice a month) with their Enrollment Consultant. Granted, Richland is the smallest of the pilot counties and does not face the time and volume constraints larger pilot counties do. However, other pilot counties, as well as those counties poised for expansion of the Family Care program, might benefit from regularly sharing information with an Enrollment Consultant to make certain that any recurring problems or inconsistencies consumers might be facing can be addressed and rectified. For example, it was noted in meetings with the Enrollment Consultants that it is not uncommon for them to meet with consumers who are under the impression they are Medicaid eligible and want Medicaid card services who turn out to be non-Medicaid eligible, but it was not properly indicated in the

correspondence between the Resource Center and the consumer or the Resource Center and the Enrollment Consultant.

G. *Provider Network Capacity*

In order to assure that members have sufficient access to services, as part of the contract between DHFS and the CMOs, CMOs are required to provide information on their provider network (including provider/agency name, location, services furnished by the provider, and whether the provider is accepting new CMO members or not) as evidence that there is adequate capacity to serve the membership. However, provider network capacity could not be evaluated as part of the Independent Assessment because the provider network data available from the Department was in various documents and was incomplete. For example, only information for two counties (Milwaukee and Portage) was available for CY 2002. A compilation of the available data is provided in **Attachment 2**.

1. Site Visit Comments Pertaining to Provider Networks

Additional pieces of information related to the provider network were gleaned through site visits during the Spring of 2003 (see Section VIII. A. 1. for additional details of these site visits). CMOs noted, in general, to have more providers available than initially expected. Surprising to those counties were services for members with developmental disabilities that had been a difficult area in the past with service providers for these members ended up being more plentiful than anticipated. The most frequently mentioned shortage of a particular type of service provider was that of home health care workers. The primary reason mentioned for this was that the Medicaid reimbursement rate is low[18]. An additional noted service that was doing well across counties was that of skilled nursing, a previously unmet need that was now being fulfilled. Access to sufficient numbers of transportation providers was noted by at least one more rural county.

In terms of "buy-in" to the Family Care program by the providers in the CMO counties, supportive employment continues to improve among the counties while pharmacy and durable medical supplies and equipment providers were noted several times as working well with members and embracing the spirit of the program. Additionally, if there is a provider who is outside of the existing network, but is preferred by a CMO member, CMOs indicated a willingness to bring them into the network as long as the provider agrees to meet all of the contractual obligations. This is an aspect of the Family Care program that was noted as very positive by all CMOs and the CMOs cited few instances where members desired a provider not in the network and fewer instances where they could not come to terms with the provider chosen by the member.

2. Variances from Medicaid Payment Rate

For services provided by the CMO under the Family Care capitation rate, the CMO is required to pay the provider the comparable Medicaid rate for that services. For example, if Medicaid pays $80 for a home health nurse visit, the CMO is supposed to pay $80 for that same service. In keeping with the goal of making Family Care a flexible program that meets local needs, a provision was created to allow CMOs to seek a waiver from these payment level requirements.

[18] CMOs pay a Medicaid reimbursement rate or seek a waiver.

To date there have only been two instances where CMOs have made a request to deviate from the current Medicaid rate. These requests were made by Portage and Fond du Lac counties. The Portage county CMO asked for a waiver to pay over the Medicaid rate for adult diapers. This request was made so that higher quality diapers could be purchased when necessary. DHFS approved this request with a conditional blanket waiver. The condition of the approval was that the CMO would indicate in its care plan the reason the higher quality product was needed.

The Fond du Lac county CMO requested a transportation variance waiver. The reason for this request was that Medicaid transportation has numerous authorization codes and associated rates. Since each of these codes are associated with a specific set of services within the benefit, the Fond du Lac CMO wanted to collapse categories for a more streamlined process for billing and payment purposes. These five new aggregated categories included Medicaid trip, Medicaid miles, Non-Medicaid trip and Non-Medicaid Miles and Medicaid wait time. This request was approved by DHFS and is presently being utilized in Fond du Lac county.

These two examples illustrate the flexibility the Family Care program offers to better serve program members with higher quality services as well as providing the CMOs with operational flexibility to more efficiently work with providers in their network.

H. Family Care Disenrollment Process

All Family Care members have the right to disenroll from Family Care at any time for any reason. If a Family Care member expresses a desire to disenroll from the program, the CMO makes a referral to the Resource Center for choice counseling and the Resource Center notifies the CMO as to the member's final decision. The CMO is responsible for providing services until the official date of disenrollment. CMOs are prohibited from counseling or otherwise influencing a member regarding disenrollment.

Individuals may be disenrolled from the program if he or she loses eligibility for any of the following reasons:

- The member fails to meet functional eligibility requirements.
- The member fails to meet financial eligibility requirements.
- The member moves out of the CMO service area.
- The member fails to pay or make arrangements to pay any required cost share (the CMO is required to grant a 30 day grace period).
- The member becomes ineligible for Medicaid because they are an inmate of a public institution.
- The member becomes ineligible for Medicaid because they are under the age of 65 and are a patient in an institution for mental diseases (IMD).

Death of a member is also considered a disenrollment for reporting purposes.

A CMO cannot involuntarily disenroll a member from the program without approval from DHFS. If a CMO submits a request for disenrollment to DHFS, the CMO must inform the member of the request and refer the member to the Resource Center for choice counseling and potential transition to fee-for-service Medicaid.

The following table provides a summary of Family Care disenrollments through calendar year 2002:

Table 6 Cumulative Disenrollments through December 31, 2002

	Deceased	Voluntary Disenrollment	Lost Eligibility	Total
Fond du Lac	171	78	12	261
La Crosse	221	73	40	334
Milwaukee	557	237	96	890
Portage	135	38	5	178
Richland	36	11	1	48
Total	1,120	437	154	1,711

Source: APS analysis of county disenrollment data.

Analyses conducted on cumulative disenrollments for CYs 2000-2002 revealed that when all reasons for disenrollment are included, not excluding a members death, there was an 11.1 percent total of disenrollments. However, when excluding deceased members from the analysis, the percentage decreased to 5.6 percent[19]. This figure is well within national norms for disenrollment rates for members being served by the Family Care program[20].

Historically, DHFS has not been able to report comprehensive data on the reasons individuals disenroll from Family Care, because it does not have a system for maintaining disenrollment data. As described above, members who express a desire to disenroll from the program are referred to the Resource Center who is responsible for completing a disenrollment form. These forms are maintained by the counties, unless the county is unable to enter the disenrollment date in CARES, then the form is sent to DHFS for processing. Data from those forms is extracted and maintained by the Department. In addition, Resource Centers report aggregate disenrollment data to DHFS, which is accompanied by a narrative that offers some insight into the reasons for disenrollment.

Based on these narratives and the disenrollment forms received by DHFS, the four most common reasons for disenrollment have been identified as:

1. Member had found other ways of meeting long-term care needs, such as family or friends.
2. Member had concerns about Family Care cost-share and estate recovery requirements.
3. Member prefers fee-for-service care, including nursing home care[21].
4. Members in Milwaukee County chose to enroll in another Medicaid managed care program, most notably the Partnership Program.

[19] Figures based on APS analysis of disenrollment data through the HSRS LTS query for CYs 2000-2002 for all Family Care members.

[20] Perlberg, Art. Presentation the *Serving Persons with Disabilities in Medicaid Managed Care: Assuring Continuity, Quality, and Cost-Effectiveness* Technical Assistance Conference. April 17, 2002. Los Angeles, CA. Co-Sponsored by Health Resources and Services Administration and the Centers for Medicare and Medicaid Services.

[21] While nursing home care is a covered benefit under Family Care, the CMO may determine that the member can receive appropriate, high-quality care in the community at a lower cost than the nursing home.

The following table provides a summary of disenrollment data extracted from the subset of disenrollment forms processed by the Department, which appear to represent approximately 10% of all disenrollments[22]. Although DHFS maintains cumulative tabulation of disenrollments, failing to examine and review data for isolated quarterly and annual time periods prevents DHFS from being able to readily identify instances of excessive disenrollment trends and patterns.

Table 7 Reasons for Disenrollment – Non-Random Sample of Forms (N=115)

	Services Not Needed	Finance-Related	Prefers Other Program*	Prefers FFS Medicaid	Prefers FFS Nursing Home	Dissatisfied with CMO	Unknown Reason/ Multiple Reason
Fond du Lac	0	1	N/A	8	2	1	0
La Crosse	3	1	N/A	0	7	0	1
Milwaukee	11	9	11	0	22	2	26
Portage	2	4	N/A	0	1	1	2
Richland	0	0	N/A	0	0	0	0
TOTAL	**16**	**15**	**11**	**8**	**32**	**4**	**29**

Note:* Other Medicaid Managed Care programs are only available in Milwaukee County.
While Richland County shows no disenrollments from this 115 sampling, a HSRS query for CY 2002 found that the Richland County CMO had only 1 identifiable disenrollment. The noted reason was involuntary disenrollment.
Source: APS analysis of county disenrollment data.

Recognizing the need for better data on the reasons that people choose to leave Family Care, DHFS has been working with the Resource Centers to develop new guidelines for recording and reporting disenrollments. In April 2003, Resource Centers were instructed to record a single, primary reason for every disenrollment from the following list:

Loss of Eligibility

- Loss of financial eligibility
- Loss of functional eligibility
- Incarceration or IMD placement
- Moved out of service area
- Non-cooperation with re-certification
- Unwilling to pay cost share
- Estate recovery

Personal Choice

- No longer needs services
- Wants to enroll in another program
- Wants fee-for-service care
- Other personal choice disenrollment

When a member cites a reason related to personal choice, the Resource Centers have been asked to ask additional questions to determine whether or not the member was dissatisfied with the

[22] DHFS does not maintain disenrollment data by calendar year. The 4th quarter 2001 Family Care Activity Report indicates that there were 651 cumulative disenrollments through February 2002. The 4th quarter 2002 Family Care Activity Report indicates that there were 1,711 cumulative disenrollments through December 2002. A query of HSRS LTS data was conducted by APS Healthcare for CY 2002 and revealed a total of 475 disenrollments.

CMO or the Family Care benefit and, if so, why. Counts of disenrollments by the new reason codes and brief narratives on personal choice disenrollments are forwarded to DHFS quarterly.

In addition, the protocol for member care plan reviews performed by the EQRO has been modified so that assessments and care plans of disenrollees are no longer excluded from the sample. A special review tool was developed for reviewing the records of individuals who are no longer active CMO members and EQRO staff will be looking for apparent quality issues and whether or not disenrollment procedures were followed appropriately.

Finally, DHFS has conducted two ad-hoc reviews to look more closely at instances where an individual disenrolls from Family Care and then immediately receives fee-for-service nursing home care. The Department has found that the circumstances involved a complex set of actions and decisions by the CMO, the member, the member's family and other involved individuals, such as nursing home staff or the member's physician.

Between 2000-2002 among the Family Care Independent Assessment Population, there were 446 unique individuals who disenrolled from the Family Care program. The two most prevalent reasons for disenrollment among these individuals were 'Deceased' (57.8 percent) and 'Voluntary Disenrollment' (20.2 percent), followed by a distant 'Not or No Longer Income Eligible' (5.8 percent).

Over two-thirds of these individuals are elderly (69.7 percent). Of the remaining individuals, 20.9 percent have physical disabilities and 9.4 percent have developmental disabilities. Women accounted for 66.8 percent of individuals who disenrolled. Each of the five CMO pilot counties had some individuals who disenrolled, with La Crosse having the highest percentage (35.4) and Richland the lowest percentage (0.2) among the 446 individuals (Fond du Lac, Milwaukee and Portage had 30.3, 20.0 and 14.1 percent, respectively). Among elderly members, 74.9 percent had three or more ADLs and 86.8 percent had 3 or more IADLs. Members with developmental disabilities had overall ADL and IADL means of 2.83 and 4.43, respectively. Those members with physical disabilities had ADL and IADL means of 3.02 and 2.60.

It is recommended that DHFS establish disenrollment "red flags" based on information that has been collected and analyzed thus far. By utilizing historical data from the program DHFS staff will be better suited to recognize trends and patterns, understand them more thoroughly, and differentiate them from anomalies. Further, while it has been noted that disenrollment rates are one alternative to using satisfaction measures as a proxy for acceptability, these data are not as robust at providing the unique and detailed insight that disenrollment surveys allow[23].

[23] General Accounting Office. (1998, April). Many HMOs Experience High Rates of Beneficiary Disenrollment (Report to the Special Committee on Aging, U.S. Senate). (GAO/HEHS-98-142); Office of the Inspector General, Department of Human Resources. (1995, March). Beneficiary Perspectives of Medicare Risk HMOs; and Tudor,

Therefore, it is also recommended that DHFS survey those individuals who chose to disenroll from the Family Care program as to why and utilize this information to discover areas in where the program can be strengthened and demonstrate greater member retention.

C.G., Riley, G., & Ingbar, M. (1998). Satisfaction with Care: Do Medicare HMOs Make A Difference? Health Affairs. 17(2), 165-176.

VI. Quality of Services

Family Care is expected to improve the quality of services provided to consumers of long-term care by creating a comprehensive and flexible system, which is focused on both health and social services. Since the implementation of the Family Care program, the Department has invested considerable effort and resources to develop a comprehensive quality assurance and quality improvement (QA/QI) system to ensure the program is meeting is quality goals.

The QA/QI programs focus on member health, functioning and satisfaction. Specifically, QA/QI activities are intended to ensure that the program preserves the preferences, rights, and self-determination of members, and also works for the best possible quality of life for every individual. Assuring the safety and rights of members, while maximizing their ability to define and assess their services is also a QA/QI goal. Measurement of these goals is achieved through a multi-level QA/QI system.

Quality assurance is a shared responsibility between DHFS, Resource Centers, and CMOs. In addition, DHFS has contracted with an External Quality Review Organization (EQRO) who is charged with monitoring State, Resource Center and CMO quality activities. EQRO monitoring includes activities, such as member record reviews, staff and member interviews, and procedural reviews. Technical assistance around quality improvement and assurance is provided both formally (e.g. EQRO site reviews, DHFS quality liaison) and informally (e.g. workgroups facilitated by state staff) on an ongoing basis.

The CMO Family Care contract contains very specific QA/QI requirements. One of the contractual requirements related to quality is the development of an annual written QA/QI plan, which is approved by the CMOs governing board and DHFS. The QA/QI plan outlines the CMOs QA/QI goals, the scope of QA/QI activities and associated timelines. At a minimum, the CMO QA/QI plan must include the following activities:

- Conduct performance improvement projects.
- Implement a process to monitor and detect underutilization and overutilization of services.
- Implement a process to monitor and assess the quality and appropriateness of care provided to CMO members.

CMOs are also required to maintain an information system that can support these QA/QI activities. At a minimum, the system must include data on utilization, grievances and appeals and disenrollments.

Through the development of a comprehensive strategy to assess quality in Family Care, the Department is able to address aspects of quality at both the county level and at the individual member level between target groups. In order to assess quality within the Family Care program, APS staff reviewed the following:

- Family Care Quality Assurance Contract Requirements
- Member Outcome Surveys
- EQRO Quality Findings

- Family Care Member Grievances and Appeals
- Measures of Members' Health and Functioning
- Long-term Care Functional Screen Quality Assurance Efforts
- Service Quality

Using available data, APS reviewed quality measures at the CMO and individual level. In addition, when possible, DHFS and EQRO quality monitoring processes were assessed.

A. *CMO Certification Process and Annual Reviews*

CMOs must be certified by DHFS to provide Family Care services. The Department certifies CMOs by evaluating each organization using a set of standards, which are derived from a number of sources. These sources include the Family Care authorizing legislation and administrative rules. In addition to state standards for CMOs, federal regulations require states that use federal Medicaid dollars in a risk-based contracting arrangement to assure that contractors have the capacity to meet federal Medicaid managed care regulations.

1. CMO Certification Process

A primary focus of the certification standards relates to the CMO's provider network. In order to be certified, a CMO must demonstrate that it has adequate availability of providers to meet the preferences and needs of potential enrolled members. To meet the requirements of the Family Care statute, the CMO must submit documentation of its capacity to assure timely provision of Family Care services to the expected enrollment in the CMO's service area. As part of the documentation, the CMO must show that it is not merely creating a situation where members are steered to existing residential slots, but are instead treated as individuals whose preferences are honored. Such documentation may be in the form of written agreements with providers who are available to provide all LTC services in the Family Care benefit in sufficient quantity to meet the needs of the potential enrolled membership or a description of how the CMO plans to provide the service directly to the expected enrollment.

During the pre-certification review State staff evaluate compliance with a number of organizational standards that are established under the CMO contract. These standards cover program dimensions such as financial stability, member rights, appeals and grievance specifications, member safety and risk plans, advance authorization and utilization management systems standards, provider selection and retention policies, QA/QI program and workplan, member information and marketing materials. As part of the pre-contract review, each CMO must submit organizational documents that show that it has the capacity to meet contract requirements. Department staff with specific technical knowledge will review all relevant CMO documentation for consistency with the guiding principles of Family Care, as well as for evidence of adequate capacity to meet state and federal managed care contract requirements.

Subsequent to the review, DHFS notifies the CMO as to whether the CMO's documentation was acceptable or whether additional documentation is needed prior to certification. In some cases, a CMO may be required to participate in technical assistance sessions or attend mandatory training in specified areas. Additionally, a CMO may be required to meet performance expectations during the contract period that are attached to the contract in the form of an amendment. In such

cases, the department conducts reviews and site visits as necessary to validate progress made in those areas.

2. Annual Site Reviews

In addition to site visits conducted during the contract period on an as needed basis to address issues identified through the pre-certification review and the start-up phase, the department also conducts annual reviews of all CMOs. These reviews generally occur on-site and are conducted by review teams composed of DHFS, a relevant LTC provider, a registered nurse, a social worker and a consumer if possible. If it is not possible to secure consumer participation for all site visits, consumer input on relevant materials is obtained off-site. Consumers who participate in this process are compensated.

Annual site reviews emphasize CMO system level issues including such issues as system-wide quality improvement, access, choice, quality of life of members, safety and the system in place to ensure safety and, most importantly, the degree to which Family Care outcomes are being achieved. It is expected that these reviews will incorporate findings of other monitoring and oversight activities undertaken by DHFS and the EQRO.

The annual site visit focuses on the following areas:

CMO QA/QI Program Implementation

In Family Care, the CMO becomes the organization that is responsible for delivering a set of services and supports for a defined population of individuals. The Department, in turn, has an obligation to monitor and assess how the CMO performs as a whole and how it plans to continually improve its performance. The CMO's internal QA/QI program is the mechanism used to monitor and evaluate care delivered to its members and take actions as necessary to improve care rendered by all CMO providers. How the CMO implements its internal QA/QI program is of foremost importance to the Department.

In risk-based contracting situations, managed care organizations are required by federal law to operate a QA/QI programs. The QA/QI program should support a continuous improvement process and involves a number of interrelated activities, such as monitoring basic health and safety, performance measurement and improvement using objective quality indicators, developing standards of care and monitoring providers against established standards, and implementing methods to strengthen consumer involvement in CMO quality activities. The CMO is expected to provide documentation that it has or is actively implementing an internal QA/QI program that meets contract standards and that the CMO has a plan for incorporating the experience of CMO members into the evaluation of the QA/QI program.

As part of its quality monitoring and oversight activities, DHFS reviews, at least annually, how well the CMO is implementing key quality assurance and quality improvement functions CMO-wide, and the impact and effectiveness of the CMO QA/QI program. This monitoring is done on-site and entails interviewing key staff, providers and consumers and reviewing relevant documentation. The review focuses primarily on the assurances made by the CMO during the pre-certification review on the QA/QI plan, access standards and other contractually required standards to assess the CMO's progress on implementation. Also, the Department reviews the CMO's own evaluation of its internal QA/QI program. For example, reviewers assess whether or

QA/QI

not the CMO is completing the activities on its QA/QI workplan on a timely basis and whether or not the CMO's self-evaluation includes recommendations for needed changes.

CMO Provider Network Monitoring

In addition to the pre-certification review, on an annual basis, the department conducts an on-site review to evaluate the geographic distribution of available service providers and whether the CMO is meeting standards for timeliness of services. As part of this review, the DHFS ensures that each CMO's network is structured in a way that considers the geographic location of providers and members, including such factors as distance, travel time, and the means of transportation normally used by members. If the CMO contracts with providers outside its service area, the CMO has to justify these arrangements as either making it easier for some members to reach the particular provider or other reasons such as inability to contract with a sufficient number of providers within the service area.

Monitoring CMO Provider Selection

CMOs are required to have a local process to assure that persons providing services and/or supports are trained and qualified to perform their duties. In part, this consists of verifying that any subcontracted provider meets pre-set CMO specific standards that have been prior approved by DHFS. Additionally, CMOs must evaluate the performance of each subcontracted provider on a periodic basis, using member input on the quality of providers, complaints and grievance reports, performance measures and other information. They also must report to the department whenever a subcontract is terminated because of quality problems with a provider.

During the annual on-site review, State staff interview CMO staff and providers and review CMO documentation to determine if the CMO is adhering to its policies and procedures in this area. DHFS may also conduct a survey of CMO subcontracted providers in order to assess CMO performance from the provider's perspective.

3. Examples of CMOs Success Stories and Performing at Exceptional Levels

Through the assistance of DHFS staff and EQRO Quarterly Reports, APS has been able to compile various stories and activities of how CMOs have gone above and beyond the contract requirements related to quality. While this accounting is by no means comprehensive, it is illustrative of some of the quality work taking place within the pilot counties.

1. All the CMOs have begun developing specialty teams for special or challenging populations. For example, each of the CMOs has developed teams with mental health expertise and some have developed special teams for people with substance abuse issues and people with challenging behaviors.
2. All CMOs now have flexible self-directed support (SDS) programs in place and operational to provide consumers with more input regarding their care providers.
3. All CMOs have learned the value of good data and are in the process of improving data collection and recording to be used more at the local level to assist in making policy and fiscal decisions.

The following are a sample of CMO specific instances, which illustrate how the flexibility of the Family Care benefit has been used to enhance service quality:

of her current physical and occupational therapy programs. She continued to make gains in her independence and her care provider assisted her with shopping, errands and home management for a family of four. This support allowed the member's husband to maintain his full-time employment.

B. *EQRO Quality Findings*

On an annual basis, Family Care CMOs, are required to submit self-reported quality assurance and improvement data for specified performance measures, performance improvement projects (PIPs) and other standards measured during the contract year.

1. Performance Measure Rates

For 2002-03, the performance measure focus area was health and safety, and the member outcomes were: people have the best possible health; and, people experience continuity and security.

Specifically, the CMO performance measures were:

1. Care management team turnover - Percent of the care management team members (case managers and registered nurses) who separate during calendar year 2002. High turnover rate results in the reduction of continuity of care for Family Care Members.
2. Influenza vaccination – Percent of CMO members who received a vaccination in the past 12 months.
3. Pneumonia vaccination – Percent of CMO members who received a vaccination in the past 10 years.

Performance measure data submitted by the CMO's is validated by the EQRO to ensure reliability and to provide constructive feedback to the CMOs to assist them in their ongoing quality improvement efforts.

Through the EQRO's data validation review process, it was determined that all the CMOs reported care management team turnover data and vaccination counts[24]. The EQRO noted that no CMO accurately documented its processes and procedures for the performance measures. EQRO reviewers found that each CMO carried these processes out in an informal and unwritten manner. As a result, it was recommended by the EQRO that the CMOs maintain more accurate documentation and records to ensure that procedures and processes are carried out in consistent and accurate fashion.

[24] Metastar, Inc. Family Care Annual Report and Attachments. August 7, 2002.

In Richland County, a husband and wife both enrolled in Family Care. The wife's physician was recommending that she be hospitalized to deal with her extremely low O_2 saturation levels. She was reluctant; however, as she felt she needed to remain in her home for her husband, who also needed care. Both husband and wife were very private individuals who were very reluctant in general to accept services. Working with the wife, husband and physician, and enlisting the aid of family members, the care management team was able to arrange for both husband and wife to receive services that were able to keep the wife out of the hospital by getting them to accept more services for both of them. It was at this time that it was discovered that the wife provided more care for the husband then was originally thought. Other family members now participate more in the care of both individuals.

In Fond du Lac County, a member was living in his home with his wife. Other family members lived with them and were their primary supports. This situation was historically very trying, as family left them alone without supports in the past. Abuse and neglect allegations by family members were investigated. The member is a mentally ill veteran with significant trust issues. Both he and his wife now have significant physical disabilities as well. There are mobility limitations for both of them.

In May 2002 the member required surgery and his wife moved to a community –based residential facility (CBRF) the day of his surgery. Five days after the surgery, he was transferred to a nursing home. CMO staff visited the nursing home and discovered that the surgery was not entirely successful. The discharge plans from the hospital to the nursing home were also poor.

The nursing home provided excellent care and nearly healed the wound by the end of October, but the member was suffering from a variety of psychiatric issues. The CMO staff assisted the member in finding a new psychiatrist in his area and arranged transportation for the member and wife to be together 2-3 days per week at the nursing home.

Eventually the member was able to leave the nursing home and go to the CBRF where his wife resided. The CMO continuously worked with the CBRF to get him assessed and to coax this process along. The discharge from the nursing home was also very poor, which resulted in the CMO providing significant assistance to obtain correct orders and appropriate supplies. The member is now living with his wife, sharing a room at the CBRF. They are both much happier now after being reunited.

In Portage County, a member was involved in an automobile accident in December 2001. She was comatose for more than one month in the ICU of a local hospital and then was transferred to a coma recovery program in the Milwaukee area where she stayed for 3 months. When she had reached the maximum benefit from this program, she entered an intensive brain injury recovery facility. She made steady gains in her physical and psychological functions, exceeding the expectations of the rehabilitation staff. After 7 1/2 months in this program, she returned to her home in Portage County two weeks before the anniversary of her accident.

The brain injury resulted in physical and cognitive limitations but with the support of Family Care this member was able to return home to her husband and family and resume involvement in day-to-day activities. The CMO provided in-home support to assist her with the follow through