Know the Facts: Long Term Managed Care Options For Individuals with Developmental Disabilities & Acquired Brain Disorders

Prepared by Community Support Network Inc. (CSNI, a not for profit organization that works in support of the 10 Area Agencies throughout the state of New Hampshire that provide services to individuals with developmental disabilities and acquired brain injury and their families.

Background

The State is facing a challenging budget situation and is looking for cost-effective alternatives to providing high quality care to its Medicaid population. The Department of Health and Human Services (DHHS) is examining managed care program design, rate setting, and other related services to drive down costs and serve the growing numbers of people eligible for Medicaid supports (Source: Milliman 2008).

Currently, about 70% of the country's 58 million Medicaid enrollees receive all or part of their services through some form of managed care program. According to the Kaiser Family Foundation, 27 states have 1915(b) waiver allowing them to mandate some form of managed care for a certain population or region. However, in many states the enrollment in managed care for populations needing long term care and/or behavioral health services has been voluntary. Nationwide health care reform will encourage states to reconsider managed care options moving forward.

New Hampshire (NH) currently operates a fee-for-service program for children and adults who are eligible for Medicaid. NH discontinued a voluntary Medicaid managed care program in fiscal year 2004 after it was determined not to be cost effective. Provider Anthem was the only health plan to have participated in the voluntary managed care program.

As part of the design of a Medicaid managed care program, DHHS is considering wrapping all eligible populations statewide into a mandatory plan, including children and adults, with Developmental Disabilities (DD) and Acquired Brain Disorders (ABD) that typically require long term care services and supports. People with DD/ABD generally have long term support needs that are focused on daily, consistent habilitation. Their service patterns afford less opportunity for savings than people with episodic patterns of care – such as people with mental illness or acute medical care needs (Source: HMA 2010).

Only a few states have implemented managed care that includes long term care for people with DD and ABD. In these states, Arizona, Michigan, Vermont, and Wisconsin, the managing entity is the traditional community based providers or the state agency serving people with DD/ABD rather than commercially based Managed Care Organizations (MCOs). Each of these states has implemented a form of capitated risk-based managed care that includes institutional and HCBS waiver services for individuals with DD. Other states considering a managed care option for DD/ABD include New York, Virginia, Florida, and Texas.

NH's Medicaid Care Organization Defined and Success Criteria

A Managed Care Organization, as defined in the Senate's NH SB147-FN (1/2010), means "an entity that is authorized by law to provide covered health services on a capitated risk basis and arranges for the provision of medical assistance services and applies and coordinates the care of Medicaid recipients residing in all areas of the state, including the elderly, those meeting federal supplemental security income and state standards for disability, and those who are currently enrolled in Medicare."

For a Medicaid managed care program to be "successful" (defined as providing quality care for a lower cost than fee-for-service), several goals must be achieved (Milliman 2008):

- Medicaid managed care plans' provider reimbursement should be at or near Medicaid fee-for-service levels.
- Medicaid managed care plans must be able to reduce fee-for-service utilization by a large enough margin to cover administration and profit targets.
- Medicaid managed care plans must be able to enroll enough members to develop a critical mass and cover fixed administrative fees.

A key principle of managed care is diversion to less costly programs and services. Privatized managed care organizations typically use 20% or more of their funding revenues for program administration and many are Health Maintenance Organizations (HMOs) that are publicly traded entities who are faced with the goal of increasing profits quarter over quarter. An HMO model for managed care, with its triage assessment of needs, capped rates, and overriding cost containment practices raises questions about the potential for diminished quality of care (Source: Florida ARF 2010).

NH – Proven Model for DD/ABD Support

NH's community based, consumer driven services and supports for the DD/ABD population have maintained the lowest average cost of any New England state while ranking 34th in the country in terms of fiscal effort (Braddock, 2010). In addition, NH ranked 3rd nationally in a recently published study of Medicaid services in four key outcome measures for people with developmental disabilities (Source: UCP 2011). The UCP report also indicated that NH ranks 15th in the nation in supporting meaningful employment opportunities for those with developmental disabilities.

The 10 Area Agencies that comprise NH's service delivery system for those with DD/ABD maintain an efficient general management rate of 8.4% while managing contracts with vendor agencies and aggressively handle a growing number of Wait List clients who are eligible for services (CSNI 2011).

Services for DD/ABD include ongoing evaluation, planning, coordination and integration of services, including employment goals, to help individuals function at their greatest ability and lead quality lives. Community based, consumer driven services are utilized by a growing number of people, while residential settings are an option for a proportionally small number of intensive clients. Payments for all services are based on a fee for service model; meaning the state only pays for recognized costs that support pre-approved rates, thus avoiding fraudulent billing or increases in utilization. NH is efficiently managing the cost of DD/ABD care and has strict laws governing increases. The model is predictable and manageable. State policy, along with Federal regulation, demands intense scrutiny for eligibility.

Since the closing of the Laconia State School thirty years ago, the 10 Area Agencies have aggressively demonstrated that they can provide quality care at a low cost; especially in comparison to publicly owned, institutional based settings. Over the next 10 years, the Agencies will continue to design models for care to reduce costs by engaging more clients and families to acquire Consumer Directed Services (CDS) that have consistently proven to be lower in cost than traditional case managed services (Source: NH Bureau of Developmental Services, 2011). There are 3,655 adults receiving services right now in NH; 540 have CDS budgets, while 3,125 have non-CDS budgets. The average cost to NH for the CDS client is $39,398, while the non-CDS client is at $52,327. The 10 Area Agencies are moving more and more clients to a CDS approach to services which will drive future cost down a projected average of 25% representing a $12,298 savings per client.

Transformation and entrepreneurial spirit continue to drive NH's 10 Area Agencies to deliver high quality care models at low costs. The 10 non-profit 501c-3 Area Agencies manage the care of those with DD/ABD with an 8.4% GM (fixed administrative cost) from state-approved rates that are predictable and manageable. Intense scrutiny is given to eligibility for services by the Agencies and the practice to transfer clients into CDS will result in the potential of a 25%

reduction in costs (Source: BDS June 5, 2011) which meaningfully increases the number of waiver slots statewide for those entering services.

New York, Virginia, and Texas Considering Options

New York (NY) and Texas rely heavily on a high-cost institutional-based model of care for their DD/ABD populations and not extensively on community based supports l (Source: HMA 2010). Both states are examining options to reduce reliance on high cost institutional care models and improve the quality of life for their citizens in community-based settings. No final decisions have been made in Texas or New York at this point in time.

Texas is deliberating launching a three year pilot for managed care for those with developmental disabilities in collaboration with their state's Mental Retardation Authorities (MRAs) rather than commercial MCOs. The pilot will entail costs to the State and will not address elements of the Texas DD system that stakeholders have uniformly expressed concern with; namely the imbalance of Texas' investment in institutional services versus community based services. The managed care pilot will only address community based DD services, specifically services within the HCBS Medicaid waiver, and will not move to correct the historic imbalance in institutional care for those with DD. Before Texas can make an informed decision on whether capitation is an effective model for DD services, it must first test two assumptions: 1.) that the management of DD services offers opportunities for savings and 2.) that state MRAs (Mental Retardation Authorities), given the necessary tools and latitude, can apply tools of managed care to harness savings. Texas is considering a managed care implementation with its current delivery system of MRAs. This presents a financial risk for the MRAs, which have limited care experience, and for clients with DD since capitation creates incentives to reduce risk levels in ways that may not be clinically appropriate. Although these risks can be managed by strong state oversight and use of risk sharing arrangements, there is not enough evidence that capitation would create savings sufficient to justify the risks and effort involved with significantly restructuring the DD system (Source: HMA 2010).

New York state currently exempts from managed care "people who live in an alcohol/substance abuse program or a facility for the mentally retarded, are mentally retarded and get care from an intermediate care facility (or have health needs like a person in a facility), and have a developmental or physical disability and receives home and community based waiver services (or have health needs like a person receiving these services." (Source: New York States 1115 Waiver and NY Health Access Web Site at http://wnylc.com/health/entry/50/). NY is in the process of involving stakeholders, lawmakers, and other interested parties, as part of a mandated task force, in crafting a managed Medicaid option that provides medical and long term care services to individuals with developmental disabilities and other populations. To learn more, visit the New York Medicaid Reform Web Site at. http://www.health.ny.gov/health_care/medicaid/redesign/.

The state of Virginia, after failing to comply with the American with Disabilities Act (ADA) requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs, launched an investigation into what steps the state should take to meet its obligations under law. As part of the inquiry, it was concluded that Virginia had an institutional system model that isolated and harmed individuals with disabilities resulting in the violation of civil rights for people with disabilities and unnecessary expense. The average cost of institutionalizing a person with a disability in Virginia is $194,000 per year, while the cost of servicing the same person with a disability in the community was estimated at $76,400. As a result, Virginia must transition to a community based care model funded through the Medicaid-funded waiver program. Virginia must build community infrastructure and capacity to support the closing of its institutions. Lack of capacity puts people at risk for unnecessary institutionalization and prevents those in institutions from entering the community. As part of the recommended remedial measures of this ruling, Virginia is at the early stages of exploring programmatic changes including managed care for those with developmental disabilities (Source: US Department of Justice, Civil Right Division, 2011).

Florida – "Carving Out" Those with Developmental Disabilities

Managed care implementations are being crafted right now by Florida lawmakers. On May 7, 2011, after thoughtful consideration of a proposed Medicaid program that is designed to combat skyrocketing enrollment gains over the past two years of recession, lawmakers voted to exempt from managed care developmentally disabled Floridians now served by the Agency for Persons with Disabilities and those on its waiting list.

Florida will move to consolidate acute care and long term care Medicaid funded services, for the elderly only, under a fully integrated care model. A June 2009 report entitled *Medicaid Reform: Legislature Should Delay Expansion until More Information is Available to Evaluate Success (#09-29), Florida's Office of Program Policy Analysis and Government Accountability (OPPGA)* stated: "Little data is yet available on whether Medicaid Reform has produced cost savings or is more cost-effective than traditional Medicaid. We recommend that the Legislature not expand Medicaid Reform until more information is available. In addition, expanding a pilot would be costly to the state at a time when state revenues are experiencing shortfalls."

Note that Florida's average monthly enrollment for individuals with DD in Medicaid waiver programs for Fiscal Year 2009-2010 was 29,920 clients with average total waiver expenditures of $77,350,131. Florida has looked into implementation in four other states – Arizona, Michigan, North Carolina, and Wisconsin – that have programs that vary in enrollment from 500 in Wisconsin to 39,000 in Michigan. Florida reports concerns with rate setting and risk assumption for these four states since there is little history on how to capitate these programs (Source: The Florida Senate December 2010).

State lawmakers supported the "carve out" of Medicaid reform for programs that serve individuals with developmental disabilities so as not to put themselves in the position of "Trying to fix something that is not broken." (Sources: Florida ARF 2010 and The Palm Beach Post News, May 2011).

Vermont – Cautiously Adopting (excerpted directly from HMA 2010)
Vermont is operating its entire Medicaid program, except long term care for elders and adults with physical disabilities, under a Section 1115 Waiver: The Global Commitment Waiver. The state Medicaid agency has entered into a managed care arrangement with the federal government; essentially, the state Medicaid program is the managed care organization.

The waiver's sole impact on the agency serving individuals with I/DD is to leverage Medicaid matching funds for two previously unmatched service types: employment supports and family supports. Services remain fee for service, and there are no Medicaid HMOs in Vermont. The additional federal financial participation that results from matching family support funding is returned to the waiver and not specifically to the agency responsible for serving individuals with I/DD. (Division of Disability and Aging Services, Department of Disabilities, Aging & Independent Living, Developmental Disability Services).

Vermont has no ICFs/MR and no residents with I/DD in state institutions. Vermont has implemented a "priority" system (State System of Care Plan) for provision of services and supports for individuals with DD. In FY 2008, the Vermont Division of Disability and Aging Services provided supports to 3,545 people with developmental disabilities in Vermont.

There were 241 people on Vermont's Applicant List at the end of June 2008, representing people who are eligible for services based on their disability but whose needs do not meet the State System of Care Plan's funding priorities.

Wisconsin – Lessons Learned (excerpted directly from HMA 2010)
Wisconsin operates two managed care programs that include long term care services: Family Partnership (Partnership) and Family Care. Partnership includes all Medicaid services and predominantly serves elders. Family Care is the larger program and serves a larger proportion of individuals with DD. Family Care was implemented in 2000 and operates under the authority of a 1915(b) waiver and two 1915(c) waivers (one for elders and individuals with physical disabilities

and the other for individuals with DD). Family Care began as a pilot and is now operating in 53 counties with the enrollment of 26,000 individuals.

Family Care covers long term care (including nursing homes, ICF/MR and HCBS waiver services), behavioral health services, and state plan HCBS, such as home health and therapies, but not acute care services. Family Care MCOs must be certified by the Wisconsin Department of Health Services as meeting all requirements for statute and rule including requirements related to adequacy of the network, expertise in long term care and the ability to manage a network within the capitation payment. In addition, MCOs must demonstrate capacity for financial solvency and stability. The MCOs are not required to be HMOs.

Family Care implementation is typically preceded by up to three years or longer of planning in the region(s) where implementation is scheduled. In addition, Wisconsin state staff have a very close relationship with MCOs. The State reports that daily contact with the MCOs to respond to questions and provide technical assistance is typical. Once Family Care is fully implemented in a county or region, HCBS become an entitlement.

Family Care is one aspect of Wisconsin's long term care system transformation. The State has also implemented a comprehensive nursing facility and ICF/MR restructuring program and a State Center reduction initiative. ICF/MR restructuring includes mandated court review of each Individuals' community based plan. If the court finds that the community is the most integrated setting suited to the individual with DD's needs, the court orders community services. Counties must serve the individual in the community in accordance with the court finding or assume 100 percent of the cost of institutional care. Since starting this restructuring in 2006, more than 50 percent of ICFs/MR have closed.

HCBS are an entitlement in Wisconsin once Family Care is fully implemented in a county or region. The entitlement was authorized by the Wisconsin legislature. Wisconsin serves over 26,000 persons in Family Care; about 9,100 are persons with I/DD. The State believes their overall long term care program changes are rebalancing the long term care system. Initial evaluations have found Family Care to be cost effective overall and to achieve savings in some areas and for some groups.

Arizona – Evolving and Testing (excerpted directly from HMA 2010)

Arizona's Medicaid program for those with DD operates under a unique, statewide managed care structure known as the Arizona Health Care Cost Containment System (AHCCCS). Medicaid recipients with long term care needs receive all their Medicaid services, including home and community based services (HCBS) and institutional services, under a managed care arrangement overseen by the Arizona Long Term Care System (ALTCS), a part of Medicaid. ALTCS is "split" into two population groups: 1.) aged person and person with physical disabilities and 2.) persons with DD.

ALTCS contract with nine contractors to provide most Medicaid services, including long term care and behavioral health services, through managed care contracts. Eight of the contractors are regional health plans that provide acute/medical services to aged persons and persons with physical disabilities. Arizona serves 22,339 ALTCS members with DD.

The ninth, remaining contractor is the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES is a separate agency from Medicaid and is the statutorily-authorized division responsible for providing services to those with DD. DDD is required by state statute to contract with Arizona Medicaid (and vice-versa). DDD negotiates a managed care contract with AHCCS. The contract specifies DDD's responsibilities for Medicaid members with DD who have long term care needs. DDD is responsible for delivering and arranging for delivery of all services including monthly capitation for acute care services, behavioral health services provided through Regional Behavioral Health Agencies, and long term

care services including HCBS for persons with DD; provided fee for service by HCBS providers that serve people with DD.

Approximately 85% of Arizonians with DD served by ALTCS reside in their own home, a family home or a shared home (not owned or leased by a provider). Three percent reside in state institutions. HCBS are an entitlement in Arizona authorized by the Arizona legislature and available to individuals with DD at "immediate risk to institutionalization." According to Arizona Medicaid, substantial cost savings have been achieved by ALTCS even with the entitlement to HCBS.

Michigan – Building Community Supports Gradually (excerpted directly from HMA 2010)
Michigan implemented a managed long term care program, the Michigan Managed Specialty Services and Support Program (MSSSP), in 1998. Michigan serves over 219,000 persons through managed care with 39,000 classified with DD. All services are delivered through Prepaid Inpatient Health Plans (PIHPs). PIHPs are delivered through Community Mental Health Services Programs (CMHSPs) that are county-based organizations serving people with mental illness, substance abuse or DD. PIHPs are selected through competitive procurement, but the procurement is open to non-CMHSP providers only if the CMHSP in a service area is able to enter a contract with the state. To date this has not occurred.

PIHPs receive capitated per member per month payments for Medicaid behavioral health, substance abuse, and long term care services, including HCBS waiver services. The HCBS waiver services are available only to individuals with DD. Since 2010, PIHPs have received two managed care payments each month for Medicaid covered services. One payment based on Medicaid eligibles with the region and cover mental health, developmental disability, and substance abuse state services; including targeted case management and special children's Medicaid services. The second payment is based on the subset of Medicaid eligibles that are also enrolled in Habilitation Support Waiver (persons with DD served in residential group homes) and covers the cost of these services.

There is only one institutional unit serving individuals with DD which is housed at the Michigan psychiatric hospital. In 1978, Michigan set out to develop community care options and legislation was enacted to change zoning laws statewide to permit construction of 6-bed residential homes anywhere in the state. The objective was to replace institutions with smaller residential homes so 700-800 homes, operated as cost based providers, were created; typically operating under contract to state institutions. With the advent of MSSSP in 1998, the state moved to convert these residential facilities to HCBS waiver homes (foster homes) and to move people with DD whenever possible to community based setting or to remain with their families with supports.

Michigan's system is being built gradually and has some way to go for trust to be developed to implement true community based care in homes with families. Thus far, the quality of care improvements have been favorable despite bumps in the road.

The Four States Compared (see *Comparison of Key Features from 4 Study States*, Source: HMA 2010)
Institutional and ICF/MR Beds Have Been Substantially Reduced or Almost Eliminated. The four states reviewed have transitioned, or are close to transitioning, out of the private or state ICF/MR "residential" model to HCBS waiver residential settings and to individuals' homes and other supported living arrangements. They have also either substantially reduced their state institutional population or are in the process of doing so.

HCBS Are an Entitlement in Arizona, Michigan and Wisconsin. Arizona and Michigan offer HCBS to all individuals who meet an institutional level of care. Wisconsin also offers HCBS as an entitlement once Family Care is fully implemented in a region or county, which typically takes up to three years.

Traditional I/DD Providers Are the Managed Care Organization in Two States. The two states implementing risk based managed care for institutional and HCBS services for persons with DD (Michigan and Wisconsin) either contract exclusively with managed care organizations that were the traditional providers (Michigan) or include these providers (Wisconsin) as eligible MCOs.

Move toward Regionalization. Michigan and Wisconsin Have Regionalized some Aspects of Their Programs. Michigan has 49 Community Mental Health Service Programs (CMHSPs) but 18 Prepaid Inpatient Health Plans (PIHPs). The CMHSPs had (since the mid 1980s) been operating under a "global budget" comprised of multiple state and federal funding streams. The regionalization of the 49 CMHSPs in order to form the PIHPs provided a more efficient and financially viable system for delivery of the contracted services and management of funds and permitted expansion of HCBS to individuals who did not meet institutional level of care (funded from the savings achieved through managed care). The CMHSPs continue to function as the single entry points for access to behavioral health and I/DD services.

In Wisconsin, some counties have formed Long Term Care Districts (originally called Family Care Districts), which are regional units of government created specifically to plan and administer services to eligible frail elderly people and people with physical and developmental disabilities. The Long Term Care Districts may elect to become either a Resource Center providing information and referral, eligibility determination and case management services, or a Family Care managed care organization (called Care Management Organizations in Wisconsin), but may not be both.

Cost Savings? According to Arizona Medicaid, substantial cost savings have been achieved by ALTCS even with the entitlement to HCBS. Arizona Medicaid estimated that although savings were reduced as a result of expanding access to HCBS, they were still substantial, approaching $870 million in 2006 (compared to an estimated savings of $992 million if access to HCBS had been limited). However, Arizona supports the vast majority of persons with I/DD in home settings (non-provider owned). Arizona also has a rigorous preadmission screening and targeting program that identifies persons at "immediate risk" of institutionalization, which likely contributes to cost savings.

A 2005 study by APS Healthcare examined Wisconsin's Family Care costs during a two year period and concluded that all but two of the Family Care groups had total long term care costs less than their comparison group counterparts (individuals with physical disabilities and those members with no prior waiver experience before enrollment in Family Care in the four non Milwaukee County CMOs). The study also revealed that Family Care produces Medicaid savings both directly by controlling service costs and indirectly by favorably affecting Family Care members' health and abilities to function so that they have less need for services. The only Family Care group for which average individual monthly costs did not differ significantly from comparison group individuals were individuals with developmental disabilities in the non Milwaukee CMO counties.

In state fiscal year 2002, Michigan spent $1.8 billion on specialty services, serving over 195,000 people. Total Medicaid capitation payments were $1.52 billion, and grant awards totaled $318 million. These funds served over 161,000 people with mental illness and over 31,000 people with developmental disabilities. An independent evaluation concluded that the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were $0.01 per eligible person per month (PEPM), savings for addiction disorders services were $0.12 PEPM, and savings for developmental disabilities services were $10.16 PEPM.5

There is some disagreement among researchers concerning the validity of the cost savings estimates associated with managed long term care as well as the "transferability" of savings

from state to state. In "The Cost Effectiveness of Non-institutional Long Term Care Services: Review and Synthesis of the Most Recent Evidence" (2006), Gabrowski notes that "Although the recent literature did not unequivocally support any one model, managed care and consumer directed care were both identified as potential mechanisms toward providing services more efficiently, although this conclusion hinges on the specific features of the various programs." He notes that most prior evaluations have had methodological problems and that new evaluations using more rigorous analytical models are needed to provide a more accurate savings analysis.

In the same study, it was noted that home and community based services help people with disabilities stay in their homes while reducing long term care spending. The authors found that over the long term, growth in long term care spending for states with well established non-institutional programs saw much less spending growth than states with minimal non-institutional services. There is an initial period of HCBS when overall LTC spending increases at a faster rate because of a lag in reduced institutional spending. This finding perhaps argues for the more aggressive rebalancing efforts as undertaken in states like Michigan and Wisconsin in order to accelerate reduced institutional spending.

Wisconsin has noted that several of the MCOs have incurred operating deficits as the program expanded from 5 pilot counties to 53 counties as of June 2010. Three MCOs have been identified as an increased risk for insolvency. Despite increases in capitation amounts they are paid, the MCOs contend that capitation amounts are not sufficient to pay for all necessary services, in part because of increasing numbers of participants with high cost needs. High-cost participants represented 16.9% of the total caseload for FY2009-2010, and the number of participants with developmental disabilities, who tend to require more expensive care than elders or those with physical disabilities in the Wisconsin model, represented 41.2% of the total caseload that fiscal year. Its cost-effectiveness remains difficult to assess, in part because the type and quality of services available under Family Care may be prompting enrollment by some individuals who would otherwise not seek public assistance. The Governor's 2011-13 biennial budget proposal caps Family Care enrollment at existing levels, pending results of this evaluations (Source: An Evaluation Family Care, April 2011).

Closing Thoughts

As NH considers long term managed care for those with DD/ABD, the State should consider if a managed care option will meet the following goals as recognized by nationally noted consulting group Health Management Associates (HMA) and industry leader Allan Bergman (Curriculum Vitae: http://www.thearc.org/document.doc?id=2501):

- Increase consumer access to services by increasing waiver slots
- Promote high quality care
- Encourage and allow for consumer choice and direction
- Deliver services in a cost-efficient manner
- Prevent unnecessary institutionalization
- Allow for coordinated care across service delivery systems and
- Take full advantage of the current infrastructure

A successful managed care program for those with DD/ABD in New Hampshire will meet, and hopefully exceed, these goals while at the same time, achieving greater savings than the current regionally based 10 Area Agency delivery system.

In addition, NH should consider, like Florida, New York, and Texas, what the up front cost will be for implementing managed care and should consider pilot operations like those conducted in the 4 pioneer states. Ultimately, NH does not want to "throw the baby out with the bathwater" and experience intense learning costs like Wisconsin.

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