

Policy Insights

Reassessing the Impact of Managed Care in the Developmental Disabilities Sector

The National Leadership Consortium on Developmental Disabilities, Co-Directed by Steven M. Eidelman and Nancy R. Weiss, is a project of the [University of Delaware's Center for Disabilities Studies](#).

Funding for this bulletin series is made possible by Liberty Healthcare Corporation. Liberty Healthcare Corporation exercises no editorial control over the content.



EXECUTIVE SUMMARY

The oft-predicted encroachment of managed care into long-term community-based services and supports for people with developmental disabilities has not occurred. However, managed care approaches are being utilized by states for other service populations. The experiences of four states are highlighted in this brief report, and a more extensive report is on-line for the interested reader.

Welcome to the first *Policy Insights Bulletin* from The National Leadership Consortium on Developmental Disabilities (NLCDD). NLCDD was formed in 2006 to focus on key leadership development issues in the field of services and supports for people with intellectual and developmental disabilities. As a supporter of participants in our week-long Leadership Institutes, Liberty Healthcare is interested in the implications of changes in public policy as it impacts people with intellectual and developmental disabilities (I/DD). With their support, Robert M. Gettings has agreed to undertake an analysis of key issues that impact people with I/DD today, as they are unfolding. This first bulletin is one of a series developed by Mr. Gettings who, for more than three decades, led the National Association of State Directors of Developmental Disabilities Services. He is one of this nation's leading experts on public policy as it impacts people

with intellectual and developmental disabilities.



Robert M. Gettings

BACKGROUND

In the mid-1990s, many observers were predicting that managed health care principles would be widely applied to the delivery of publicly funded services for individuals with developmental disabilities. For a variety of reasons, managed care fizzled in the developmental disabilities sector while thriving in the acute

and behavioral health sectors.

In recent years, however, a number of states have been granted authority by the federal government to convert Medicaid-funded long-term services to a managed care format. Most such plans are targeted to low-income frail elders and adults with physical disabilities, but a few also encompass specialized services to persons with developmental disabilities. Why have these states moved in this direction? Are we on the brink of a revival of interest in managed care for the I/DD population? Which states have spearheaded the thrust toward managed long-term services in the I/DD sector and what can we learn from their experiences? What are the views of disability stakeholders in these states regarding the introduction of managed long-term services? These are among the key questions explored in this inaugural issue of the *Policy Insights Bulletin* series. ❖

Aims, Organization and Methodology

This bulletin focuses primarily on the experiences of the four states (Arizona, Michigan, Vermont, and Wisconsin) which currently operate specialized developmental disabilities services under the umbrella of a Medicaid long-term services plan. The information contained in this bulletin is based, in part, on publicly available documents, most of which can be found on the websites of the four target states. The written materials were supplemented by information obtained during a series of telephone interviews with a cross section

of DD stakeholders in each of the four states. The common aim of these interviews was to obtain first-hand perspectives on the impact of the state's managed LTC program on services to persons with developmental disabilities. The principal findings and conclusions of the analysis are summarized in this bulletin. Additional details are contained in the complete study report, which is posted on the website of the National Leadership Consortium on Developmental Disabilities at <http://www.nlcdd.org/managedcare>. ❖

Past Interest in Managed Long-Term Care

Section 1115 Waiver

Enacted in 1962, Section 1115 of the Social Security Act delegates broad authority to the Secretary of Health and Human Services to waive various provisions of the Act in order to permit “...any experimental, pilot or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of programs authorized under the statute. While over the years this authority has been used to launch experiments related to various programs established under the Act (including Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF; former Aid to Families with Dependent Children (AFDC)), in recent years it has been used primarily to establish broad-scaled Medicaid reform initiatives in selected states, with the principal focus on managed health care and long-term services arrangements.

The earlier spurt of interest in managed long-term care for persons with developmental disabilities was precipitated by several converging trends: (a) the rapid expansion of Medicaid managed health care during the ‘80s and ‘90s, coupled with a recognition that adopting cost-effective approaches to serving Title XIX beneficiaries with chronic illnesses and disabilities was a key to dampening the growth in Medicaid outlays; (b) the growth in managed behavioral health plans and the corresponding interest in expanding such arrangements to DD services; (c) the escalating waiting lists for community DD services and the resulting search for more cost effective ways of managing public resources and thereby improving service access.

Early Opposition

Opposition to the introduction of managed care, however, was strong among disability advocates as well as many DD professionals. Due in part to changes in federal policies, community DD services, moreover, grew rapidly during the late ‘90s and early ‘00, deflecting some of the pressure for radical reforms. In addition, interests among commercial health and behavioral health plans dissipated as it became clear that there would be few opportunities in the DD sector to shift costs to other payers. All of these factors led to a waning interest in employing managed care techniques in the DD sector.

Managed Care Systems in Four States

Despite these hurdles, four states – Arizona, Michigan, Vermont and Wisconsin – decided to include long-term supports for individuals with developmental disabilities in their Medicaid managed long-term services initiatives. Why did they elect to include the I/DD population? The answer to this question differs depending on the state. Each of the four states pursued its own unique pathway toward a managed long-term support system. However, one motivating factor that united these states was the recognition on the part of policymakers that the state’s former fee-for-service approach was fiscally unsustainable over the long haul. They all adopted a managed care approach in an attempt not to trim overall public outlays but rather to improve the cost effectiveness,

quality and accessibility of long-term services.

ARIZONA. Prior to 1982, Arizona did not participate in the Medicaid program. The health and long-term services available to low-income, uninsured citizens at the time were provided by county governments, with some financial assistance from the state. Faced with increasing demand for health care coverage combined with a recession-induced fiscal crisis, however, by the early 1980s several county assistance agencies were on the brink of bankruptcy. The state became involved and decided to negotiate a deal with the federal government under which Arizona would receive federal Medicaid payments on behalf of low-income individuals and families in exchange for operating services in compliance with federal standards. This agreement was formalized in a Section 1115 demonstration/waiver program called the Arizona Health Care Cost Containment System (AHCCCS). The principal advantage of the AHCCCS waiver/demonstration program was that it allowed the state to share with the federal government a wide range of program costs which heretofore had been borne entirely by state and local governments.

When a long-term care component (called the Arizona Long Term Care System or ALTCS) was added to the AHCCCS waiver/demonstration program in the late 1980s, the basic requirements governing the new program were a mirror image of the original AHCCCS managed health care requirements. There were from the start two components of the ALTCS program – one focused on elders and adults with physical disabilities and the other on individuals with developmental disabilities.

MICHIGAN. Beginning in the mid-1980s, Michigan launched an initiative aimed at giving county mental health boards (later re-designated Community Mental Health Services Programs (CMHSPs)) greater flexibility in administering state and federal funds in return for developing stronger managerial capabilities. Any board that was able to demonstrate that it had the requisite capabilities to plan, develop, and manage a

(continued on page 3)

Implication for Developmental Disability Stakeholders

catchment area-wide network of MH/DD services was certified a “full service” board.

Various federal and state funding streams were amalgamated and full service boards operated under a “global budget,” which afforded them greater latitude in deploying resources. By the early 1990s, all 49 CMHSPs had been certified full service programs. By the late 1990s, however, it became clear to state officials, CMHSP managers and non-governmental advocates that, if system-wide finances were to be stabilized over the long haul and quality services made available to all eligible individuals, further actions would be necessary to expand access to federal funding and streamline the management of available public dollars at the local level.

The solution state officials came up with was to transform the state’s 49 (now 46), county-based CMHSPs into a network of pre-paid, capitated managed care organizations with responsibility for overseeing all publicly funded mental health, developmental disabilities and substance abuse services. The transformation was accomplished through a combination of statutory waivers granted under Section 1915(b) and (c) of the Social Security Act. Individuals eligible for Section 1915(c) home and community-based waiver services would continue to receive services through the waiver program. But, as a result of the Section 1915(b) waivers, wrapped around these services would be Medicaid-funded benefits for persons not qualified to receive HCB waiver services. In effect, the combination of the two sets of statutory waivers allowed Michigan to claim federal financial participation (FFP) for all Medicaid-eligible persons with mental and developmental disabilities, without reference to whether they otherwise would need institutional services. Moreover, as a result of the Section 1915(b) waivers, the state was allowed to consolidate all local, state and federal Medicaid funding sources and administer them on a capitated payment basis through a statewide network of Pre-Paid Inpatient Health Plans (PIHPs) operated by the CMHSPs. In 2001, the state adopted a revised PIHP procurement plan, setting a minimum threshold for the number of eligible individuals

(20,000) in any given PIHP catchment area. As a result, the number of PIHPs statewide was reduced from 49 to 18 and many counties which previously had operated its own PIHP joined other nearby counties to form a PIHP.

The PIHP is responsible for receiving (in the form of capitated payments) and managing all Medicaid-funded specialty MH, DD, and Substance Abuse (SA) services. By state statute, the CMHSP continues to serve as the single-point-of-entry to public MH, DD, and SA services. The CMHSP also manages all non-Medicaid dollars and, in many cases, contracts with the PIHP to provide or procure Medicaid-funded services to eligible persons in their respective catchment areas.

VERMONT. The state was facing a \$600 million Medicaid funding gap in 2004-05 when the Global Commitment to Health Section 1115 waiver/demonstration program (GC) was developed. The key goal of the initiative was to gain the flexibility necessary to both sustain existing health and long-term services and make new, “upstream investments” in improving access to health and health-related services. In order to secure federal backing, the state agreed to assume a degree of financial risk by operating its program under a global federal spending cap. The cap was set at \$4.7 billion spread over a five-year period.

One key area of flexibility is the ability to include in the GC initiative state expenditures for health and health related activities which heretofore had not qualified for federal Medicaid funds. The second major area of flexibility is the authority under the GC waiver to make new and expanded investments with the “excess dollars” generated by expending less than the amounts projected.

Developmental disabilities services were rolled into the Global Commitment along with all other components of the state’s Medicaid program except for long-term services to low-income elders and other adults with physical disabilities, which are operated under a separate Section 1115 waiver/demonstration program. Managed care-like techniques had been used in administering DD services for more than a

Section 1915(b) & 1915(c) Waiver Authorities

Section 1915(b) empowers the Secretary of Health and Human Services to grant waivers to the “freedom of choice” provision and certain other requirements of federal Medicaid law (i.e., Section 1902(a)(10) of the Act, which prohibits a state from restricting a beneficiary’s choice among qualified providers of a Medicaid reimbursable service). These so-called “freedom of choice” waivers permit states to mandatorily enroll beneficiaries in managed health care plans. Section 1915(c) of the Act empowers the Secretary to approve waivers of certain statutory requirements (the statewide availability of services; comparability in the provision of services to all eligible beneficiaries; etc.) in order to furnish home and community-based services to Medicaid beneficiaries who otherwise would require care in a Title XIX hospital, nursing facility or ICF/MR.

Implications (continued)

“While each of the four states uses a different approach, there are some common themes.”

decade before the GC waiver/demonstration program was initiated. State officials did not intend to alter the financing and management of DD services when the program was folded into the GC waiver and, indeed, few, and mostly unrelated, changes have occurred in the management of DD services over the past three years.

WISCONSIN. In 1994, an intra-departmental work group hammered out a set of principles to guide the state’s long-term reform efforts; but, when the details of the plan were announced the following year, aging and disabilities advocates voiced opposition to several key plan features. Following legislative intervention, a compromise plan was worked out. The main features of this compromise, announced in December 1997 and subsequently enshrined in law in 1999, specified that: (a) the new managed care concepts would be piloted in a limited number of counties and evaluated before legislative authority was sought to implement the program statewide; (b) the program, to be called Family Care (FC), would encompass long-term services only; (c) the Wisconsin Partnership program, which involves the co-management of health and long-term care benefits under a single umbrella plan, would be operated separately from the Family Care

program; and (d) all FC enrollees would have the option of self-directing their services and supports.

Governor Tommy Thompson, as part of his January 1998 State of the State Address, called for the creation of the Family Care Program. The pilot counties were selected using an RFP process later that year. A subsequent independent assessment of the pilot programs concluded that Family Care had: (a) substantially increased participant choice and access to needed services, while improving quality by focusing on social outcomes; (b) eliminated waiting lists for services in the participating counties; (c) improved access to information concerning long-term service options among the target populations; (d) achieved a high level of consumer satisfaction; and (e) saved an average of \$452 per month, per participant in four out of the five participating counties when compared to previous fee-for-service funding arrangements. Based on these findings, Governor Jim Doyle in 2006 announced plans to implement the Family Care program statewide by 2011. As of September 2008, the Family Care program was operating in 22 of the state’s 72 counties, with a total enrollment of 15,688 individuals, including slightly over 4,000 adults with development disabilities. ❖

Similarities and Differences

In Arizona, Michigan, and Vermont, the managed care plan is in effect statewide and incorporates essentially all publicly funded long-term supports for the covered populations, while Wisconsin’s plan is being phased in over a multi-year period, with statewide implementation scheduled to be completed in 2011. Wisconsin’s plan limits participation to adults; whereas in Arizona, Michigan and Vermont there is no lower age limit on participation by persons with developmental disabilities.

The operational features of the programs in these four states are different than those of a prototypical managed **health** care plan. First, none of these states has chosen to rely on commercial health maintenance (management) organizations (HMOs) to act as the managed care organization (MCO) – i.e., the entity responsible for purchasing and orchestrating the delivery of long-term services. Indeed, in Arizona and Vermont, an agency of state government functions as the MCO (with respect to DD long-term supports only in Arizona). Michigan and Wisconsin, in contrast, procure Medicaid-

funded long-term services through risk-based contracts with a network of area-wide MCOs (called, in Michigan, Pre-paid In-Patient Health Plans (PIHPs)). Thus far at least, the MCOs in these states are all “home grown” organizations; in Michigan (as well as a number of catchment areas of Wisconsin), MCOs have been formed largely from the elements of the existing local service delivery system. Second, the sharing of financial risk is handled differently under the long-term service plans of these four states than it is in most managed health care systems.

In Vermont and Arizona, state government assumes 100 percent of the financial risk of

(continued on page 5)

Similarities and Differences *(continued)*

extending long-term supports to all eligible persons with developmental disabilities.

In the Michigan and Wisconsin plans, state government shares the financial risks of cost overruns with county or multi-county managed care entities. Michigan limits the risk exposure of PIHPs to 7.5 percent over the total amount of the entity's annual contract with the state. Wisconsin has not established the same types of "risk corridors" in its contracts with MCOs. But, lacking the ability to divert costs to private insurers (especially for persons with developmental disabilities), it is clear that over the long haul state government is widely (and, no doubt, rightly) viewed as the ultimate guarantor of these plans. Arizona and Vermont rely on federal waivers granted under Section 1115(a) of the Social Security Act.

In contrast, the authority to operate the Medicaid managed long-term services programs in Michigan and Wisconsin are based on statutory waivers granted under Section 1915(b) and (c) of the Act. All four states are subject to the managed care provisions of Title XIX of the Social Security Act, many of which were added under the provisions of the Balanced Budget Act of 1997 (BBA-97).

In two of the states (Arizona & Vermont), responsibility for administering managed long-term services for persons with developmental disabilities is shared between the state DD program agency and the single state Medicaid agency. In Michigan and Wisconsin, the managed care plan is administered by the single state Medicaid agency, which also functions as the DD program agency. The Mental Health and Substance Abuse Administration within the Michigan Department of Community Health (MDCH) administers all Medicaid (and state) funded services to persons with developmental and mental disabilities. Similarly, in Wisconsin the state Department of Health Services is both the single state Medicaid agency and the agency responsible for serving elders and persons with physical and developmental disabilities.

In Arizona, the seven district offices of the state Division of Developmental Disabilities manage all aspects of the delivery of ALTCS/DD services, including the direct provision of support coordination services. In Michigan, DCH's Mental Health and Substance Abuse Administration contracts with a network of 18 PIHPs to procure all Medicaid-funded specialty services for eligible individuals with mental illness, developmental disabilities, and substance abuse problems. A network of ten area-wide nonprofit Designated Agencies (DAs) acts as the single-point-of-entry to DD services in Vermont. These agencies, under contracts with the state Department of Disabilities, Aging and Independent Living (DAIL), also are responsible for eligibility determination and either providing or purchasing the vast majority of community services for the DD population. In counties participating in Wisconsin's Family Care program, a Managed Care Organization (MCO) is responsible for planning and procuring all long-term services required by program enrollees, while a separate network of Aging and Disability Resource Centers is charged with assisting individuals and families to locate appropriate services and for determining Family Care eligibility.

Eligibility determination is a two-tiered process in all four states. First, to qualify for state assistance, an individual must meet the state's statutory definition of a "developmental disability" or of "mental retardation" and certain, specified related conditions. Then, there is a secondary test of whether the individual meets Medicaid financial eligibility standards and has a disability of sufficient severity to qualify him/her for enrollment in the state's Medicaid managed long-term services program. A functional screening tool is used in making the latter determination in all four states. Michigan and Wisconsin have adopted the federal functional definition of a "developmental disability," while Arizona and Vermont link eligibility to definitions of "mental retardation" and certain other related conditions, plus functional criteria similar to the federal definition.

1915 (b) and 1915 (c) (Continued)

The Medicaid managed long-term services programs in Michigan and Wisconsin are based on a combination of waivers granted under Section 1915 (b) and Section 1915 (c) of the Act, with the (b) waivers allowing the state to adopt a managed care operating format and the (c) waivers permitting the state to claim reimbursement for elements of home and community-based services which otherwise would not be reimbursable under federal Medicaid law. Both Section 1915(b) and Section 1915(c) were initially added to Act as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

Similarities and Differences *(continued)*

Each of the four states has a low institutional utilization rate, especially with respect to beneficiaries with developmental disabilities.

All four states have consolidated a variety of funding streams to form a single, flexible source of financing for long-term services. In Arizona, the capitated payments DDD receives from the AHCCCS agency includes Medicaid funding for home and community-based services, support coordination and ICF/MR services. Also included in the capitated payments to DDD are the dollars necessary to enroll ALTCS/DD recipients in participating health plans and to purchase necessary behavioral health services. Capitated payments for MH/DD/SA Specialty Services in Michigan are drawn from the following pre-existing sources: DD waiver services, ICF/MR services, certain other state Medicaid plan services (e.g., personal care; clinic services; and rehabilitative services); plus state and county matching contributions. HCBS waiver services for children with developmental disabilities and Early Periodic Diagnosis, Screening, and Treatment (EPSDT) services are not included in the Specialty Services bundle and continue to be offered on a fee-for-services basis. In Vermont, funding under the state's former DD home and community-based waiver program, ICF/MR funding plus Flexible Family support grants have been rolled into the Global Commitment funding package. A variety of other state plan coverages, including personal care services, EPSDT benefits, and home-based care for technology dependent children are billed separately on a fee-for-services basis. Like Michigan, Wisconsin draws upon a mix of HCBS waiver services, ICF/MR services, certain elements of state plan services (such as personal/attendant care services for adults) to finance Family Care services. Waiver services for children, EPSDT services, and services under the special Katie Beckett eligibility option for children with severe disabilities continue to be offered on a fee-for-service basis.

The long-term services benefits offered through the managed care organizations in Arizona, Michigan and Wisconsin to eligible persons with developmental disabilities include: a wide range of home and community-based services;

service coordination (or case management); and ICF/MR services when deemed to be the only viable alternative. Vermont offers a similar range of DD services, but rather than providing them through a managed care entity, DAIL uses its network of community, single-point-of-entry agencies (DAs) that function as departmental contractors. Besides long-term services and supports, Arizona DDD contracts separately with qualified health plans for the provision of primary, preventive, and acute health services as well as for behavioral health services furnished through a contract with the state Division of Behavioral Health Services.

Each of the four states has a low institutional utilization rate, especially with respect to beneficiaries with developmental disabilities. Only Wisconsin serves a significant number of individuals in public and privately operated ICFs/MR; and here steps have been taken in recent years to reduce the census of large public and private ICFs/MR. In operating a Medicaid managed long-term services program, there are distinct advantages to maintaining a low rate of institutionalization:

First, when a state's institutionalization rate is low, huge amounts of money don't get drained away from the overall funding pool to support a comparative small number of individuals, many of whom could receive equal or better services at a lower average per capita cost in community settings.

Second, it is almost always easier to avoid an institutional placement than it is to arrange for an institutionalized individual to return to the community.

Finally, the state and its local service delivery agents (MCOs, etc.) are able to concentrate their energies and resources on building a more flexible, resilient network of community resources, without having to deal with the political and logistical challenges of simultaneously managing a major deinstitutionalization initiative. ❖

TABLE A

Four State Comparison of Medicaid Managed Long-Term Service Plans

KEY FEATURES	AZ	MI	VT	WI
Target Population	EPD (adults) DD (children & adults)	MI, DD & SA (children & adults)	DD (children & adults)	E, PD & DD (adults only)
State Management Responsibility	AHCCCS & DDD for DD services	MDCH	OVHA & DAIL	DHS
Local/Area-Wide Management Responsibility	7 DDD Regional Offices	46 CMHSPs & 18 PIHPs	10 DAs	10 MCOs
Local Service Providers	Qualified vendors & independent providers under contract with DDD	CMHSPs & other service providers under contracts with PIHPs	DAs, SSAs & other providers under contracts with DAs	Service agencies and independent providers under contract with MCOs
Other Components	–	–	SSAs	ADRCs
DD Eligibility	Persons with MR & related conditions	Persons with DD	Persons with MR & related conditions	Persons w/DD
Combined Funding Streams	HCBS and ICF/MR dollars; health plan coverage; behavioral health coverage	HCBS waiver and ICF/MR dollars; certain state plan coverages; + state and county match	HCBS waiver and ICF/MR dollars + flexible family grants	HCBS waiver and ICF/MR dollars; certain state plan coverages; + state and county match
DD Services	HCBS waiver + ICF/MR services; health plan services; behavioral health services & limited state only services	HCBS waiver + ICF/MR services & parallel Section 1915(b) services + state plan coverages	HCBS waiver + ICF/MR services & state plan services & flexible family grants	HCBS waiver + ICF/MR services + state plan services + state/county aid
Federal Waivers	Section 1115	Section 1915(b) + (c) combo waivers	Section 1115	Section 1915(b) + (c) combo waivers
Capitation	State level only (AHCCCS contracts with DDD)	MDCH contracts with 18 PIHPs; state only aid to 46 CMHSPs	State level only (OVHA contracts with AHS); funds transferred to AHS departments	DHS contracts with MCOs

Stakeholder Assessments

The author sought feedback from key I/DD system stakeholders in each state in preparing this bulletin. In particular, all interviewees were asked about their current views regarding the state's decision to institute a Medicaid managed long-term support system. What do they see as the principal strengths and weaknesses of the system today? Has managed long-term care lived up to the promises made when the plan was initially conceived and sold to system stakeholders? And, what advice do they have for stakeholders in other states contemplating a similar move?

When interviewees were asked for their overall assessment of their state's managed care plan, the responses ranged from enthusiastic support to disappointment and disillusionment. While acknowledging important unrealized goals and the need for further improvements, proponents of their state's managed LTC plan found significantly more pluses than minuses. Non-government advocates and provider agency executives tended to be less sanguine about the state's program, with some respondents expressing considerable frustration with the continuing gap between promises and reality. Plan critics generally acknowledged that services were more uniformly accessible than prior to implementation of the plan; but, they expressed deep disappointment with the failure of the program to promote community integration, individualization and enhanced self-direction and independence. But even the sharpest critics of their state's program conceded that a managed care approach has important advantages when compared to past system management practices, especially the commitment to ensure that all eligible individual receive prompt access to needed services. Among the major strengths of a managed LTC care approach mentioned by the interviewees were:

The obligation to make services and supports available to all eligible individuals when, where and how they need them. Often this point was expressed in terms of eliminating the need for waiting lists – a troublesome reality for proponents of I/DD services in most states. Noting the steady funding increases the ALTCs/DD program has enjoyed over the past 20+ years (during good fiscal times and bad), one Arizona official said he didn't believe a similar growth pattern could have been achieved, especially in a fiscally conservative state like Arizona, had the program been operated under a conventional (non-managed care) funding arrangement.

The flexibility to design supports around the needs and aspirations of each individual once all relevant Medicaid and non-Medicaid funding streams have been combined. When the Family Care program is implemented in a

Wisconsin county, for example, some 40 pre-existing funding streams for elder and disability services are combined to form a single, flexible funding package, thus affording the local managed care organization the latitude to develop more individually tailored support plans. The consolidation of disparate funding streams also allows local/area-wide managers to avoid the "silo effects" of having to synthesize funding from programs with differing eligibility requirements and operating policies.

The emphasis on cost-effectiveness and the related tools to craft support plans that make more sense and also often cost less. Because an MCO is obligated to enroll all eligible persons who apply for services, the prudent use of available resources and achieving equity of access across all enrollees become the predominant management priority.

The benefits of coordinating the delivery of long-term supports with the provision of health care services. The prevalence of chronic health conditions is high among persons with long-term support needs. As a result, there are tangible payoffs to closely coordinating the delivery of health and long-term support to such persons.

The establishment of a fixed point of accountability for meeting the entire continuum of an enrollee's support needs. When a single entity is responsible for assuring that all long-term supports are delivered to an individual in a timely, coordinated manner, it is much easier to fix accountability when performance lags behind expectations.

When dollars are managed globally and there is an obligation to serve all eligible persons, managed care entities have incentives to intervene BEFORE major life crises occur. The incentives to avoid institutional placements in a managed LTC system, for example, are strong since the financial consequences of failing to intervene early and effectively are catastrophic.

The available support options often are broader under a managed care approach, especially in sparsely populated areas of a state. Typically in a managed LTC system enrollees are able to choose between two or more providers of any given service, an option not always available when services are offered on a fee-for-service basis. A managed care approach introduces competition, thus forcing all providers to maintain a high level of performance or face a decline in their customer base.

(continued on page 9)

Stakeholder Assessments *(continued)*

With a larger customer base and access to single-stream funding, local management entities are able to build and maintain much stronger administrative capabilities.

MCOs are forced to adopt standardized approaches to managing the service delivery process in order to achieve consistency in access to services and uniformity in the way eligible individuals are treated. Moreover, when all funding streams are combined, the MCO has the resources necessary to hire staff specialists to perform various managerial functions.

The additional federal payments a state receives as a result of its managed care agreement with CMS helps to stabilize the overall financial status of the state's Medicaid program.

Negotiations surrounding the development of a managed LTC system often open up new avenues for increasing federal financial participation in system-wide costs.

Among the weaknesses of the managed LTC plans mentioned by the interviewees were:

Managed care has failed to substantially reduce geographic inequities in access to services which promote community integration, independence and productivity.

Generally, the interviewees agreed that individuals are being promptly enrolled in services once their eligibility has been determined and a service plan has been developed. But, serious concerns were expressed – especially by interviewees from the two states (Michigan & Wisconsin) where county governments historically have played a lead role in serving individuals with disabilities – about persistent geographic variations in the types of services being furnished. The tendency has been to enroll existing HCBS waiver recipients in the same service programs they were participating in prior to the switch to managed care. For most adults with developmental disabilities, the result is more of the same – i.e., living in a provider-operated group home, attending a sheltered workshop or adult activity center during the day, and having few opportunities to be employed in an integrated work setting or otherwise interact with non-disabled peers.

Concerns about the potential for “medicalizing” long-term services linger despite substantial efforts to emphasize person-centered, social support principles.

Because the DD component frequently is such a small part of the overall managed care program, the tendency is to impose health-oriented requirements which may be efficacious in the larger program context but do little to improve the quality or appropriateness of DD supports.

The commitment to achieving geographic equity in the provision of long-term services benefits all current and potential recipients.

One of the central goals of most managed long-term services plans is to ensure that all eligible individuals are able to receive the same types, quantity, and quality of services regardless of where they live in the state. Geographic equity in access to services is a principal widely violated in many existing fee-for-service systems.

The streamlined process of gaining access to services makes the system more consumer and family-friendly.

While the mechanisms often differ, another basic commitment of a Medicaid managed LTC system is that consumers will find it easy to obtain information, have their eligibility and service needs determined, and receive help in developing a service plan, choosing a provider(s) and gaining access to needed services and supports.

Federal managed care requirements are framed around the delivery of acute health services and sometimes are of questionable utility when applied to long-term supports.

Some of the managed care requirements of Balanced Budget Act of 1997 are viewed by frontline staff as a source of unnecessary paperwork that erodes the amount of time they are able to spend supporting individuals with disabilities and their families.

To varying degrees, the targeted states are struggling to recruit and maintain an adequate number of qualified personnel to administer a managed care system.

A managed care system is complex, with many moving parts; and, to function effectively, these systems require the active engagement of skilled management staff at the state level. State officials who were interviewed for this report all expressed differing levels of concern about their agency's capability to recruit and retain the number and types of staff members required.

For individuals involved in a state's service delivery system, the learning curve in adapting to a newly introduced managed care system often is very steep.

A lot of re-tooling is required when a state adopts a managed care approach and not everyone adjusts well to operating in the new environment. One local managed care executive estimated, for example, that the turnover rate among care coordinators in her county was about 25 percent after the managed care program was introduced. ❖

The advice interviewees offered to stakeholders:

Stakeholders in other states were contemplating the development of a Medicaid managed LTC plan that fell into two categories: the process of designing the plan and the process of implementing the plan. Among the plan design issues highlighted by the respondents were:

Assess your state’s situation carefully before deciding to employ the principles of managed care in restructuring publicly-financed long-term services. A managed care approach might be the right answer for some, but certainly not all, states.

Make sure your plan clearly reflects the core values you aim to instill in the program. Basing the state’s managed long-term services program on a clear, unambiguous set of consumer-centered support principles provides a reference point that can be used as a guide to implementing and operating the program in the years ahead.

Involve representatives of key stakeholder groups – including self-advocates and family members – in all aspects of developing and implementing the state’s LTC reform plan. A wide range of stakeholders should be involved in the process of building a plan that will work for everyone.

Take the time to resolve potential issues during the design and initial implementation phases of the program. By doing so, you’ll avoid serious problems downstream.

The interviewees offered the following recommendations regarding plan implementation strategies:

Make sure the responsible state agency has the resources necessary to actively oversee and, if it becomes necessary, enforce performance expectations. As one state agency director put it: “Don’t even contemplate the adoption of a managed long-term services plan unless you have the administrative capacity within state government to manage and oversee the quality and appropriateness of services.”

Special initiatives are needed to ensure that the goals of community inclusion, independence and productivity are reflected in the lives of program participants. A managed care approach should result in enhanced opportunities for individuals with disabilities to live fuller, more participatory and inclusive lives in their local communities.

But, based on the comments of the interviewees, many jurisdictions across each of the focus states have made limited progress in capitalizing on these opportunities to date.

Understand the state’s primary motivations for adopting a managed care plan and focus on the actions necessary to secure the interests of people with developmental disabilities. There may be – indeed usually there are – overriding factors that lead a state to adopt a Medicaid managed long-term support plan. Lay and professional advocates for persons with developmental disabilities need to study these underlying motivations carefully and assess the likely impact on existing I/DD services. Then, they should participate in the process of developing the plan, with the stated aim of building in safeguards that protect the interests of people with disabilities

Design the plan to promote the efficient use of available resources. A primary aim of any managed care approach is to achieve efficiencies in the use of scarce resources. It is important, therefore, to utilize strategies aimed at ensuring that resources are deployed in an efficient manner.

Learn from the experiences of other state. Each state is unique and has its own set of program goals. Nonetheless, it is helpful to draw upon the experiences of other states – both their successes and their failures – in designing your state’s LTC reform strategy. ❖

The solution to this problem does not lie in ramped up rhetoric, but instead in a demonstrable commitment from all parties – spearheaded by state government – to improve the situation.

Make sure that community provider agencies have the tools and the qualifications necessary to provide high quality supports. Start-up funds and technical assistance are needed to help provider agencies – especially small “mom and pop” agencies – to transition to a managed care operating environment. In addition, workforce stabilization can’t be treated as a peripheral issue in efforts to improve the quality of services. These are the people who work directly with program participants everyday and if we are unable to offer them fair compensation, reasonable benefits, a positive work environment and recognition for their services, the ability of provider agencies to deliver quality services will be seriously compromised. ❖

Implications for Other States

Are other states likely to fold public developmental disabilities services into a Medicaid managed long-term services plan? While predicting the future course of policy is best left to soothsayers, unquestionably the nation faces enormous problems in meeting the future costs of social entitlement programs. Assuming health care costs continue to grow at the current rate, Medicare and Medicaid outlays are projected to increase as a share of the Gross National Product by five fold between now and 2050 and consume by the late 2040s the equivalent of the entire 2009 federal budget. That, as budget experts keep reminding us, is an unsustainable situation. Given the states' nearly total reliance on Medicaid dollars to finance public developmental disabilities services, it is inconceivable that state/local DD service systems will escape unscathed from any major realignment of federal social entitlement programs.

The structural shortfall in financing entitlement benefits is exacerbated by the fallout from the current financial crisis on Wall Street and the potentially deep, prolonged nationwide economic recession it has triggered. Given the circumstances, you can be sure that state policymakers will not only be looking for near term spending cuts but also examining alternative ways of controlling the growth in public outlays over the long haul. If, in their eyes, managed care appears to be a promising tool for reining in health and long-term service costs, they will find ways of using it.

The interests of people with developmental disabilities were not the

primary motivation for adopting a managed care approach in any of the four states examined during this study. And, those interests probably won't be a major factor in shaping future state Medicaid managed care proposals. States are likely to seek broad authority to operate all or most of their Medicaid programs under policies that deviate from existing federal statutes and, when they do, developmental disabilities services will be included.

Advocates for services to persons with developmental disabilities are likely to face stark choices without simple, straight-forward answers. Do you advocate for having I/DD services carved out of the plan? Or, do you join forces with other interest groups in opposing the adoption of the overall plan?

Or, do you secure a seat at the table and seek to ensure that safeguards are built into the plan to protect the interests of people with lifelong disabilities? None of these strategies are foolproof. Before adopting a strategy, therefore, advocates for DD services need to take stock of the unique circumstances facing their respective states as well as the nature of the reform proposals on the table. In mapping out such a strategy, the advice offered by the stakeholders interviewed during the course of this study represents a solid starting point.

Don't be too quick to reject a managed care approach. As the experiences of the four states that were the focus of this study reveal, a managed care plan can be a vehicle that affords eligible individuals reasonably prompt access to the long-term supports they need. And, while none of these states has completely solved

service access issues, most affected consumers and families are better off than they would be if they were living in many other states. At the same time, there is no question that hastily conceived plans that are aimed primarily at slashing state outlays can have disastrous consequences.

So what key lessons can other states learn from the experiences of Arizona, Michigan, Wisconsin, and Vermont in operating services under a managed care umbrella?

First, as Vermont and Arizona (for DD services at least) have demonstrated, having a state agency serve as the hub of a managed care system – rather than farming out this critical function to a non-governmental managed care organization(s) – makes a lot of sense if the primary goal is to protect the interests of the taxpaying public and assure ongoing public accountability for services.

Second, as Arizona's experience in particular reveals, there are clear benefits to having one state agency co-manage the provision of health, behavioral health and long-term services.

Finally, the experiences of all four states teach us the importance of a value-based policy foundation if the risk of "over-medicalizing" long-term services is to be avoided. ❖

“The experiences of all four states teach us the importance of a value-based policy foundation if the risk of “over-medicalizing” long-term services is to be avoided.”

Conclusion

Smith and Ashbaugh, in a groundbreaking 1995 analysis of potential applications of managed care within the developmental disabilities services sector, wrote:

“Whatever mistrust there might be about managed care has to be balanced against its trinity of promises: lower costs, better access, and higher quality. Curbing Medicaid payments to the states means developmental disabilities systems will face a far different fiscal landscape in the foreseeable future than has been true over the past decade. This altered [low growth] fiscal landscape has enormous implications for the health and vitality of these systems and even more profound implications for the people and families who depend on these systems for supports. In this vein, dismissing managed care makes no sense. DD service systems will need to take advantage of every tool available in order to survive and be responsive to the people they support.”

These words were written at a time when Congress appeared to be on the brink of imposing an across-the-board cap on federal Medicaid spending. Today, our nation is rapidly approaching another crisis in financing not only of Medicaid services but of other major social entitlement programs as well (e.g., Medicare; Social Security, SSI, Food Stamps, etc.). Given the circumstances, Smith and Ashbaugh’s admonition to consider all of the “arrows in our quiver” seems as relevant today as it was thirteen years ago. And, as unsettling as it may seem, managed care is one of those arrows.

Smith, Gary and John Ashbaugh, *Managed Care and People with Developmental Disabilities: A Guidebook*, National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute: Alexandria, Virginia, 1995, p. 119. ❖

References

ARIZONA. The website of the Arizona Division of Developmental Disabilities (<https://www.azdes.gov/ddd/>) contains a wide range of information regarding both the Division's general service policies and policies specific to the Arizona Long Term Care System (ALTCS). For a general layman's description of services provided by DDD, click on "Navigating the System," a consumer/family guide to DDD services (accessible from the Division's home page or by clicking on "Consumer & Family Information"). For specific information concerning ALTCS services, click on "ALTCS Member Information." Further information concerning the ALTCS program can be found on the website (<http://www.azahcccs.gov/site/>) of the Arizona Health Care Cost Containment System (AHCCCS). In particular, here you can find current ALTCS enrollment data (click on "Statistics and Studies" and then on "Statistics") or on the terms and conditions associated with Arizona's Section 1115 AHCCCS waiver agreement with the federal Centers for Medicare and Medicaid Services (CMS).

MICHIGAN. Information concerning the Specialty Services waiver program for persons with mental illnesses, developmental disabilities and substance abuse disorders can be found on the "Mental Health and Substance Abuse" web pages of the Michigan Department of Community Health (MDCH; http://www.michigan.gov/mdch/0,1607,7-132-2946_5107---,00.html). Click on the "Mental Health and Developmental Disability" link to access a variety of materials related to the Specialty Services program, including a recent DMCH concept paper on needed system-wide improvements and a draft "Application for "Renewal and Recommitment" paper spelling out the steps the department plans to take to rectify existing shortcomings in the program. Here you also can find various reports on the state's MH/DD/SA waiver program, including recent External Quality Review reports, summary reports on the findings from recent on-site reviews conducted by departmental quality review teams, and an explanation of (and findings from) DMCH's Mission-based Performance Indicator System. Finally, for information concerning the department's reporting requirements, from the "Mental Health and Substance Abuse" web page click on to "Reporting Requirements."

VERMONT. The website of the Vermont Department of Disabilities, Aging and Independent Living (DAIL) contains a wide range of materials explaining state- and federally-funded developmental disabilities services (<http://dail.vermont.gov>). From the DAIL home page, click on the icon of the Division of Disability and Aging Services; then click on the "developmental disabilities" icon, followed by the "Policies and Guidelines" link. Here you will find various documents, including DDAS' current "system of care" plan for DD services, plus the 2008 update to the plan; a copy of the department's most recent annual report on developmental disabilities services; a copy of the division's "Health and Wellness Guidelines;" and various other documents related to the operation of DD services in Vermont. For information concerning the Global Commitment to Health waiver/demonstration program, go to the website of the Office of Vermont Health Access (<http://ovha.vermont.gov>). From OVHA's home page, click on to "Administration," Then hit the link to "Global Commitment to Health." There you will find a copy of the state's original, 2005 GCH waiver request and various other, related documents. Copies of annual progress reports on the Global Commitment, as well as quarterly progress reports, also can be found at this location.

WISCONSIN. The website of the state Department of Health Services (<http://dhs.wisconsin.gov>) contains a wide range of information concerning the Family Care initiative. Click on the "Family Care" icon, located in the upper, left-hand portion of the home page. Then, click on the following sections of the Family Care web page: "Background" to obtain general information about the key operating features of the program; "Research and Reports" to obtain copies of various evaluation, quality assessment, progress and other reports on the program; "Program Operations" to obtain details on the operating components of the program as well as the current status of efforts to expand the program statewide; "State and Federal Requirements" to access a copy of the state's Section 1915(b)/(c) waiver request plus copies of state statutes and administrative rules governing the program; and "History of Long-Term Care Redesign" to access documents related to the development of the Family Care program.

Disability Rights of Wisconsin, Inc. (DRW), "Family Care Expansion Envisioning a Positive Future," a DRW position statement, March 2007. A copy of this position statement is posted on the DRW website at <http://www.disabilityrightswi.org>.

Guyer, Jocelyn, "Vermont's Global Commitment Waiver: Implications for the Medicaid Program, Issue Paper, Kaiser Commission on Medicaid and the Uninsured: Washington, D.C., April 2006.

Saucier, Paul and Wendy Fox-Grage, "Medicaid and Managed Long-Term Care, Issue Brief No. 79, AARP Public Policy Institute, 2005.

Smith, Gary and John Ashbaugh, Managed Care and People with Developmental Disabilities: A Guidebook, National Association of State Directors of Developmental Disabilities and the Human Services Research Institute: Alexandria, Virginia, 1995. ❖

The National Leadership Consortium

on Developmental Disabilities

**The National Leadership Consortium
on Developmental Disabilities**

Center for Disabilities Studies

461 Wyoming Avenue

Newark, DE 19716

Tel 302-831-8536

Fax 302-831-7220

Email nlcddonline@udel.edu

Sponsorship of this bulletin series is made possible by a generous grant from:



Liberty Healthcare

*Expertise, experience, and proven programs and support for people
with intellectual and developmental disabilities.*

Contact Mike Hanna at mhanna@libertyhealth.com

or (800) 331-7122 x 118